ATI RN MATERNAL PRACTICE PROCTORED 2023 RETAKE EXAM WITH NGN WUESTIONS AND ANSWERS WITH RATIONALES (VERIFIED REVISED)

A nurse is caring for a client who is to receive oxytocin to augment her labor. Which of the following findings contraindicates the initiation of the oxytocin infusion and should be reported to the provider? - Late decelerations

Late decelerations are indicative of uteroplacental insufficiency. Therefore, this is a contraindication for the administration of oxytocin and should be reported to the provider.

A nurse is caring for a client who is 32 weeks of gestation and has gonorrhea. The nurse should identify that the client is at an increased risk for which of the following complications? - Premature rupture of membranes

The nurse should identify that a client who is pregnant and has gonorrhea is at an increased risk for premature rupture of membranes, chorioamnionitis, preterm birth, neonatal sepsis, and intrauterine growth restriction.

A nurse is performing a vaginal examination on a client who is in labor and observes the umbilical cord protruding from the vagina. After calling for assistance, which of the following actions should the nurse take? - Insert two gloved fingers into the vagina and apply upward pressure to the presenting part.

The nurse should quickly apply gloves and insert two fingers into the vagina toward the cervix, exerting upward pressure onto the presenting part to relieve umbilical cord compression and increase oxygenation to the fetus.

A nurse is teaching a client who is at 37 weeks of gestation and has a prescription for a nonstress test. Which of the following instructions should the nurse include? - "You should press the handheld button when you feel your baby move."

The nurse should instruct the client to press the handheld button when the fetus moves. This action will mark the fetal monitor tracing with the client's reports of fetal movement. This will assist in the interpretation of the nonstress test to determine if it is reactive or nonreactive.

A nurse in a provider's office is reviewing the medical record of a client who is in the first trimester of pregnancy. Which of the following findings should the nurse identify as a risk factor for the development of preeclampsia? - Pregestational diabetes mellitus

Pregestational diabetes mellitus increases a client's risk for the development of preeclampsia. Other risk factors include preexisting hypertension, renal disease, systemic lupus erythematosus, and rheumatoid arthritis.

A nurse is assessing a client who is at 38 weeks of gestation during a weekly prenatal visit. Which of the following findings should the nurse report to the provider? - Weight gain of 2.2 kg (4.8 lb)

A weight gain of 2.2 kg (4.8 lb) in a week is above the expected reference range and could indicate complications. Therefore, this finding should be reported to the provider.

A nurse is performing a physical assessment of a newborn upon admission to the nursery. Which of the following manifestations should the nurse expect? (SATA) - Acrocyanosis

Positive Babinski reflex

Two umbilical arteries visible

A nurse is caring for a client who is at 38 weeks of gestation. Which of the following actions should the nurse take prior to applying an external transducer for fetal monitoring? - Perform Leopold maneuvers.

The nurse should perform Leopold maneuvers to assess the position of the fetus to best determine the optimal placement for the external fetal monitoring transducer.

A nurse in a prenatal clinic is assessing a group of clients. Which of the following clients should the nurse see first? - A client who is at 11 weeks of gestation and reports abdominal cramping

When using the urgent vs nonurgent approach to client care, the nurse should determine that the priority finding is a client who is at 11 weeks of gestation and reports abdominal cramping. Abdominal cramping can indicate an ectopic pregnancy or manifestations of spontaneous abortion. The nurse should request that the provider see this client first.

A nurse is caring for a client who is at 30 weeks of gestation and has a prescription for magnesium sulfate IV to treat preterm labor. The nurse should notify the provider of which of the following adverse effects? - Respiratory rate 10/min

The nurse should report a respiratory rate of less than 12/min to the provider, because this is a manifestation of magnesium toxicity. The nurse should ensure that the antidote, calcium gluconate, is readily available.

A nurse is assessing a newborn who is 16 hr old. Which of the following findings should the nurse report to the provider? - Substernal retractions

The nurse should identify that substernal retractions, apnea, grunting, nasal flaring, and tachypnea are manifestations of neonatal infection or respiratory distress in the newborn. The nurse should report these findings to the provider for immediate intervention.

A nurse is caring for a client who is at 36 weeks of gestation and has a positive contraction stress test. The nurse should plan to prepare the client for which of the following diagnostic tests? - Biophysical profile

A positive contraction stress test indicates that further evaluation of the fetus is necessary. A biophysical profile will provide further evaluation with a real-time ultrasound.

A nurse is developing a plan of care for a client who has preeclampsia and is receiving magnesium sulfate via a continuous IV infusion. Which of the following interventions should the nurse include in the plan? - Monitor the FHR continuously.

Magnesium sulfate, which is used to prevent seizures in clients who have preeclampsia, is a high-alert medication that requires close monitoring. The FHR and uterine contractions should be monitored continuously while the client is receiving magnesium sulfate.

A nurse is caring for a client who is receiving heparin via a continuous IV infusion for thrombophlebitis in her left calf. Which of the following actions should the nurse take? - Maintain the client on bed rest.

The client should remain on bed rest to decrease the risk of dislodging the clot, which could cause a pulmonary embolism. Elevation of the affected leg is recommended.

A nurse in an antepartum clinic is providing care for a client who is at weeks of gestation. Upon reviewing the client's medical record, which of the following findings should the nurse report to the provider? - Fundal height measurement

A fundal height measurement of 30 cm should be reported to the provider. Fundal height should be measured in centimeters and is the same as the number of gestational weeks plus or minus 2 weeks from 18 to 32 weeks gestation. Therefore, the nurse should report this finding to the provider.

A nurse is admitting a client to the labor and delivery unit when the client states, "My water just broke." Which of the following interventions is the nurse's priority? - Begin FHR monitoring.

The greatest risk to the client and her fetus following a rupture of membranes is umbilical cord prolapse. The nurse should monitor the fetus closely to ensure well-being. Therefore, this is the priority action the nurse should take.

A nurse is providing discharge teaching to a client who had a cesarean birth 3 days ago. Which of the following instructions should the nurse include? - "You can still become pregnant if you are breastfeeding."

The nurse should instruct the client that breastfeeding does not prevent ovulation. Therefore, the client can become pregnant. The nurse should discuss contraception that is safe to use while breastfeeding.

A nurse is assessing a client who has gestational diabetes mellitus and is experiencing hyperglycemia. Which of the following findings should the nurse expect? - Reports increased urinary output

Increased urinary output, nausea and vomiting, reports of thirst, abdominal pain, constipation, drowsiness, and headaches are manifestations of hyperglycemia. Other manifestations include weak

rapid pulse, fruity breath odor, urine positive for sugar and acetone, and a blood glucose level greater than 200 mg/dL.

A nurse is assessing four newborns. Which of the following findings should the nurse report to the provider? - A newborn who is 18 hr old and has an axillary temperature of 37.7° C (99.9° F)

An axillary temperature greater than 37.5° C (99.5° F) is above the expected reference range for a newborn and can be an indication of sepsis. Therefore, the nurse should report this finding to the provider.

A nurse is caring for a client who is at 15 weeks of gestation, is Rh-negative, and has just had an amniocentesis. Which of the following interventions is the nurse's priority following the procedure? - Monitor the FHR.

The greatest risk to this client and her fetus is fetal death. Therefore, the priority nursing intervention is to monitor the FHR following an amniocentesis.

A nurse is caring for a patient who has hyperemesis gravidarum and is receiving IV fluid replacement. Which findings should the nurse report to HCP? - BUN 25 mg/dL

The nurse should report an elevated BUN to the provider since it can indicate dehydration.

A nurse is caring for a client who's 26 weeks gestation and has epilepsy. The nurse enters the room and observes the patient having a seizure. After turning patient's head to one side, which actions should the nurse take immediately after the seizure? - Administer oxygen via a nonrebreather mask.

When using the airway, breathing, and circulation approach to client care, the nurse should place the priority on administering oxygen to the client via a nonrebreather mask at 10 L/min to ensure adequate oxygenation to the fetus.

A nurse is assessing a late preterm newborn. Which of the following manifestations is an indication of hypoglycemia? - Respiratory distress