(VERSION 2)

1. Two days after delivery, a postpartum client prepares for discharge. What should the nurse teach her about lochia flow?

The color of the lochia changes from a bright red to white after four days

Numerous large clots are normal for the next three to four days

Saturation of the perineal pad with blood is expected when getting up from the bed

Lochia should last for about 3 weeks, changing color every few days

2. A nurse monitors fetal well-being by means of an external monitor. At the peak of the contractions, the fetal heart rate has repeatedly dropped 30 beats/min below the baseline. Late decelerations are suspected and the nurse notifies the physician. Which is the rationale for this action? **.**

The umbilical cord is wrapped tightly around the fetus' neck

The fetal cord is being compressed due to rapid descent of the fetal head

Maternal contractions are not adequate enough to deliver the fetus

The fetus is not receiving adequate oxygen and is in distress

3. Which preoperative nursing interventions should be included for a client who is scheduled to have an emergency cesarean birth?

Monitor oxygen saturation and administer pain medication.

Assess vital signs every 15 minutes and instruct the client about postoperative care.

Alleviate anxiety and insert an indwelling catheter.

Perform a sterile vaginal examination and assess breath sounds.

4. Which nursing instruction should be given to the breastfeeding mother regarding care of the breasts after discharge?

The baby should be given a bottle of formula if engorgement occurs.

The nipples should be covered with lotion when the baby is not nursing.

The breasts should be pumped if the baby is not sucking adequately.

The breasts should be washed with soap and water once per day.

5. A client in preterm labor is admitted to the hospital. Which classification of drugs should the nurse anticipate administering?

Tocolytics

Anticonvulsants

Glucocorticoids

Anti-infective

6. Which of the following are probable signs, strongly indicating pregnancy?

Presence of fetal heart sounds and quickening

Missed menstrual periods, nausea, and vomiting

Hegar's sign, Chadwick's sign, and ballottement

Increased urination and tenderness of the breasts

7. Two hours after delivery the nurse assesses the client and documents that the fundus is soft, boggy, above the level of the umbilicus, and displaced to the right side. The nurse encourages the client to void. Which is the rationale for this nursing action?

A full bladder prevents normal contractions of the uterus.

An overdistended bladder may press against the episiotomy causing dehiscence.

Distention of the bladder can cause urinary stasis and infection.

It makes the client more comfortable when the fundus is massaged.

8. Which site is preferred for giving an IM injection to a newborn?

Ventrogluteal

Vastus lateralis

Rectus femoris

Dorsogluteal

9. During the first twelve hours following a normal vaginal delivery, the client voids 2,000 mL of urine. How should the nurse interpret this finding?

High output renal failure

Normal diuresis after delivery

10. If a pregnant client diagnosed with gestational diabetes cannot maintain control of her blood sugar by diet alone, which medication will she receive?

Metformin (Glucophage)

Glucagon

Insulin

11. Which assessment finding indicates that placental separation has occurred during the third stage of labor?

Decreased vaginal bleeding

Contractions stop

Maternal shaking and chills

Lengthening of the umbilical cord

12. The nurse midwife is concerned about a pregnant client who is suspected of having a TORCH infection. Which is the main reason TORCH infections are grouped together? They are:

benign to the woman but cause death to the fetus.

sexually transmitted.

capable of infecting the fetus.

transmitted to the pregnant woman by a vector.

13. During the postpartum period, a hospitalized client complains of discomfort related to her episiotomy. The nurse assigns the diagnosis of “pain related to perineal sutures.” Which nursing intervention is most appropriate during the first 24 hours following an episiotomy?

Instruct the client to use petroleum jelly on the episiotomy after voiding.

Encourage the client to practice Kegel exercises.

Advise the client to take a warm sitz bath every four hours.

Apply ice packs to the perineum.

14. A client asks the nurse about the benefits of breastfeeding. Which response by the nurse provides the most accurate information?

Breastfeeding helps women lose weight faster.

Breast milk is easier to digest than formula.

Breastfeeding is a good method of contraception.

15. Which physiological change takes place during the puerperium?

The endometrium begins to undergo alterations necessary for menstruation.

The placenta begins to separate from the uterine wall.

The uterus returns to a pre-pregnant size and location.

16. A client delivered two days ago and is suspected of having postpartum "blues." Which symptoms confirm the diagnosis?

Uncontrollable crying and insecurity

Depression and suicidal thoughts

Sense of the inability to care for the family and extreme anxiety

Nausea and vomiting

17. Shortly after delivery, the nursery nurse gives the newborn an injection of phytonadione (Vitamin K). The infant's grandmother wants to know why the baby got “a shot in his leg.” Which response by the nurse is most appropriate?

"Vitamin K promotes bone and muscle growth."

"Vitamin K helps the baby digest milk."

"Vitamin K helps stabilize the baby's blood sugar."

"Vitamin K is used to prevent bleeding."

18. At 10 weeks gestation, a primigravida asks the nurse what is occurring developmentally with her baby. Which response by the nurse is correct?

"The skin is wrinkled and fat is being formed."

"The eyelids are open and he can see."

"The kidneys are making urine."

19. A nurse in the clinic instructs a primigravida about the danger signs of pregnancy. The client demonstrates understanding of the instructions, stating she will notify the physician if which sign occurs?

Abdominal pain

20. An hour after delivery, the nurse instills erythromycin (Ilotycin) ointment into the eyes of a newborn. The main objective of the treatment is to prevent infection caused by which organism?

Gonorrhea

21. A woman in active labor receives a narcotic analgesic for pain control. If the narcotic is given a half an hour before delivery, which effect will the medication have on the infant? It will cause the infant's:

blood sugar to fall.

respiratory rate to decrease.

heart rate to increase.

movements to be hyperactive.

22. For a client in the second trimester of pregnancy, which assessment data support a diagnosis of pregnancy-induced hypertension (PIH)?

Hemoglobin 10.2 mg/dL and uterine tenderness

Polyuria and weight loss of 3 pounds in the last month

Blood pressure 168/110 and 3+ proteinuria

Hematuria and blood glucose of 160 mg/dL

23. A 35-week gestation infant was delivered by forceps. Which assessment findings should alert the nurse to a possible complication of the forceps delivery?

Weak, ineffective suck, and scalp edema

Molding of the head and jitteriness

Shrill, high pitched cry, and tachypnea

Hypothermia and hemoglobin of 12.5 g/dL

24. In which position should the nurse place the laboring client in order to increase the intensity of the contractions and improve oxygenation to the fetus?

Left side-lying

High Fowler's

25. A woman enters the birthing center in active labor. She tells the nurse that her membranes ruptured 26 hours ago. The nurse immediately takes the client's vital signs. Which is the rationale for the nurse's actions?

Pulse rates rise the longer the membranes are ruptured

Respiratory rates decrease due to lack of fluid in the uterus

Prolonged rupture of membranes can lead to transient hypertension

Infection is a complication of prolonged rupture of membranes

26. A new client's pregnancy is confirmed at 10 weeks gestation. Her history reveals that her first two pregnancies ended in spontaneous abortion at 12 and 20 weeks. She has a4-year-old and a set of 1-year-old twins. How should the nurse record the client's current gravida and para status?

Gravida 2, para 3

Gravida 4, para 2

Gravida 5, para 2

Gravida 5, para 4

27. A 16-year-old client reports to the school nurse because of nausea and vomiting. After exploring the signs and symptoms with the client, the nurse asks the girl whether she could be pregnant. The girl confirms that she is pregnant, but states that she does not know how it happened. Which nursing diagnosis is most important?

Knowledge deficit related to the client's developmental stage and age

28. A client is admitted to the hospital for induction of labor. Which are the main indications for labor induction?

Placenta previa and twins

Pregnancy-induced hypertension and postterm fetus

Breech position and prematurity

Cephalopelvic disproportion and fetal distress

29. A client in active labor receives a regional anesthetic. Which is the main purpose of regional anesthetics?

To relieve pain by decreasing the client's level of consciousness

To provide general loss of sensation by blocking sensory nerves to an area

To provide pain relief by blocking descending impulses from the central nervous system

To relieve pain by decreasing the perception of pain leading to the pain centers in the brain

30. The nursery nurse reviews a newborn's birth history and notes that the Apgar scores were 5 at one minute after birth, and 7 at five minutes after birth. How should the nurse interpret these scores? The infant:

needed brief oral and nasal suctioning.

required endotracheal intubation and bagging with a hand-held resuscitator.

was stillborn and required CPR.

required physical stimulation and supplemental oxygen.

31. With routine prenatal screening, a woman in the second trimester of pregnancy is confirmed to have gestational diabetes. How may the nurse explain the role of diet and insulin in the management of blood sugar during pregnancy?

"Insulin lowers an elevated blood sugar during pregnancy to meet the increased metabolic needs of the baby."

32. A breastfeeding mother complains of cramping. Which is the main cause of the client's afterpains?

Contractions of the uterus

33. A client who is 37 weeks gestation comes to the office for a routine visit. This is the client's first baby and she asks the nurse how she will know when labor begins. Which signs indicate that true labor has begun?

Contractions that are irregular and decrease in intensity when walking

Abdominal pain that starts at the fundus and progresses to the lower back

Increased pressure on the bladder and urinary frequency

Expulsion of pink-tinged mucous and contractions that start in the lower back

34. A multiparous woman with a history of all vaginal births is admitted to the hospital in labor. After several hours, the client's labor has not progressed and she is getting tired and restless. The decision is made to proceed with cesarean delivery. The nurse recognizes the client's knowledge deficit regarding the surgical delivery and care afterbirth. Which is the appropriate expected outcome for correction of the client's knowledge deficit? The client will:

demonstrate appropriate coping mechanisms needed to get through the surgery.

accept that the type of delivery will not affect the bonding with the baby.

verbalize understanding about the reason for the unplanned surgery.

demonstrate decreased anxiety and fear of the unknown.

35. The physician performs an amniotomy for a woman in labor. Which nursing action should follow the procedure?

Assess the fluid for color, odor, and amount.

36. For a pregnant adolescent who is anemic, which foods should the nurse include In the client's dietary plan to increase iron levels?

Milk and fish

Orange juice and apricots

Chicken and cottage cheese

Pickles and peanut butter sandwiches

37. Which condition must occur in order for identical (monozygotic) twins to develop?

One sperm fertilizes two ova

Two sperm fertilize two ova

One sperm fertilizes one ovum

Two sperm fertilize one ovum

38. Which fetal structure is responsible for carrying oxygenated blood from the placenta to the fetus?

Ductus arteriosus

Umbilical artery

Portal vein

Umbilical vein

39. A client at 33 weeks gestation is admitted for suspected abruptio placenta. Which factor in the client's history supports this diagnosis? The client states that she:

used crack an hour before the symptoms began.

40. Which explanation is most appropriate when describing physiological jaundice to the parents of a newborn?

"The baby has a minor incompatibility of the blood."

“The baby is breaking down the extra red blood cells that were present at birth.”

“The baby is getting too much breast milk, but this is not dangerous.”

“The baby may have gotten exposed to hepatitis B during the delivery.”

41. A woman at 42 weeks gestation enters the hospital for induction of labor. Since the infant is postterm, which complications should the nurse anticipate when planning for the delivery?

Cephalopelvic disproportion and hypothermia

Asphyxia and meconium aspiration

Intraventricular hemorrhage and dry, cracked skin

Hyperbilirubinemia and hypocalcemia

42. Which method of temperature regulation would safely and effectively prevent cold stress in a newly delivered infant?

Wrap the baby loosely with a blanket.

Be sure the baby's feet are covered.

Cover the baby's head with a hat.

Position the baby on a heating pad.

43. The nurse performs Leopold's maneuvers for a client admitted in labor. Which is the main goal of Leopold's maneuvers?

To determine whether the client's cervix has dilated

To assess the frequency and intensity of the contractions

To assess whether membranes have been ruptured

To determine the presentation and position of the fetus

44. Immediately after birth, the nurse places the newborn under a radiant warmer. Which is the primary rationale for the nurse's action?

an efficient means of thermoregulation

To facilitate initial assessment by the nurse

To permit the use of the cardiac monitor

To permit close observation by the family members

45. A client, gravida 1, para 0, in active labor, is becoming increasingly anxious. Which statement by the nurse will block therapeutic communication with the client?

"What concerns are you having now?"

"Tell me how you are feeling."

"Everything is going just fine."

"You seem a little nervous."

46. A nurse prepares to teach a class regarding postpartum care and includes infections in the teaching plan. Which is the main cause of mastitis in the postpartum client?

Poor breast feeding technique

47. A postterm infant is delivered by cesarean section because of fetal distress and meconium-stained amniotic fluid. The nursery nurse frequently monitors the baby's respiratory rate, observing for tachypnea. Which is the reason for the nurse's actions? The infant may:

experience respiratory depression from the medications used during delivery.

develop meconium aspiration pneumonia.

have an elevated temperature.

have a pneumothorax related to delivery.

48. The nurse notices a variable deceleration on a fetal monitor strip. Which nursing action is appropriate?

Instruct the mother to breathe slowly because this is a sign of hyperventilation.

Decrease the amount of Pitocin because this is a sign of hypertonic uterine contractions.

Turn the woman onto her left side to relieve pressure on the umbilical cord.

Reduce the oral and IV fluids to decrease circulatory overload.

49. The nursery nurse delays the first bottle feeding of a newborn. Which is the most common reason for the nurse's actions? The infant has:

a blood glucose of 45 gm/dL.

a respiratory rate above 60.

blue hands and feet.

a heart murmur.

50. During active labor, after a sudden slowing of the fetal heart rate, the nurse assesses the woman's perineum and observes a prolapsed cord. Which nursing action is most appropriate?

Hold the presenting part away from the cord.

Insert a scalp electrode for an internal fetal monitor.

Place the client in reverse Trendelenburg position.

Cover the cord with a dry, sterile gauze.

51. A client is in the latent stage of labor. Which nursing intervention is most appropriate?

Encourage the client to walk in the hall until membranes rupture.

Instruct the client to place her head on her chest and push with the contraction.

Teach the client to use the “pant-blow” method of breathing.

52. Which conditions create a risk for uterine atony in the immediate postpartum period?

Multiparity and multiple gestation

53. A client at ten weeks gestation tells the nurse that she has been having “morning sickness.” The nurse advises the client to eat foods that are easy to digest and low in fat. Which is the rationale for the nurse's instruction?

A low-fat diet increases peristalsis, which reduces the food volume in the stomach

A low-fat diet is digested faster and leaves less in the stomach that can be vomited

Easily digested foods provide a better balance of fluids and electrolytes, resulting in less nausea and vomiting

Easily digested foods are less likely to cause relaxation of the cardiac sphincter, which causes regurgitation and vomiting

54. Which information is most important for the nurse to gather when a client is admitted to the unit in labor?

Name of the support person

Medical problems or complications

Fluid preferences

Amount of weight gained during the pregnancy

55. The nurse conducting a physical assessment notes that a 1-day-old newborn with dark skin has a bluish-gray discoloration over the lower back, the buttocks, and the scrotum. How should this assessment finding be documented?

Mongolian spot

56. A small-for-gestational-age infant is irritable and jittery, and has hyperreflexia and clonus. He is jaundiced, has temperature instability, and spitty after feedings. The nurse suspects the infant is displaying signs of passive addiction during pregnancy. When planning for the infant's care at home, which nursing assessment is most important for the infant experiencing neonatal abstinence syndrome?

The mother's ability to provide a safe environment

The extent of addiction of the mother

The mother's ability to obtain treatment

The severity of the infant' s withdrawal

57. A woman in active labor is admitted to the labor and delivery unit, accompanied by her partner. As labor progresses, the nurse notes he is not interacting with the woman and sits in the corner, looking out the window. How may the nurse understand the man's actions?

His actions reflect personality or cultural differences, which do not necessarily indicate a lack of concern.

58. A client is admitted to the hospital with severe pregnancy-induced hypertension (PIH). The physician orders magnesium sulfate. Which nursing intervention is important when administering this drug?

Assess blood pressure and respiratory rate every fifteen minutes.

Monitor blood glucose levels every eight hours.

Evaluate for orthostatic hypotension when getting the client up to walk.

Observe for premature labor every shift.

59. A 27-week gestation infant is taken to a newborn intensive care unit 150 miles away. Initially, which emotion should the nurse expect the mother to display after the transfer?

Denial

Frustration

Guilt

Anger

60. A 38 week gestation newborn weighs 4020 grams, is sluggish, and has limp muscle tone. The baby experienced a broken clavicle during delivery. Based on this information, which can the nurse conclude about the baby?

Neonatal abstinence symptoms

Large for gestational age

Congenital cardiac defect

Respiratory depression

61. Which assessment finding suggests thrombophlebitis in a postpartum client?

Dyspnea, tachypnea, and apprehension

Chills, hypotension, and abdominal tenderness

Positive Homan's sign, calf warmth, and pain

Dizziness, loss of consciousness, and chest pain

62. A client comes to the clinic to confirm that she is pregnant. Her last menstrual period was January 31st. According to Naegele's rule, when should the client expect to deliver?

November 31

December 7

November 7

December 24

63. Which procedure should be avoided for the client known to have a placenta previa?

A non-stress test

A urinary catheterization

A sterile vaginal exam

An abdominal ultrasound

64. A woman in the first trimester comes to the clinic with vaginal bleeding. The physician determines that the fetus has died and that the placenta, fetus, and tissues still remain in the uterus. How should the findings be documented?

Complete abortion

Stillborn abortion

Missed abortion

Incomplete abortion

65. A woman in the transition stage of labor is using paced breathing to relieve pain. She complains of blurred vision, numbness, and tingling of her hands and mouth. Which condition is indicated by these signs and symptoms?

Hyperventilation

66. Which data support a diagnosis of abruptio placenta in a pregnant woman?

Uterine rigidity and abdominal pain

67. A women in her first trimester contracts rubella. How is the fetus likely to be affected?

Reproductive and urinary defects

Heart defects and cataracts

Spinal cord and skeletal defects

68. An hour after delivery, a 4000 gram infant exhibits pallor, jitteriness, a blood sugar level of 40 gm/dL, irritability and periodic apnea. Which maternal condition could be the cause of the newborn's symptoms?

Gestational diabetes

69. A client delivered vaginally six hours ago. Which assessment finding can be interpreted as normal?

Temperature 100.0 degrees F

70. A new mother receives instructions about care of her newborn son's circumcision. Which statement made by the mother indicates that further teaching is needed?

"I should wash off any yellowish mucous on my baby's penis."

71. A 17-year-old client delivered her first baby 8 hours ago. Which of the following is an indication that appropriate bonding is occurring? The client:

makes eye contact with the baby.

72. A new mother is crying in her room. She tells the nurse that her new baby boy has enlarged breasts and she thinks that there is something wrong. How should the nurse respond?

"Enlarged breasts are common for both boys and girls. It will go away."

73. During the active phase of labor, the membranes rupture and the nurse notes green amniotic fluid. Which nursing action should be initiated immediately?

Assess fetal heart rate.

74. At 28 weeks gestation, a woman enters the hospital in preterm labor and receives atocolytic medication to stop labor. Which assessment findings should be reported immediately to the physician?

Irregular contractions every 15-20 minutes that last 30 seconds before stopping

75. A labor and delivery nurse suspects that a client is in the transition stage of labor. Which information supports this conclusion? The client is:

irritable and needs frequent repetition of directions.

1. Two days after delivery, a postpartum client prepares for discharge. What should the nurse teach her about lochia flow?

Incorrect: Lochia does change color but goes from lochia rubra (bright red) on days 1-3, to lochia serosa (pinkish brown) on days 4-9, to lochia alba (creamy white) days 10-21.

Incorrect: Numerous clots are abnormal and should be reported to the physician.

Incorrect: Saturation of the perineal pad is considered abnormal and may indicate postpartum hemorrhage.

Correct: Lochia normally lasts for about 21 days, and changes from a bright red, to pinkish brown, to creamy white.

The color of the lochia changes from a bright red to white after four days

Numerous large clots are normal for the next three to four days

Saturation of the perineal pad with blood is expected when getting up from the bed

Lochia should last for about 3 weeks, changing color every few days

2. A nurse monitors fetal well-being by means of an external monitor. At the peak of the contractions, the fetal heart rate has repeatedly dropped 30 beats/min below

the baseline. Late decelerations are suspected and the nurse notifies the physician. Which is the rationale for this action?

Incorrect: A nuchal cord (cord around the neck) is associated with variable decelerations, not late decelerations.

Incorrect: Variable decelerations (not late decelerations) are associated with cord compression.

Incorrect: Late decelerations are a result of hypoxia. They are not reflective of the strength of maternal contractions.

Correct: Late decelerations are associated with uteroplacental insufficiency and are a sign of fetal hypoxia. Repeated late decelerations indicate fetal distress.

The umbilical cord is wrapped tightly around the fetus' neck

The fetal cord is being compressed due to rapid descent of the fetal head

Maternal contractions are not adequate enough to deliver the fetus

The fetus is not receiving adequate oxygen and is in distress

3. Which preoperative nursing interventions should be included for a client who is scheduled to have an emergency cesarean birth?

Incorrect: Monitoring O2 saturations and administering pain medications are postoperative interventions.

Incorrect: Taking vital signs every 15 minutes is a postoperative intervention. Instructing the client regarding breathing exercises is not appropriate in a crisis situation when the client's anxiety is high, because information would probably not be retained. In an emergency, there is time only for essential interventions.

Correct: Because this is an emergency, surgery must be performed quickly. Anxiety of the client and the family will be high. Inserting an indwelling catheter helps to keep the bladder empty and free from injury when the incision is made.

Incorrect: The nurse should have assessed breath sounds upon admission. Breath sounds are important if the client is to receive general anesthesia, but the anesthesiologist will be listening to breath sounds in surgery in that case.

Monitor oxygen saturation and administer pain medication.

Assess vital signs every 15 minutes and instruct the client about postoperative care.

Alleviate anxiety and insert an indwelling catheter.

Perform a sterile vaginal examination and assess breath sounds.

4. Which nursing instruction should be given to the breastfeeding mother regarding care of the breasts after discharge?

Incorrect: Engorgement occurs on about the third or fourth postpartum day and is a result of the breast milk formation. The primary way to relieve engorgement is by pumping or longer nursing. Giving a bottle of formula will compound the problem because the baby will not be hungry and will not empty the breasts well.

Incorrect: Applying lotion to the nipples is not effective for keeping them soft. Excessive amounts of lotion may harbor microorganisms.

Correct: In order to stimulate adequate milk production, the breasts should be pumped if the infant is not sucking or eating well, or if the breasts are not fully emptied.

Incorrect: Using soap on the breasts dries the nipples and can cause cracking.

The baby should be given a bottle of formula if engorgement occurs.

The nipples should be covered with lotion when the baby is not nursing.

The breasts should be pumped if the baby is not sucking adequately.

The breasts should be washed with soap and water once per day.

5. A client in preterm labor is admitted to the hospital. Which classification of drugs should the nurse anticipate administering?

Correct: Tocolytics are used to stop labor. One of the most commonly used tocolytic drugs is ritodrine (Yutopar).

Incorrect: Anticonvulsants are used for clients with pregnancy-induced hypertension who are likely to seize.

Incorrect: The glucocorticoids (e.g., betamethasone and dexamethasone) are used for accelerating fetal lung maturation and production of surfactant. They are commonly used if the membranes are ruptured or labor cannot be stopped.

Incorrect: Anti-infective are used if there is infection. Preterm labor may or may not involve ruptured membranes with its accompanying risk of infection.

Tocolytics

Anticonvulsants

Glucocorticoids

Anti-infective

6. Which of the following are probable signs, strongly indicating pregnancy?

Incorrect: The presence of fetal heart sounds is a positive sign of pregnancy; quickening is a presumptive Sign of pregnancy.

Incorrect: These are presumptive signs. They may indicate pregnancy or they may be caused by other conditions, such as disease processes.

Correct: These are probable signs that strongly indicate pregnancy. Hegar's sign is a softening of the lower uterine segment, and Chadwick's sign is the bluish or purplish color of the cervix as a result of the increased blood supply and increased estrogen. Ballottement occurs when the cervix is tapped by an examiner's finger and the fetus floats upward in the amniotic fluid and then falls downward.

Incorrect: These are presumptive signs that might indicate pregnancy, but they might be caused by other conditions, such as disease processes.

Presence of fetal heart sounds and quickening

Missed menstrual periods, nausea, and vomiting

Hegar's sign, Chadwick's sign, and ballottement

Increased urination and tenderness of the breasts

7. Two hours after delivery the nurse assesses the client and documents that the fundus is soft, boggy, above the level of the umbilicus, and displaced to the right side. The nurse encourages the client to void. Which is the rationale for this nursing action?

Correct: Bladder distention can lead to postpartum hemorrhage. A full bladder displaces the uterus causing it not to contract properly. Emptying the bladder allows the uterus to contract more firmly.

Incorrect: A distended bladder rises out of the abdomen, causing the uterus to be displaced and increasing the risk of hemorrhage. It does not affect the perineum.

Incorrect: Bladder distention can lead to urinary stasis and infection. This, however, does not relate to the soft, boggy uterus or the potential for hemorrhage.

Incorrect: Massaging is uncomfortable regardless of whether the bladder is full or not. A full bladder displaces the uterus causing it not to contract properly, which may lead to postpartum hemorrhage.

A full bladder prevents normal contractions of the uterus.

An overdistended bladder may press against the episiotomy causing dehiscence.

Distention of the bladder can cause urinary stasis and infection.

It makes the client more comfortable when the fundus is massaged.

8. Which site is preferred for giving an IM injection to a newborn?

Incorrect: Ventrogluteal muscles are located in the hip area. It is not the preferred site for injections in the newborn because of lack of muscle mass.

Correct: The middle third of the vastus lateralis is the preferred site for injections.

Incorrect: Ventrogluteal muscles are located in the hip area. It is not the preferred site for injections in the newborn because of lack of muscle mass.

Incorrect: Newborns do not receive injections in the dorsogluteal site (gluteus maximus) due to decreased muscle mass.

Ventrogluteal

Vastus lateralis

Rectus femoris

Dorsogluteal

9. During the first twelve hours following a normal vaginal delivery, the client voids 2,000 mL of urine. How should the nurse interpret this finding?

Incorrect: Urinary tract infections are common during pregnancy and in the postpartum period. Urinary frequency is a common finding. However, voiding large amounts of urine is not a sign of a UTI.

Incorrect: High output renal failure occurs with injury/trauma to the kidneys. There has been no damage to the kidneys. Incorrect: Most women do receive some IV fluids during labor and delivery, however the IV rates are carefully calculated according to weight.

Correct: During pregnancy, the circulating blood volume increases by about 50%. In order to get rid of the excess fluid volume after delivery, the woman experiences an increased amount of urine output during the first few hours.

Urinary tract infection

High output renal failure

Excessive use of IV fluids during delivery

Normal diuresis after delivery

10. If a pregnant client diagnosed with gestational diabetes cannot maintain control of her blood sugar by diet alone, which medication will she receive?

Incorrect: Glucophage is an oral hypoglycemic. Oral hypoglycemic cross the placenta and can cause damage to the fetus. They are not used in gestational diabetes for that reason.

Incorrect: Glucagon is a hormone used to raise blood sugar and manage severe hypoglycemia. Clients with gestational diabetes have hyperglycemia.

Correct: Insulin is the drug of choice for gestational diabetes. Insulin lowers the client's blood sugar without harming the fetus.

Incorrect: DiaBeta is an oral hypoglycemic drug. Oral hypoglycemic agents cross the placenta and can cause damage to the fetus. They are not used for gestational diabetes for that reason.

Metformin (Glucophage)

Glucagon

Insulin

Glyburide (DiaBeta)

11. Which assessment finding indicates that placental separation has occurred during the third stage of labor?

Incorrect: There is usually an increase in bleeding (a sudden gush of blood) when the placenta separates.

Incorrect: Contractions continue in an attempt to expel the placenta. The contractions may not be as intense, but they do not stop. Also, fundal massage helps contract the uterus preventing postpartum bleeding.

Incorrect: Shaking and chills occur about 10-15 minutes after the delivery of the baby, but are not related to the placental detachment. They are a result of the release of pressure on pelvic nerves and the release of epinephrine during labor.

Correct: As the placenta detaches, the cord that has been clamped becomes longer as it slides out of the vagina.

Decreased vaginal bleeding

Contractions stop

Maternal shaking and chills

Lengthening of the umbilical cord

12. The nurse midwife is concerned about a pregnant client who is suspected of having a TORCH infection. Which is the main reason TORCH infections are grouped together? They are:

Incorrect: Most TORCH infections can cause mild flu-like symptoms for the mother. Death may or may not occur in the fetus.

Incorrect: TORCH is an abbreviation for Toxoplasmosis, Other (syphilis, HIV and Hepatitis B), Rubella, Cytomegalovirus, and Herpes simplex—not all of these are sexually transmitted.

Correct: All TORCH infections have the capability of infecting the fetus or causing serious effects to the newborn.

Incorrect: A vector is a carrier of the disease such as a mosquito. Not all of the TORCH infections are carried by vector.

benign to the woman but cause death to the fetus.

sexually transmitted.

capable of infecting the fetus.

transmitted to the pregnant woman by a vector.

13. During the postpartum period, a hospitalized client complains of discomfort related to her episiotomy. The nurse assigns the diagnosis of “pain related to perineal sutures.” Which nursing intervention is most appropriate during the first 24 hours following an episiotomy?

Incorrect: Petroleum jelly will harbor bacteria, which may hinder healing.

Incorrect: The client should practice Kegel exercises to increase bladder tone, but these exercises would add to the client's discomfort during the first 24hours.Incorrect: Taking a warm sitz bath is recommended after the first 24 hours.

Correct: Ice packs will decrease edema and discomfort, and prevent formation of a hematoma.

Instruct the client to use petroleum jelly on the episiotomy after voiding.

Encourage the client to practice Kegel exercises.

Advise the client to take a warm sitz bath every four hours.

Apply ice packs to the perineum.

14. A client asks the nurse about the benefits of breastfeeding. Which response by the nurse provides the most accurate information?

Incorrect: Breastfeeding does not help speed up weight loss. The lactating mother requires more calories, but usually has an increased appetite to accommodate that need.

Incorrect: Protein amounts are greater in formula and cow's milk.

Correct: Breast milk is easier to digest because of the type of fat and protein in the milk.

Incorrect: Breastfeeding does not prevent to woman from getting pregnant because it does not prevent ovulation. Most women ovulate within the first 6 weeks after delivery.

Breastfeeding helps women lose weight faster.

Breast milk contains a greater amount of protein.

Breast milk is easier to digest than formula.

Breastfeeding is a good method of contraception.

15. Which physiological change takes place during the puerperium?

Incorrect: The puerperium is the first 6 weeks after delivery. The client will experience lochia for the first few weeks, and hormone levels will stabilize. Menstruation cannot occur until ovulation occurs.

Incorrect: This occurs in stage three of labor.

Correct: The uterine changes are called involution. The uterus should return to its pre-pregnancy state within 6 weeks after delivery.

Incorrect: This describes the labor process, not the puerperium.

The endometrium begins to undergo alterations necessary for menstruation.

The placenta begins to separate from the uterine wall.

The uterus returns to a pre-pregnant size and location.

The uterus contracts at regular intervals with dilation of the cervix occurring.

16. A client delivered two days ago and is suspected of having postpartum "blues." Which symptoms confirm the diagnosis?

Correct: These are signs of the postpartum blues, which typically diminishes within three-four days after delivery. Postpartum blues, a transient period of

tearfulness, is a result of hormonal shifts. Other symptoms of the blues include: sadness, anxiety about the health of the baby, insomnia, anorexia, anger, feelings of anticlimax.

Incorrect: Postpartum blues, a transient period of tearfulness, is a result of hormonal shifts. Depression and suicidal thoughts are signs of postpartum depression, not the blues and should be followed up with psychiatric treatment.

Incorrect: Excess anxiety and the inability to care for the family are signs of postpartum depression, not the blues. Postpartum blues, a transient period of tearfulness, is a result of hormonal shifts.

Incorrect: Nausea and vomiting are psychosomatic symptoms of postpartum depression and require psychiatric treatment. Postpartum blues, a transient period of tearfulness, is a result of hormonal shifts.

Uncontrollable crying and insecurity

Depression and suicidal thoughts

Sense of the inability to care for the family and extreme anxiety

Nausea and vomiting

17. Shortly after delivery, the nursery nurse gives the newborn an injection of phytonadione (Vitamin K). The infant's grandmother wants to know why the baby got “a shot in his leg.” Which response by the nurse is most appropriate?

Incorrect: Calcium is needed for bone and muscle growth, not Vitamin K.

Incorrect: Vitamin K is used to promote clotting, and does not affect digestion.

Incorrect: The B vitamins are responsible for carbohydrate metabolism and the energy derived from glucose, not Vitamin K.

Correct: Vitamin K is given to prevent bleeding until the intestinal bacteria can start to produce it. The intestines of a newborn are sterile until it starts to feed. Vitamin K helps with the clotting factors necessary to control bleeding.

"Vitamin K promotes bone and muscle growth."

"Vitamin K helps the baby digest milk."

"Vitamin K helps stabilize the baby's blood sugar."

"Vitamin K is used to prevent bleeding."

18. At 10 weeks gestation, a primigravida asks the nurse what is occurring developmentally with her baby. Which response by the nurse is correct?

Incorrect: Wrinkles do not form until late in the pregnancy. Fat stores usually do not form until the third trimester.

Incorrect: The eyelids are fused until about 26 weeks.

Correct: The kidneys are making urine, which is excreted by the fetus into the amniotic fluid.

Incorrect: The heart is already formed and beating at 8 weeks.

"The skin is wrinkled and fat is being formed."

"The eyelids are open and he can see."

"The kidneys are making urine."

"The heart is being developed."

19. A nurse in the clinic instructs a primigravida about the danger signs of pregnancy. The client demonstrates understanding of the instructions, stating she will notify the physician if which sign occurs?

Incorrect: White vaginal discharge is a normal occurrence during pregnancy due to increased amounts of estrogen and increased blood supply to the cervix and vagina. It is not a “danger sign. “

Incorrect: Backache is common in pregnancy due to the alteration of the woman's center of gravity; it is not a “danger sign.” Backaches become worse as the uterus enlarges.

Incorrect: Frequent, urgent urination is a common discomfort; it is not a danger sign. The pressure of the enlarging uterus causes frequency and urgency.

Correct: Abdominal pain is a danger sign and can be indicative of an abruptio placenta. It is important for a physician to evaluate this symptom. It is one of several danger signs, including: headache, rupture of membranes, vaginal bleeding, edema, epigastric pain, elevated temperature, painful urination, prolonged vomiting, blurred vision, change in or absence of fetal movement.

White vaginal discharge

Dull backache

Frequent, urgent urination

Abdominal pain

20. An hour after delivery, the nurse instills erythromycin (Ilotycin) ointment into the eyes of a newborn. The main objective of the treatment is to prevent infection caused by which organism?

Incorrect: Erythromycin (Ilotycin) is an antibiotic ointment used to prevent blindness related to gonorrhea. Antibiotics are effective against bacteria. Rubella is a virus.

Correct: Ilotycin, an antibiotic, is used for the prophylaxis treatment of gonorrhea and chlamydia. If left untreated, it could result in blindness.

Incorrect: Ilotycin, an antibiotic, is not effective in combating syphilis infections.

Incorrect: HIV is a virus. Antibiotics are effective against bacteria. Ilotycinis an antibiotic ointment and therefore not effective against HIV.

Rubella

Gonorrhea

Syphilis

Human immunodeficiency virus (HIV)

21. A woman in active labor receives a narcotic analgesic for pain control. If the narcotic is given a half an hour before delivery, which effect will the medication have on the infant? It will cause the infant's:

Incorrect: Narcotic analgesics cause respiratory depression and do not affect the infant's blood sugar.

Correct: Narcotic analgesics can cause respiratory depression for the infant and also for the mother. This is evidenced by low Apgar scores (apnea and bradycardia) in the infant. If respiratory depression occurs, a narcotic antagonist (Narcan) is usually given.

Incorrect: Narcotic analgesics, if given too close to delivery, can cause bradycardia, not tachycardia.

Incorrect: Narcotics, such as Demerol, cause CNS depression, not hyperactivity.

blood sugar to fall.

respiratory rate to decrease.

heart rate to increase.

movements to be hyperactive.

22. For a client in the second trimester of pregnancy, which assessment data support a diagnosis of pregnancy-induced hypertension (PIH)?

Incorrect: A decrease in hemoglobin is indicative of anemia, while uterine tenderness may indicate abruptio placenta.

Incorrect: Polyuria and weight loss are signs of gestational diabetes.

Correct: PIH is characterized by two components: elevated blood pressure and proteinuria. Vasospasm in the arterioles leads to increased blood pressure and a decrease in blood flow to the uterus and placenta. This results in a questionable outcome for the fetus due to placental insufficiency. Renal blood flow is affected, ultimately resulting in proteinuria.

Incorrect: Elevated blood glucose is a sign of gestational diabetes. Hematuria may indicate a U.T.I.

Hemoglobin 10.2 mg/dL and uterine tenderness

Polyuria and weight loss of 3 pounds in the last month

Blood pressure 168/110 and 3+ proteinuria

Hematuria and blood glucose of 160 mg/dL

23. A 35-week gestation infant was delivered by forceps. Which assessment findings should alert the nurse to a possible complication of the forceps delivery?

Correct: A weak, ineffective suck could be a result of facial paralysis which is a major complication of forceps deliveries. Scalp edema is another complication and should subside within 2-3 days. Other complications of forceps deliveries include: cephalohematomas, intracranial hemorrhage (especially in premature infants) and excessive bruising, which increases the risk for hyperbilirubinemia.

Incorrect: Molding of the head is a common occurrence with vaginal deliveries. Jitteriness is a sign of low blood sugar, not forceps delivery.

Incorrect: A shrill, high-pitched cry and tachypnea are signs of drug withdrawal, not a complication of forceps delivery.

Incorrect: Hypothermia is not a complication of forceps deliveries. The hemoglobin level is quite low (should be about 15-16 g/dL), but unless there is excessive bleeding, the hemoglobin level should be unaffected by the forceps delivery.

Weak, ineffective suck, and scalp edema

Molding of the head and jitteriness

Shrill, high pitched cry, and tachypnea

Hypothermia and hemoglobin of 12.5 g/dL

24. In which position should the nurse place the laboring client in order to increase the intensity of the contractions and improve oxygenation to the fetus?

Incorrect: This position is contraindicated because the fetus creates pressure on the mother's vena cava. Incorrect: Squatting widens the pelvic inlet, but does not improve contractions or fetal oxygenation.

Correct: This prevents vena cava compression and, therefore, improves fetal oxygenation; at the same time, it provides a restful position between contractions.

Incorrect: High Fowler's (sitting upright) will assist with the intensity of the contractions because of gravity, but it will not help with fetal oxygenation.

Supine with legs elevated

Squatting

Left side-lying

High Fowler's

25. A woman enters the birthing center in active labor. She tells the nurse that her membranes ruptured 26 hours ago. The nurse immediately takes the client's vital signs. Which is the rationale for the nurse's actions?

Incorrect: Pulse rates increase due to pain, not because of rupture of membranes.

Incorrect: The woman is not reporting pain and ruptured membranes do not cause pain. Lack of fluid (ruptured membranes) has no influence on respiratory rates.

Incorrect: Blood pressure is not affected by prolonged rupture of membranes.