VERSION 2

A nurse in a health clinic is reviewing contraceptive use with a group of adolescent clients. Which of the following statements by an adolescent reflects an understanding of the teaching?
A. "A water-soluble lubricant should be used with condoms."
B. "A diaphragm should be removed 2 hours after intercourse."
C. "Oral contraceptives can worsen a case of acne."
D. "A contraceptive patch is replaced once a month."

A nurse is instructing a client who is taking an oral contraceptive about danger signs to report to her provider. The nurse determines the client understands the teaching when the client states the need to report which of the following?
A. Reduced menstrual flow.
B. Breast tenderness.
C. Shortness of breath.
D. Headaches.

A nurse in an obstetrical clinic is teaching a client about using an IUD for contraception. Which of the following statements by the client indicates an understanding of the teaching?
A. "An IUD should be replaced annually during a pelvic exam."

B. "I cannot get an IUD until after I've had a child."
C. "I should expect intermittent abdominal pain while the IUD is in place."
D. "A change in the string length of my IUD is expected."

A nurse is teaching a client about potential adverse effects of implantable progestins. Which of the following adverse effects should the nurse include? (SATA)
A. Tinnitus.
B. Irregular vaginal bleeding.
C. Weight gain.
D. Breast changes.
E. Gingival hyperplasia.

A nurse in a clinic is teaching a client about her new prescription for medroxyprogesterone. Which of the following information should the nurse include in the teaching? (SATA)
A. "Weight loss can occur."
B. "You are protected against STIs."
C. "You should increase your intake of calcium."
D. "You should avoid taking antibiotics."
E. "Irregular vaginal spotting can occur."

A nurse in a clinic is caring for a group of female clients who are being evaluated for infertility. Which of the following clients should the nurse anticipate the provider will refer to a genetic counselor?
A. A client whose sister has alopecia.
B. A client whose partner has von Willebrand disease.
C. A client who has an allergy to sulfa.
D. A client who had rubella 3 months ago.

C. "The man is the easiest to assess, and the provider will usually begin there."
A nurse is caring for a couple who is being evaluated for infertility. Which of the following statements by the nurse indicates understanding of the infertility assessment process?
A. "You will need to see a genetic counselor as part of the assessment."
B. "It is usually the woman who is having trouble, so the man doesn't have to be involved."
C. "The man is the easiest to assess, and the provider will usually begin there."
D. "Think about adopting first because there are many babies that need good homes."

A. Occupation.
B. Menstrual history.
C. Childhood infectious diseases.
A nurse in an infertility clinic is providing care to a couple who has been unable to conceive for 18 months. Which of the following data should be included in the assessment? (SATA)

A. Occupation.
B. Menstrual history.
C. Childhood infectious diseases.
D. History of falls.
E. Recent blood transfusions.

A. "It is good to know that I won't have a tubal pregnancy in the future."
A nurse in a clinic is caring for a client who is to be seen by the provider for a postoperative appointment following a salpingectomy due to an ectopic pregnancy. Which of the following statements by the client requires clarification?
A. "It is good to know that I won't have a tubal pregnancy in the future."
B. "The doctor said that this surgery can affect my ability to get pregnant again."
C. "I understand that one of my fallopian tubes had to be removed."
D. "Ovulation can still occur because my ovaries were not affected."
A. January 8.
A nurse is caring for a client who is pregnant and states that her last menstrual period was April 1st. Which of the following is the client's estimated date of delivery?
A. January 8.
B. January 15.
C. February 8.
D. February 15.
A. Client has delivered one newborn at term.
D. Client has had two prior pregnancies.
E. Client has one living child.
A nurse in a prenatal clinic is caring for a client who is in the first trimester of pregnancy. The client's health record includes this data: G3 T1 P0 A1 L1. How should the nurse interpret this information? (SATA)
A. Client has delivered one newborn at term.
B Client has experienced no preterm labor.
C. Client has been through active labor.
D. Client has had two prior pregnancies.
E. Client has one living child.
B. Goodell's sign.
C. Ballottement.
D. Chadwick's sign.
A nurse is reviewing the health record of a client who is pregnant. The provider indicated the client exhibits probable signs of pregnancy. Which of the following findings should the nurse expect? (SATA)
A. Montogomery's glands.
B. Goodell's sign.
C. Ballottement.
D. Chadwick's sign.
E. Quickening.
C. "This is due to the weight of the uterus on the vena cava."

A nurse in a prenatal clinic is caring for a client who is pregnant and experiencing episodes of maternal hypotension. The client asks the nurse what causes these episodes. Which of the following responses should the nurse make?
A. "This is due to an increase in blood volume."
B. "This is due to pressure from the uterus on the diaphragm."
C. "This is due to the weight of the uterus on the vena cava."
D. "This is due to increased cardiac output."

D. "You should collect urine from the first morning void."
A nurse in a clinic receives a phone call from a client who believes she is pregnant and would like to be tested in the clinic to confirm her pregnancy. Which of the following information should the nurse provide to the client?
A. "You should wait until 4 weeks after conception to be tested."
B. "You should deb off any medications for 24 hours prior to the test."
C. "You should be NPO for at least 8 hours prior to the test."
D. "You should collect urine from the first morning void."

C. Perform the pelvic rock exercise every day.
D. Use proper body mechanics.
A nurse is teaching a group of women who are pregnant about measures to relieve backache during pregnancy. Which of the following measures should the nurse include in the teaching? (SATA)
A. Avoid any lifting.
B. Perform kegel exercises twice a day.
C. Perform the pelvic rock exercise every day.
D. Use proper body mechanics.
E. Avoid constrictive clothing.

A. Vaginal bleeding.
A nurse is caring for a client who is pregnant and reviewing signs of complications the client should promptly report to the provider. Which of the following complications should the nurse include in the teaching?
A. Vaginal bleeding.
B. Swelling of the ankles.
C. Heartburn after eating.
D. Lightheadedness when lying on back.

A. Eat crackers or plain toast before getting out of bed.
A client who is at 7 weeks of gestation is experiencing nausea and vomiting in the morning. Which of the following information should the nurse include in the teaching?
A. Eat crackers or plain toast before getting out of bed.
B. Awaken during the night to eat a snack.
C. Skip breakfast and eat launch after nausea has subsided.
D. Eat a large evening meal.

A. Breast tenderness.
B. Urinary frequency.
C. Epistaxis.
A nurse is teaching a client who is at 6 weeks of gestation about common discomforts of pregnancy. Which of the following findings should the nurse include in the teaching? (SATA)
A. Breast tenderness.
B. Urinary frequency.
C. Epistaxis.
D. Dysuria.
E. Epigastric pain.

B. "It is normal to have these feelings during the first few months of pregnancy."
A client who is at 8 weeks of gestation tells the nurse that she isn't sure she is happy about being pregnant. Which of the following responses should the nurse make?
A. "I will inform the provider that you are having these feelings."
B. "It is normal to have these feelings during the first few months of pregnancy."
C. "You should be happy that you are going to bring new life into the world."
D. "I am going to make an appointment with the counselor for you to discuss these thoughts."

A. Dark green leafy vegetables.
A nurse in a prenatal clinic is providing education to a client who is in the 8th week of gestation. The client states that she does not like milk. Which of the following foods should the nurse recommend as a good source of calcium?
A. Dark green leafy vegetables.
B. Deep red or orange vegetables.
C. White breads and rice.
D. Meat, poultry, and fish.

B. 3.6kg (8lb) weight gain and is in her first trimester.
A nurse in a prenatal clinic is caring for four clients. Which of the following clients' weight fain should the nurse report to the provider?
A. 1.8kg (4 lb) weight gain and is in her first trimester.
B. 3.6kg (8 lb) weight gain and is in her first trimester.
C. 6.8kg (15 lb) weight gain and is in her second trimester.
D. 11.3kg (25 lb) weight gain and is in her third trimester.

D. Neural tube defects.
A nurse in a clinic is teaching a client of childbearing age about recommended folic acid supplements. Which of the following defects can occur in the fetus or neonate as a result of folic acid deficiency?
A. Iron deficiency anemia.
B. Poor bone formation.

C. Macrosomic fetus.
D. Neural tube defects.

D. Orange juice.
A nurse is reviewing a new prescription for iron supplements with a client who is in the 8th week gestation and has iron deficiency anemia. Which of the following beverages should the nurse instruct the client to take the iron supplements with?
A. Ice water.
B. Low-fat or whole milk.
C. Tea or coffee.
D. Orange juice.

D. "I will continue my calcium supplements because I don't like milk."
A nurse is reviewing postpartum nutrition needs with a group of new mothers who are breastfeeding their newborns. Which of the following statements by a member of the group indicates an understanding of the teaching?
A. "I am glad I can have my morning coffee."
B. "I should tai folic acid to increase my milk supply."
C. "I will continue adding 330 calories per day to my diet."
D. "I will continue my calcium supplements because I don't like milk."

B. Fetal breathing movement.
C. Fetal tone.
E. Amniotic fluid volume.
A nurse is reviewing findings of a client's biophysical profile (BPP). The nurse should expect which of the following variables to be included in this test? (SATA)
A. Fetal weight.
B. Fetal breathing movement.
C. Fetal tone.
D. Fetal position.
E. Amniotic fluid volume.

A. Alpha-fetoprotein (AFP).
A nurse is caring for a client who is in preterm labor and is scheduled to undergo an amniocentesis. The nurse should evaluate which of the following tests to assess fetal lung maturity?
A. Alpha-fetoprotein (AFP).
B. Lecithin/sphingomyelin (L/S) ratio.
C. Kleihauer-betke test.
D. Indirect coombs' test.
D. "It awakens a sleeping fetus."
A nurse is caring for a client who is pregnant and undergoing a non stress test. The client asks why the nurse is using an acoustic vibration device. Which of the following responses should the nurse make?

A. "It is used to stimulate uterine contractions."
B. "It will decrease the incidence of uterine contractions."
C. "It lulls the fetus to sleep."
D. "It awakens a sleeping fetus."

C. "You should empty your bladder prior to the procedure."
A nurse is teaching a client who is pregnant about the amniocentesis procedure. Which of the following statements should the nurse include in the teaching?
A. "You will lay on your right side during the procedure."
B. "You should not eat anything for 24 hours prior to the procedure."
C. "You should empty your bladder prior to the procedure."
D. "The test is done to determine gestational age."

A. Decreased fetal movement.
B. Intrauterine growth restriction (IUGR).
C. Postmaturity.
A nurse is caring for a client who is pregnant and is to undergo a contraction stress test (CST). Which of the following findings are indications of this procedure? (SATA)
A. Decreased fetal movement.
B. Intrauterine growth restriction (IUGR).
C. Postmaturity.
D. Placenta previa.
E. Amniotic fluid emboli.

B. Ectopic pregnancy.
A nurse in the emergency department is caring for a client who reports abrupt, sharp, right-sided lower quadrant abdominal pain and bright red vaginal bleeding. The client states she missed one menstrual cycle and cannot be pregnant because she has an intrauterine device. The nurse should suspect which of the following?
A. Missed abortion.
B. Ectopic pregnancy.
C. Severe preeclampsia.
D. Hydatidiform mole.

B. Blunt abdominal trauma.
C. Cocaine use.
E. Cigarette smoking.
A nurse is providing care for a client who is diagnosed with a marginal abruptio placentae. The nurse is aware that which of the following findings are risk factors for developing the condition? (SATA)
A. Fetal position.
B. Blunt abdominal trauma.
C. Cocaine use.

D. Maternal age.
E. Cigarette smoking.

A. Betamethasone.
A nurse is providing care for a client who is at 32 weeks of gestation and who has a placenta previa. The nurse notes that the client is actively bleeding. Which of the following types of medications should the nurse anticipate the provider will prescribe?
A. Betamethasone.
B. Indomethacin.
C. Nifedipine.
D. Methylergonovine.

C. Hydatidiform mole.
A nurse at an antepartum clinic is caring for a client who is at 4 months of gestation. The client reports continued nausea and vomiting and scant, prune-colored discharge. She has experienced no weight loss and has a fundal height large than expected. Which of the following complications should the nurse suspect?
A. Hyperemesis gravidarum.
B. Threatened abortion.
C. Hydatidiform mole.
D. Preterm labor.

D. Report of severe shoulder pain.
A nurse is caring for a client who has a diagnosis of ruptured ectopic pregnancy. Which of the following findings is seen with this condition?
A. No alteration in meses.
B. Transvaginal ultrasound indicating a fetus in the uterus.
C. Serum progesterone greater than the expected reference range.
D. Report of severe shoulder pain.

A. Episiotomy.
C. Forceps.
E. Internal fetal monitoring.
A nurse is admitting a client who is in labor and has HIV. Which of the following interventions should the nurse identify as contraindicated for this client? (SATA)
A. Episiotomy.
B. Oxytocin infusion.
C. Forceps.
D. Cesarean birth.
E. Internal fetal monitoring.

A. Joint pain.
B. Malaise.
C. Rash.
E. Tender lymph nodes.

A nurse in an antepartum clinic is assessing a client who has a TORCH infection. Which of the following findings should the nurse expect? (SATA)
A. Joint pain.
B. Malaise.
C. Rash.
D. Urinary frequency.
E. Tender lymph nodes.

A. Ceftiaxone.

A nurse is caring for a client who has gonorrhea. Which of the following medications should the nurse anticipate the provider will prescribe?
A. Ceftiaxone.
B. Fluconazole.
C. Metronidazole.
D. Zidovudine.

A. Gonorrhea.
B. Chlamydia.
C. HIV.
D. Group B streptococcus beta-hemolytic.

A nurse is caring for a client who is in labor. The nurse should identify that which of the following infections can be treated during labor or immediately following birth? (SATA)
A. Gonorrhea.
B. Chlamydia.
C. HIV.
D. Group B streptococcus beta-hemolytic.
E. TORCH infection.

D. "A woman should avoid consuming undercooked meat while pregnant."

A nurse manager is reviewing ways to prevent a TORCH infection during pregnancy with a group of newly licensed nurses. Which of the following statements by a nurse indicates understanding of the teaching?
A. "Obtain an immunization against rubella early in pregnancy."
B. "Seek prophylactic treatment if cyomegalovirus is detected during pregnancy."
C. "A women should avoid crowded places during pregnancy."
D. "A woman should avoid consuming undercooked meat while pregnant."

A. Obesity.
B. Multifetal pregnancy.
D. Migraine headache.

A nurse is caring for a client who is at 14 weeks gestation and has hyperemesis gravidarum. The nurse should identify that which of the following are risk factors for the client? (SATA)
A. Obesity.
B. Multifetal pregnancy.
C. Maternal age greater than 40.
D. Migraine headache.
E. Oligohydramnios.

B. Urine ketones present.
A nurse is caring for a client who has suspected hyperemesis gravidarum and is reviewing the client's laboratory reports. Which of the following findings is a manifestation of this condition?
A. Hgb 12.2g/dL.
B. Urine ketones present.
C. Alanin aminotransferase 20 IU/L.
D. Serum glucose 114 mg/dL.

A. Respirations less than 12/min.
B. Urinary output less than 30 mL/hr.
D. Decreased level of consciousness.
A nurse is administering magnisium sulfate IV to a client who has severe preeclampsia for seizure prophylaxis. Which of the following indicates magnesium sulfate toxicity? (SATA)
A. Respirations less than 12/min.
B. Urinary output less than 30 mL/hr.
C. Hyperreflexic deep-tendon reflexes.
D. Decreased level of consciousness.
E. Flushing and sweating.

D. Calcium gluconate.
A nurse is caring for a client who is receiving IV magnesium sulfate. Which of the following medications should the nurse anticipate administering if magnesium sulfate toxicity is suspected?
A. Nifedipine.
B. Pyridoxine.
C. Ferrous sulfate.
D. Calcium gluconate.

C. "I plan to drink more orange juice while taking this pill."
A nurse is reviewing a new prescription for ferrous sulfate with a client who is at 12 weeks of gestation. Which of the following statements by the client indicates understanding of the teaching?
A. "I will take this pill with my breakfast."
B. "I will take this medication with a glass of milk."

C. "I plan to drink more orange juice while taking this pill."
D. "I plan to add more calcium-rich foods to my diet while taking this medication."
A. Urinary tract infection.
B. Multifetal pregnancy.
D. Diabetes mellitus.
E. Uterine abnormalities.
A nurse is caring for a client who reports indications of preterm labor. Which of the following findings are risk factors of this condition? (SATA)
A. Urinary tract infection.
B. Multifetal pregnancy.
C. Oliogohydramnios.
D. Diabetes mellitus.
E. Uterine abnormalities.
D. Betamethasone.
A nurse in labor and delivery is providing care for a client who is in preterm labor at 32 weeks of gestation. Which of the following medications should the nurse anticipate the provider will prescribe to hasten fetal lung maturity?
A. Calcium gluconate.
B. Indomethacin.
C. Nifedipine.
D. Betamethasone.
B. Dizziness.
A nurse is caring for a client who is receiving nifedipine for prevention of preterm labor. The nurse should monitor the client for which of the following manifestations?
A. Blood-tinged sputum.
B. Dizziness.
C. Pallor.
D. Somnolence.
A. Fetal distress.
C. Vaginal bleeding.
D. Cervical dilation greater than 6 cm.
A nurse is caring for a client who has a prescription for magnesium sulfate. The nurse should recognize that which of the following are contraindications for use of this medication? (SATA)
A. Fetal distress.
B. Preterm labor.
C. Vaginal bleeding.
D. Cervical dilation greater than 6 cm.
E. Severe gestational hypertension.
D. Keep a daily record of fetal kick counts.
A nurse is reviewing discharge teaching with a client who has premature rupture of membranes at 26 weeks of gestation. Which of the following instructions should the nurse include in the teaching?
A. Use a condom with sexual intercourse.
B. Avoid bubble bath solution when taking a tub bath.

C. Wipe from the back to the front when performing perineal hygiene.
D. Keep a daily record of fetal kick counts.
D. True contractions.
A nurse in the labor and delivery unit receives a phone call from a client who reports that her contractions started about 2 hr ago, did not go away when she had two glasses of water and rested, and became stronger since she started walking. Her contractions occur every 10 min and last about 30 seconds. She hasn't had any fluid leak from her vagina. However, she saw some blood when she wiped after voiding. Based on this report, which of the following clinical findings should the nurse recognize that the client is experiencing?
A. Braxton hicks contractions.
B. Rupture of membranes.
C. Fetal descent.
D. True contractions.
A. First stage, latent phase.
A nurse in the labor and delivery unit is caring for a client in labor and applies an external fetal monitor and tocotransducer. The FHR is around 140/min. Contractions are occurring every 8 min and 30-40 seconds in duration. The nurse performs a vaginal exam and finds the cervix 2 cm dilated, 50% effaced, and the fetus is at a -2 station. Which of the following stages and phases of labor is this client experiencing?
A. First stage, latent phase.
B. First stage, active phase.
C. First stage, transition phase.
D. Second stage of labor.
B. Monitor FHR for distress.
A client experiences a large gush of fluid from her vagina while walking in the hallway of the birthing unit. Which of the following actions should the nurse take first?
A. Check the amniotic fluid for meconium.
B. Monitor FHR for distress.
C. Dry the client and make her comfortable.
D. Monitor uterine contractions.
B. Infection.
A nurse in labor and delivery unit is completing an admission assessment for a client who is at 39 weeks of gestation. The client reports that she has been leaking fluid from her vagina for 2 days. Which of the following conditions is the client at risk for developing?
A. Cord prolapse.
B. Infection.
C. Postpartum hemorrhage.
D. Hydramnios.
C. Transition phase.
A nurse is caring for a client who is in active labor and becomes nauseous and vomits. The client is very irritable and feels the urge to have a bowel movement. She states, "I've had enough. I can't do this anymore. I want to go home right now." Which of the following stages of labor is the client experiencing?
A. Second stage.

B. Fourth stage.
C. Transition phase.
D. Latent phase.
A. Encourage use of patterned breathing techniques.
C. Administer opioid analgesic medication.
D. Suggest application of cold.
A nurse is caring for a client who is at 40 weeks of gestation and experiencing contractions every 3 to 5 min and becoming stronger. A vaginal exam reveals that the client's cervix is 3 cm dilated, 80% effaced, and -1 station. The client asks for pain medication. Which of the following actions should the nurse take? (SATA)
A. Encourage use of patterned breathing techniques.
B. Insert an indwelling urinary catheter.
C. Administer opioid analgesic medication.
D. Suggest application of cold.
E. Provides ice chips.
B. Sacral counterpressure.
A nurse is caring for a client who is in active labor. The client reports lower-back pain. The nurse suspects that this pain is related to a persistent occiput posterior fetal position. Which of the following non pharmacological nursing interventions should the nurse recommend to the client?
A. Abdominal effleurage.
B. Sacral counterpressure.
C. Showering if not contraindicated.
D. Back rub and massage.
C. "It is needed to counteract hypotension."
A nurse is caring for a client following the administration of an epidural block and is preparing to administer an IV fluid bolus. The client's partner asks about the purpose of IV fluids. Which of the following is an appropriate response for the nurse to make?
A. "It is needed to promote increased urine output."
B. "It is needed to counteract respiratory depression."
C. "It is needed to counteract hypotension."
D. "It is needed to prevent oligohydramnios."
A. Pudendal.
A nurse is caring for a client who is in the second stage of labor. The client's labor has been progressing, and she is expected to deliver vaginally in 20 min. The provider is preparing to administer lidocaine for pain relief and perform an episiotomy. The nurse should know that which of the following types of regional anesthetic block is to be administered?
A. Pudendal.
B. Epidural.
C. Spinal.
D. Paracervical.
D. Place an oxygen mask over the client's nose and mouth.
A nurse is caring for a client who is using patterned breathing during labor. The client reports numbness and tingling of the fingers. Which of the following actions should the nurse take?

A. Administer oxygen via nasal cannula at 2 L/min.
B. Apply a warm blanket.
C. Assist the client to a side-lying position.
D. Place an oxygen mask over the client's nose and mouth.
A. Moderate variability.
B. FHR accelerations.
D. Normal baseline FHR.
A nurse is providing care for a client who is in active labor. Her cervix is dilated to 5 cm, and her membranes are intact. Based on the use of external electronic fetal monitoring the nurse notes a FHR of 115 to 125/min with occasional increases up to 150 to 155/min that last for 25 seconds, and have beat-to-beat variability of 30/min. There is no slowing of FHR from the baseline. The nurse should recognize that this client is exhibiting signs of which of the following? (SATA)
A. Moderate variability.
B. FHR accelerations.
C. FHR decelerations.
D. Normal baseline FHR.
E. Fetal tachycardia.
B. "It can detect abnormal fetal heart tones early."
D. "It allows for accurate readings with maternal movement."
E. "It can measure uterine contraction intensity."
A nurse is teaching a client about the benefits of internal fetal heart monitoring. Which of the following statements should the nurse include in the teaching? (SATA)
A. "It is considered a noninvasive procedure."
B. "It can detect abnormal fetal heart tones early."
C. "It can determine the amount of amniotic fluid you have."
D. "It allows for accurate readings with maternal movement."
E. "It can measure uterine contraction intensity."
D. Relaxation between uterine contractions.
A nurse is reviewing the electronic monitor tracing for a client who is in active labor. The nurse should know that a fetus receives more oxygen when which of the following appears on the tracing?
A. Peak of the uterine contraction.
B. Moderate variability.
C. FHR acceleration.
D. Relaxation between uterine contractions.
A. Assist the client into the left-lateral position.
A nurse is caring for a client who is in labor and observes late decelerations on the electronic fetal monitor. Which of the following is the first action the nurse should take?
A. Assist the client into the left-lateral position.
B. Apply a fetal scalp electrode.
C. Insert an IV catheter.
D. Perform a vaginal exam.
B. Palpate the fundus of the uterus.

A nurse is performing Leopold maneuvers on a client who is in labor. Which of the following techniques should the nurse use to identify the fetal lie?
A. Apply palms of both hands to sides of uterus.
B. Palpate the fundus of the uterus.
C. Grasp lower uterine segment between thumb and fingers.
D. Stand facing client's feet with fingertips outlining cephalic prominence.
C. "The vaginal area will bulge as the baby's head appears."
A nurse is caring for a client and her partner during their second stage of labor. The client's partner asks the nurse to explain how he will know when crowning occurs. Which of the following responses should the nurse make?
A. "The placenta will protrude from the vagina."
B. "Your partner will report a decrease in the intensity of contractions."
C. "The vaginal area will bulge as the baby's head appears."
D. "Your partner will report less rectal pressure."
B. Prepare for an impending delivery.
A nurse is caring for a client who is in the transition phase of labor and reports that she needs to have a bowel movement with the peak of contractions. Which of the following actions should the nurse make?
A. Assist the client to the bathroom.
B. Prepare for an impending delivery.
C. Prepare to remove a fecal impaction.
D. Encourage the client to take deep, cleansing breaths.
A. Lengthening of the umbilical cord.
D. Appearance of dark blood from the vagina.
E. Fundus firm upon palpation.
A nurse is caring for a client in the third stage of labor. Which of the following findings indicate the placental separation? (SATA)
A. Lengthening of the umbilical cord.
B. Swift gush of clear amniotic fluid.
C. Softening of the lower uterine segment.
D. Appearance of dark blood from the vagina.
E. Fundus firm upon palpation.
D. Defer vaginal examinations.
A nurse in labor and delivery is planning care for a newly admitted client who reports she is in labor and has been having vaginal bleeding for 2 weeks. Which of the following should the nurse include in the plan of care?
A. Inspect the introitus for a prolapsed cord.
B. Perform a test to identify the fern pattern.
C. Monitor station of the presenting part.
D. Defer vaginal examinations.
D. "A distended bladder reduces pelvic space needed for birth."
A nurse is caring for a client who is in the first stage of labor and is encouraging the client to void every 2 hr. Which of the following statements should the nurse make?
A. "A full bladder increases the risk for fetal trauma."

B. "A full bladder increases the risk for bladder infections."
C. "A distended bladder will be traumatized by frequent pelvic exams."
D. "A distended bladder reduces pelvic space needed for birth."
A. Oligohydramnios.
C. Fetal cord compression.
A nurse is caring for a client who is at 42 weeks of gestation and is admitted to the labor and delivery unit. During an ultrasound, it is noted that the fetus is large for gestational age. The nurse reviews the prescription from the provider to begin an amnioinfusion. Which of the following conditions should the nurse plan to prepare an amnioinfusion? (SATA)
A. Oligohydramnios.
B. Hydramnios.
C. Fetal cord compression.
D. Hydration.
E. Fetal immaturity.
A. Fetal engagement.
A nurse is caring for a client who has been in labor for 12 hr, and her membranes are intact. The provider has decided to perform an amniotomy in an effort to facilitate the progress of labor. The nurse performs a vaginal examination to ensure which of the following prior to the performance of the amniotomy?
A. Fetal engagement.
B. Fetal lie.
C. Fetal attitude.
D. Fetal position.
C. Rho(D) immune globulin.
A nurse is caring for a client who had no prenatal care, is Rh-negative, and will undergo an external version at 37 weeks of gestation. Which of the following medication should the nurse plan to administer prior to the version?
A. Prostaglandin gel.
B. Magnesium sulfate.
C. Rho(D) immune globulin.
D. Oxytocin.
B. Duration of 90 to 120 seconds.
A nurse is caring for a client who is receiving oxytocin for induction of labor and has an intrauterine pressure catheter (IUPC) placed to monitor uterine contractions. For which of the following contraction patterns should the nurse discontinue the infusion of oxytocin?
A. Frequency of every 2 min.
B. Duration of 90 to 120 seconds.
C. Intensity of 60 to 90 mm Hg.
D. Resting tone of 15 mm Hg.
A. "They are administered in an oral form."
A nurse educator in the labor and deliver unit is reviewing the use of chemical agents to promote cervical ripening with a group of newly hired nurses. Which of the following statements by a nurse indicates understudying of the teaching?
A. "They are administered in an oral form."

B. "They act by absorbing fluid from tissue."
C. "The promote dilation of the os."
D. "They include an amniotomy."
B. Reduced fetal oxygen supply.
A nurse is caring for a client who is in lair and experiencing incomplete uterine relaxation between hypertonic contractions. The nurse should identify that this contraction pattern increases the risk for which of the following complications?
A. Prolonged labor.
B. Reduced fetal oxygen supply.
C. Delayed cervical dilation.
D. Increased maternal stress.
A. Hands and knees.
A nurse is caring for a client who is in active labor and reports severe back pain. During assessment, the fetus is noted to be in the occiput posterior positions. Which of the following maternal positions should the nurse suggests to the client to facilitate normal labor progress?
A. Hands and knees.
B. Lithotomy.
C. Trendelenburg.
D. Supine with a rolled towel under one hip.
D. Prolapsed umbilical cord.
A nurse is caring for a client who is admitted to the labor and delivery unit. With the use of Leopold maneuvers, it is noted that the fetus is in a breech presentation. For which of the following possible complications should the nurse observe?
A. Preciptitous labor.
B. Premature rupture of membranes.
C. Postmaturity syndrome.
D. Prolapsed umbilical cord.
C. Meconium aspiration.
A nurse is caring for a client who is at 42 weeks of gestation and in active labor. Which of the following findings is the fetus at risk for developing?
A. Intrauterine growth restriction.
B. Hyperglycemia.
C. Meconium aspiration.
D. Polyhydramnios.
D. Call for assistance.
A nurse is caring for a client in active labor. When last examined 2 hr ago, the client's cervix was 3 cm dilated, 100% effaced, membranes intact and the fetus was at a -2 station. The client suddenly states "My water broke." The monitor reveals a FHR of 80 to 85/min, and the nurse performs a vaginal examination, noticing clear fluid and a pulsing loop of umbilical cord in the client's vagina. Which of the following actions should the nurse perform first?
A. Place the client in the trendelenburg position.
B. Apply pressure to the presenting part with her fingers.
C. Administer oxygen at 10 L/min via a face mask.
D. Call for assistance.

A. Moderate lochia rubra.
A nurse is performing a fundal assessment for a client who is 2 days postpartum and observes there perineal pad for lochia. She notes the pad to be saturated approximately 12 cm with lochia that is bright red and contains small clots. Which of the following findings should the nurse document?
A. Moderate lochia rubra.
B. Excessive blood loss.
C. Light lochia rubra.
D. Scant lochia serosa.

C. A normal postural discharge of lochia.
During ambulation to the bathroom, a postpartum client experiences a gush of dark red blood that soon stops. On assessment, a nurse finds the uterus to be firm, midline, and at the level of the umbilicus. Which of the following findings should the nurse interpret this data as being?
A. Evidence of a possible vaginal hematoma.
B. An indication of a cervical or perineal laceration.
C. A normal postural discharge of lochia.
D. Abnormally excessive lochia rubra flow.

B. "I need a second vaccination at my postpartum visit."
A nurse is completing postpartum discharge teaching to a client who had no immunity to varicella and was given varicella vaccine. Which of the following statements by the client indicates understanding of the teaching?
A. "I will need to use contraception for 3 months before considering pregnancy."
B. "I need a second vaccination at my postpartum visit."
C. "I was given the vaccine because my baby is O-positive."
D. "I will be tested in 3 months to see if I have developed immunity."

B. Urinary retention.
A nurse is assessing a postpartum client for fundal height, location, and consistency. The funds is noted to be displaced laterally to the right, and there is uterine atony. The nurse should identify which of the following conditions as the cause of the uterine atony?
A. Poor involution.
B. Urinary retention.
C. Hemorrhage.
D. Infection.
A. Change in body fluids.
B. Metabolic effort of labor.
A nurse is caring for a client who is 1 hr postpartum following a vaginal birth and experiencing uncontrollable shaking. The nurse should understand that the shaking is due to which of the following factors? (SATA)
A. Change in body fluids.
B. Metabolic effort of labor.

C. Diaphoresis.
D. Decreases in body temperature.
E. Decrease in prolactin levels.
D. Provide education about infant care when the father is present.
A nurse concludes that the father of an infant is not showing positive signs of parent-infant bonding. He appears very anxious and nervous when the infant's mother asks him to bring her the infant. Which of the following actions should the nurse use to promote father-infant bonding?
A. Hand the father the infant, and suggest that he change the diaper.
B. Ask the father why he is so anxious and nervous.
C. Tell the father that he will grow accustomed to the infant.
D. Provide education about infant care when the father is present.
B. Give the client time to express her feelings.
A client in the early postpartum period is very excited and talkative. She is repeatedly telling the nurse every detail of her labor and birth. Because the client will not stop talking, the nurse is having difficulty completing the postpartum assessments. Which of the following actions should the nurse take?
A. Come back later when the client is more cooperative.
B. Give the client time to express her feelings.
C. Tell the client she needs to be quiet so the assessment can be completed.
D. Redirect the client's focus so that she will become quiet.
A. Demonstrates apathy when the infant cries.
C. Views the infant's behavior as uncooperative during diaper changing.
A nurse is caring for a client who is 1 day postpartum. The nurse is assessing for maternal adaptation and mother-infant bonding. Which of the following behaviors by the client indicates a need for the nurse to intervene? (SATA)
A. Demonstrates apathy when the infant cries.
B. Touches the infant and maintains close physical proximity.
C. Views the infant's behavior as uncooperative during diaper changing.
D. Identifies and related infant's characteristics to those of family members.
E. Interprets the infant's behavior as meaningful and a way of expressing needs.
B. "Your son is showing an adverse sibling response."
A nurse is caring for a client who is 2 days postpartum. The client states, "My 4-year old son was toilet trained and now he is frequently wetting himself." Which of the following statements should the nurse provide to the client?
A. "Your son was probably not ready for toilet training and should wear training pants."
B. "Your son is showing an adverse sibling response."
C. "Your son may need counseling."
D. "You should try sending your son to preschool to resolve the behavior."
D. Position the neonate skin-to-skin on the client's chest.
A nurse in the delivery room is planning to promote maternal-infant bonding for a client who just delivered. Which of the following is the priority action by the nurse?
A. Encourage the parents to touch and explore the neonate's features.
B. Limit noise and interruption in the delivery room.

C. Place the neonate at the client's breast.
D. Position the neonate skin-to-skin on the client's chest.
A. "Apply cold compresses between feedings."
A nurse is conducting a home visit for a client who is 1 week postpartum and breastfeeding. The client reports breast engorgement. Which of the following recommendations should the nurse make?
A. "Apply cold compresses between feedings."
B. "Take a warm shower right after feedings."
C. "Apply breast milk to the nipples and allow them to air dry."
D. "Use the various infant positions for feedings."
C. Sore nipple with cracks and fissures.
A nurse is providing discharge instructions for a client. At 4 weeks postpartum, the client should contact her provider for which of the following client findings?
A. Scant, non odorous white vaginal discharge.
B. Uterine cramping during breastfeeding.
C. Sore nipple with cracks and fissures.
D. Decreased response with sexual activity.
A. "Wear a supportive bra continuously for the first 72 hours."
A nurse is providing discharge teaching for a non lactating client. Which of the following instructions should the nurse include in the teaching?
A. "Wear a supportive bra continuously for the first 72 hours."
B. "Pump your breast every 4 hours to relieve discomfort."
C. "Use breast shells throughout the day to decrease milk supply."
D. "Apply warm compresses until milk suppression occurs."
C. Kegel exercises.
A nurse is providing discharge instructions to a postpartum client following a cesarean birth. The client reports leaking urine every time she sneezes or coughs. Which of the following interventions should the nurse suggest?
A. Sit-ups.
B. Pelvic tilt exercise.
C. Kegel exercises.
D. Abdominal crunches.
B. A client who does not wash her hands between perineal care and breastfeeding.
A nurse is providing care to four clients on the postpartum unit. Which of the following clients is at greatest risk for developing a postpartum infection?
A. A client who has an episiotomy that is erythematous and has extended into a third-degree laceration.
B. A client who does not wash her hands between perineal care and breastfeeding.
C. A client who is not breastfeeding and is using measures to suppress lactation.
D. A client who has a cesarean incision that is well-approximated with no drainage.
A. Increasing pulse and decreasing blood pressure.
A nurse is caring for a client who is postpartum. The nurse should identify which of the following findings as an early indicator of hypovolemia caused by hemorrhage?
A. Increasing pulse and decreasing blood pressure.

B. Dizziness and increasing respiratory rate.
C. Cool, clammy skin, and pale mucous membranes.
D. Altered mental status and level of consciousness.
A. Precipitous delivery.
C. Inversion of the uterus.
E. Retained placental fragments.
A nurse educator on the postpartum unit is reviewing risk factors for postpartum hemorrhage with a group of nurses. Which of the following factors should the nurse include in the teaching? (SATA)
A. Precipitous delivery.
B. Obesity.
C. Inversion of the uterus.
D. Oligohydramnios.
E. Retained placental fragments.
A. Calf tenderness to palpation.
C. Elevated temperature.
D. Area of warmth.
A nurse on the postpartum unit is performing a physical assessment of a client who is being admitted with a suspected deep-vein thrombosis (DVT). Which of the following clinical findings should the nurse expect? (SATA)
A. Calf tenderness to palpation.
B. Mottling of the affected extremity.
C. Elevated temperature.
D. Area of warmth.
E. Report of nausea.
D. Measure leg circumferences.
A nurse on the postpartum unit is planning care for a client who has thrombophlebitis. Which of the following nursing interventions should the nurse include in the plan of care?
A. Apply cold compresses to the affected extremity.
B. Massage the affected extremity.
C. Allow the client to ambulate.
D. Measure leg circumferences.
A. Preeclampsia.
A nurse is caring for a client who has disseminated intravascular coagulation (DIC). Which of the following antepartum complications should the nurse understand is a risk factor for this condition?
A. Preeclampsia.
B. Thrombophlebitis.
C. Placenta previa.
D. Hyperemesis gravidarum.
B. A client who had premature rupture of membranes and prolonged labor.
A nurse on the postpartum unit is caring for four clients. Which of the following liens should the nurse recognize as the greets risk for development of a postpartum infection?
A. A client who experienced a precipitous labor less than 3 hr in duration.