# ATI PROCTORED EXAM - MATERNAL NEWBORN GRADED A -ALL ANSWERS CORRECT-180 QUESTIONS AND ANSWERS

A nurse is caring for a client who has oligohydraminios. What fetal anomalies should the nurse expect?

a. renal agenesis

b. atrial septal defect

c. spina bifida

d. hydrocephalus - CORRECT ANSWER a. renal agenesis

A nurse is assessing a client who is at 37 wks gestation and has a suspected pelvic fracture due to blunt abd trauma. What findings should the nurse expect?

a. uterine contractions

b. bradycardia

c. seizures

d. bradypnea - CORRECT ANSWER a. uterine contractions

The nurse should expect the client to be experiencing uterine contractions due to abdominal trauma.

A nurse is assessing a client who is at 12 wks gestation and has hydatidiform mole. What findings should the nurse expect?

a. hypothermia

b. dark brown vaginal discharge

c. fetal heart tones

d. decreased urinary output - CORRECT ANSWER b. dark brown vaginal discharge

A hydatidiform mole, or a molar pregnancy, is a benign proliferative growth of the chorionic villi, which gives rise to multiple cysts. The products of conception transform into a large number of edematous, fluid-filled vesicles. As cells slough off the uterine wall, vaginal discharge is usually dark brown and can contain grapelike clusters.

A nurse is assessing a client who is at 35 weeks of gestation and has mild gestational HTN. What finding should the nurse identify as the priority?

a. 480 mL urine output in 24 hrs

b. 1+ protein in the urine

c. +2 edema of the feet

d. BP 144/92 - CORRECT ANSWER a. 480 mL urine output in 24 hrs

When using the urgent vs. nonurgent approach to client care, the nurse should determine that the priority finding is 480 mL of urine output in 24 hr because the minimum acceptable urine output in an adult client is 30 mL/hr. This can indicate progression of preeclampsia to preeclampsia with severe features, which requires immediate intervention. Therefore, this is the priority finding.

A nurse is teaching a client who is at 12 wks gestation and has HIV. What statement should the nurse include in the teaching?

a. you will be in isolation after delivery

b. abstain from sexual intercourse throughout pregnancy

c. breastfeed your newborn to provide passive immunity

d. you should continue to take zidovudine throughout the pregnancy - CORRECT ANSWER d. you should continue to take zidovudine throughout the pregnancy

-can be transmitted through breastfeeding

-she can continue to have sex

The nurse should inform the client that taking prescription antiviral medication every day decreases the risk of transmission of HIV to her newborn.

A nurse is providing teaching to a client who is at 8 wks gestation about manifestations to report to the provider during pregnancy. What info should the nurse include in the teaching?

a. nausea upon awakening

b. blurred or double vision

c. increase in white vaginal discharge

d. leg cramps when sleeping - CORRECT ANSWER b. blurred or double vision

A nurse is caring for a client who is in the latent phase of labor and is receiving oxytocin via continuous IV infusion. The nurse notes that the client is having contractions every 2 min which last 100-110 seconds that the fetal heart rate is reassuring. What action should the nurse take?

a. decrease the dose of oxytocin by half

b. administer oxygen via nonrebreather mask

c. decrease the infusion rate of the maintenance IV fluid

d. administer terbutaline 0.25mg subq - CORRECT ANSWER a. decrease the dose of oxytocin by half

The nurse should decrease the dose of oxytocin by half because the client is experiencing uterine tachysystole.

A nurse is caring for a client who is in active labor and has meconium staining of the amniotic fluid. The nurse notes a reassuring FHR tracing from the external fetal monitor. What action should the nurse take?

a. prepare the client for emergency c-section

b. perform endotrach suctioning as soon as the fetal head is delivered

c. prepare equipment needed for newborn resuscitation

d. prepare the client for an ultrasound exam - CORRECT ANSWER c. prepare equipment needed for newborn resuscitation

The nurse should ensure that all supplies and equipment needed for resuscitation of the newborn are readily available for every delivery. Endotracheal suctioning is recommended in cases of meconium staining only if the newborn has poor respiratory effort, decreased muscle tone, and bradycardia after delivery.

A nurse is reviewing the medical record of a client who is at 33 wks gestation and has placenta previa and bleeding. What scripts should the nurse clarify with the provider?

a. insert a large-bore IV catheter

b. perform a vaginal exam

c. perform continuous external fetal monitoring

d. obtain a blood sample for lab testing - CORRECT ANSWER b. perform a vaginal exam

When a client has a placenta previa, the placenta implants in the lower part of the uterus and obstructs the cervical os (the opening to the vagina). The nurse should clarify this prescription because any manipulation can cause tearing of the placenta and increased bleeding.

A nurse is caring for a client who is at 37 wks gestation and is undergoing a nonstress test. The FHR is 130 without accelerations for the past 10 min. What action should the nurse take?

a. request a script for an internal fetal scalp electrode

b. auscultate the FHR with a doppler transducer

c. report the nonreactive test result to the provider immediately

d. use vibroacoustic stim on the client's abd for 3 seconds - CORRECT ANSWER d. use vibroacoustic stim on the client's abd for 3 seconds

The nurse should use a vibroacoustic stimulator on the client's abdomen to elicit fetal activity because the fetus is most likely sleeping. Fetal movement should cause accelerations in the FHR.

A nurse is reviewing lab results for a client who is at 37 wks gestation. The nurse notes that the client is rubella non-immune, positive for group A beta-hemolytic strep, and has a blood type O neg. What action should the nurse take?

a. instruct the client to obtain a rubella immunization after delivery

b. request a script for an antibiotic until delivery

c. inform the client that she will have to deliver via c-section

d. administer a dose of Pho(D) immune globulin - CORRECT ANSWER a. instruct the client to obtain a rubella immunization after delivery

A nurse is reviewing the med record of a client who is at 39 wks gestation and has polyhydramnios. What finding should the nurse expect?

a. total pregnancy wt gain of 3.6 kg

b. fetal GI anomaly

c. gestational HTN

d. fundal height of 34 cm - CORRECT ANSWER b. fetal GI anomaly

Polyhydramnios is the presence of excessive amniotic fluid surrounding the unborn fetus. Gastrointestinal malformations and neurologic disorders are expected findings for a fetus experiencing the effects of polyhydramnios.

A nurse is teaching a client who has pre-eclampsia and is to receive magnesium sulfate via continuous IV infusion about expected adverse effects. What adverse effects should the nurse include in the teaching?

a. elevated BP

b. feeling of warmth

c. generalized pruritis

d. hyperactivity - CORRECT ANSWER b. feeling of warmth

The nurse should tell the client to expect the feeling of warmth all over her body while the magnesium sulfate is infusing.

A nurse is caring for a client who is in the latent phase of labor and is experiencing low back pain. What action should the nurse take?

a. position the client supine with legs elevated

b. instruct the client to pant during contractions

c. encourage the client to soak in a warm bath

d. apply pressure to the client's sacral area during contractions - CORRECT ANSWER d. apply pressure to the client's sacral area during contractions

A nurse is teaching a client who is at 12 wks gestation about manifestations of potential complications that she should report to her provider. What info should the nurse include in the teaching?

a. intermittent nausea

b. white vaginal discharge

c. swelling of the face

d. urinary frequency - CORRECT ANSWER c. swelling of the face

A nurse is teaching a client who is at 10 wks gestation about an abd. ultrasound in the first trimester. What info should the nurse include in the teaching?

a. you will need to have a full bladder during the ultrasound

b. you will have a non stress test prior to the ultrasound

c. the ultrasound will determine the length of your cervix

d. you will experience uterine cramping during the ultrasound - CORRECT ANSWER a. you will need to have a full bladder during the ultrasound

MY ANSWER

The nurse should tell the client that a full bladder helps to lift the gravid uterus out of the pelvis during the examination. Therefore, it is important to ensure that the client has a full bladder to obtain the most accurate image of the fetus.

A nurse is assessing a client who is 34 wks gestation and has mild placental abruption. What finding should the nurse expect?

a. decreased urinary output

b. fetal distress

c. dark red vaginal bleeding

d. increased platelet count - CORRECT ANSWER c. dark red vaginal bleeding

The nurse should expect the client who has a mild placental abruption to have minimal dark red vaginal bleeding.

A nurse is caring for a client whose last menstrual period began july 8. Using Nageles rule, the nurse should identify the client's estimated DOB as what?

a. oct 15

b. april 15

c. oct 1

d. april 1 - CORRECT ANSWER b. april 15

A nurse is caring for a client who is at 39 wks gestation and is in the active phase of labor. The nurse observes late decels in the FHR. What finding should the nurse identify as the cause of late decels?

a. umbilical cord compression

b. fetal head compression

c. uteroplacental insufficiency

d. fetal ventricular septal defect - CORRECT ANSWER c. uteroplacental insufficiency

A nurse is assessing a client who is at 35 wks gestation and is receiving magnesium sulfate via continuous IV infusion for severe pre-eclampsia. What finding should the nurse report to the provider?

a. DTR 2+

b. resp 16

c. BP 150/96

d. urinary output 20 mL/hr - CORRECT ANSWER d. urinary output 20 mL/hr

The nurse should report a urinary output of 20 mL/hr because this can indicate inadequate renal perfusion, increasing the risk of magnesium sulfate toxicity. A decrease in urinary output can also indicate a decrease in renal perfusion secondary to a worsening of the client's pre-eclampsia.

A nurse is teaching a client who is at 13 wks gestation about the treatment of incompetent cervix with cervical cerclage. What statement by the client indicates an understanding of teaching?

a. I should go to the hospital if I think I may be in labor

b. I should expect bright red bleeding while the cerclage is in place

c. I am sad that I won't be able to get pregnant again

d. I can resume having sex as soon as I feel up to it - CORRECT ANSWER a. I should go to the hospital if I think I may be in labor

Cervical cerclage prevents premature opening of the cervix during pregnancy. The client should immediately go to a facility for evaluation if she experiences any manifestations of labor while the cerclage is in place. If the client experiences preterm uterine contractions she might require tocolytic therapy.

A nurse is admitting a client who is in labor and experiencing moderate bright red vaginal bleeding. What action should the nurse take?

a. obtain blood samples for baseline lab values

b. place a spiral electrode on the fetal presenting part

c. prepare the client for a transvaginal ultrasound

d. perform a vaginal exam to determine cervical dilation - CORRECT ANSWER a. obtain blood samples for baseline lab values

The nurse should obtain samples of the client's blood for baseline testing of hemoglobin and hematocrit levels.

A nurse is caring for a client who is at 38 wks of gestation and reports no fetal movement for 24 hr. What action should the nurse take?

a. auscultate for a FHR

b. reassure the client that a term fetus is less active

c. have the client drink orange juice

d. palpate the uterus for fetal movement - CORRECT ANSWER a. auscultate for a FHR

Presence of a fetal heart rate is a reassuring manifestation of fetal well-being. The nurse should auscultate for the fetal heart rate using a Doppler device or an external fetal monitor. This is the priority nursing action.

A nurse is caring for a client who is at 35 wks gestation and has severe pre-eclampsia. What assessment provides the most accurate info regarding the client's fluid and electrolyte status.

a. daily wt

b. bp

c. severity of edema

d. I&O - CORRECT ANSWER a. daily wt

A nurse is teaching a client who is at 30 wks gestation about warning signs of complications that she should report to her provider. What finding should the nurse include in the teaching?

a. 10 fetal movements per hour

b. mild constipation

c. vaginal bleeding

d. nasal congestion - CORRECT ANSWER c. vaginal bleeding

Vaginal bleeding can be an abnormal finding during pregnancy that might indicate a complication such as placental abruption, placenta previa, or preterm labor.

A nurse is teaching a client who is at 8 wks gestation and has a uterine fibroid about potential effects of the fibroid during pregnancy. What info should the nurse include?

a. you will have to undergo a c-section birth because of the fibroid

b. the fibroid can increase the risk for postpartum hemorrhage

c. the fibroid will shrink during pregnancy

d. you will receive an injection of medroxyprogesterone acetate to shrink the fibroid - CORRECT ANSWER b. the fibroid can increase the risk for postpartum hemorrhage

A nurse is caring for a client who is at 26 wks gestation and reports constipation. What responses by the nurse is appropriate?

a. you should drink 1 ounce of mineral oil q morning

b. you should eat at least 3 ounces of red meat/day

c. you should walk for at least 30 minutes q day

d. you should stop taking your prenatal - CORRECT ANSWER c. you should walk for at least 30 minutes q day

The nurse should encourage the client to participate in moderate physical activity, such as walking or swimming, every day. This activity increases intestinal peristalsis, which will help alleviate constipation.

A nurse is planning care for a newborn who is receiving phototherapy for an elevated bilirubin level. What action should the nurse take?

a. apply barrier ointment to the newborn's perianal region

b. offer the newborn glucose water between feedings

c. use photometer to monitor the lamp's energy

d. keep the newborn's eye patches on during feedings - CORRECT ANSWER c. use photometer to monitor the lamp's energy

The nurse should monitor the lamp's energy throughout the therapy to ensure the newborn is receiving the appropriate amount to be effective.

A nurse is assessing a 4 hr old newborn who is to breastfeed and notes hands and feet that are cool and slightly blue What action should the nurse take?

a. check the newborns temp using temporal thermometer

b. place the naked newborn on the mothers bare chest and cover both with a blanket

c. apply an o2 hood over the newborns head and neck

d. give the newborn glucose water between feedings - CORRECT ANSWER b. place the naked newborn on the mothers bare chest and cover both with a blanket

Exposure to a cool environment causes vasoconstriction, which results in cool extremities with a bluish discoloration. Placing the newborn skin-to-skin with his mother helps stabilize his temperature and promotes bonding.

A nurse is caring for a newborn immediately following delivery. What actions should the nurse take first?

a. place the newborn directly on the client's chest

b. administer erythromycin ophthalmic ointment

c. give the newborn vit K IM

d. perform a detailed physical assessment - CORRECT ANSWER a. place the newborn directly on the client's chest

the greatest risk to the newborn is cold stress, which increases the need for oxygen and glucose. Placing the newborn directly on the client's chest will help maintain the newborn's temperature.

A nurse is providing teaching to the parents of a newborn about home safety. What statement by the parents indicates an understanding of the teaching?

a. I will use an infant carrier when I drive to places close to the house

b. I will tie my baby's pacifier around his neck with a piece of yarn

c. I will place my baby on his back when it is time for him to sleep

d. I will keep my babys crib close to heat vents to keep him warm - CORRECT ANSWER c. I will place my baby on his back when it is time for him to sleep

A nurse is assessing a newborn 1 min after birth andnotes a hr of 136/min, resp 36, well flexed extremities, responding to stimuli with a cry, blue hands and feet. What Apgar score should the nurse assign to the newborn?

a. 10

b. 9

c. 8

d. 7 - CORRECT ANSWER b. 9

A nurse is assessing a client who is 14 hr postpartum and has a 3rd degree perineal laceration. The client's temp is 37.8 C (100F), her fundus is firm and slightly deviated to the right. The client reports a gush of blood when she ambulates and no bm since delivery. What action should the nurse take?

a. notify the provider about the elevated temp

b. massage the client's fundus

c. administer bisacodyl supp

d. assist the client to empty her bladder - CORRECT ANSWER d. assist the client to empty her bladder

When the client's fundus is deviated to the right or left it can indicate that her bladder is full. The nurse should assist the client to empty her bladder to prevent uterine atony and excessive lochia.

A nurse is preparing to administer morphine oral solution 0.04 mg/kg to a newborn who weighs 2.5kg. The amount available is 0.4 mg/ml. how many ml should the nurse administer? - CORRECT ANSWER 0.25

A nurse is assessing a 12 hr old newborn and notes a resp rate of 44 with shallow respirations and periods of apnea lasting up to 10 seconds. What action should the nurse take?

a. continue routine monitoring

b. place newborn prone

c. request a script for supplemental o2

d. perform chest percussion - CORRECT ANSWER a. continue routine monitoring

The nurse should continue routine monitoring because the newborn's assessments findings indicate he is adapting to extrauterine life.

placing in sidelying or supine

A nurse is caring for a client who reports intestinal gas pain following a c-section. What action should the nurse take?

a. encourage client to drink carbonated beverages

b. instruct the client to splint the incision with a pillow

c. have the client drink fluids through a straw

d. assist the client to ambulate in the hallway - CORRECT ANSWER d. assist the client to ambulate in the hallway

Walking can help stimulate peristalsis, which will promote expulsion of gas.

A nurse is caring for a newborn who is premature at 30 wks gestation. What finding should the nurse expect?

a. heel creases covering the bottom of the feet

b. good flexion

c. abundant lanugo

d. dry, parchment-like skin - CORRECT ANSWER c. abundant lanugo

Newborns who are premature have abundant lanugo, fine hair, especially over their back. A full-term newborn typically has minimal lanugo present only on the shoulders, pinnas, and forehead.

A nurse is assessing a newborn 1 hr after birth. What assessment findings should the nurse report to the provider?

a. acrocyanosis

b. jaundice of the sclera

c. resp rate 50

d. cbg 60 - CORRECT ANSWER b. jaundice of the sclera

If the newborn has jaundice within the first 24 hr of life, this can indicate a potential pathological process such as hemolytic disease. Pathologic jaundice can result in high levels of bilirubin that can cause damage to the neonatal brain.

A nurse is providing teaching to the parents of a newborn about bottle feeding. What instructions should the nurse include?

a. discard unused refrigerated formula after 72 hrs

b. prop the bottle with a blanket for the last feeding of the day

c. dilute ready-to-feed formula if the newborn is gaining wt too quickly

d. boil water for powdered formula for 1-2 min - CORRECT ANSWER d. boil water for powdered formula for 1-2 min

The parents should run tap water for 2 min and then boil it for 1 to 2 min before mixing it with the formula to decrease the risk of contamination.

A nurse is caring for a client who is to receive a continuous IV infusion of oxytocin following a vaginal birth. What assessment findings should the nurse monitor to evaluate the effectiveness of the med?

a. pulse rate

b. bp

c. fundal consistency

d. output - CORRECT ANSWER c. fundal consistency

Oxytocin is a smooth muscle relaxant that causes contraction of the uterus. The nurse should palpate the uterine fundus to determine consistency or tone to determine if the medication is effective.

A nurse is caring for a newborn who is premature in the neonatal ICU. what action should the nurse take to promote development?

a. discourage the use of pacifiers

b. position the naked newborn on the parents bare chest

c. provide frequent periods of visual and auditory stimulation

d. rapidly advance oral feedings - CORRECT ANSWER b. position the naked newborn on the parents bare chest

A nurse is caring for a postpartum client 8hrs after delivery. What factors place the client at risk for uterine atony? select all

a. oxytocin infusion

b. prolonged labor

c. mag sulfate infusion

d. small for gestational age newborn

e. distended bladder - CORRECT ANSWER b. prolonged labor

Prolonged labor can stretch out the musculature of the uterus and cause fatigue, which prevents the uterus from contracting.

c. mag sulfate infusion

Magnesium sulfate is a smooth muscle relaxant and can prevent adequate contraction of the uterus.

e. distended bladder

After birth, clients can experience a decreased urge to void due to birth-induced trauma, increased bladder capacity, and anesthetics, which can result in a distended bladder. The distended bladder displaces the uterus and can prevent adequate contraction of the uterus.

A nurse is assessing a newborn for congenital hip dysplasia. What finding should the nurse expect?

a. temp of one leg differing from that of the other

b. symmetrical gluteal folds

c. limited abduction of one hip

d. legs that are shorter than the arms - CORRECT ANSWER c. limited abduction of one hip

A newborn who has congenital hip dysplasia can have limited abduction because the head of the femur might have slipped out of the acetabulum.

asymmetrical gluteal folds

A nurse is testing the reflexes of a newborn to assess neurologic maturity. What reflexes is the nurse assessing when she quickly and gently turns the newborn's head to one side?

a. moro

b. babinski

c. rooting

d. tonic neck - CORRECT ANSWER d. tonic neck

To elicit the tonic neck reflex, the nurse should quickly and gently turn the newborn's head to one side when he is sleeping or falling asleep. The newborn's arm and leg should extend outward to the same side that the nurse turned his head while the opposite arm and leg flex. This reflex persists for about 3 to 4 months.

A nurse is assessing a newborn who was born at 39 wks gestation. What finding should the nurse expect?

a. symmetric rib cage

b. lanugo abundant on the back

c. dry, wrinkled skin

d. vernix over the entire body - CORRECT ANSWER a. symmetric rib cage

A newborn who is born at 39 weeks of gestation is full-term and should have normal, smooth skin with good turgor and the presence of subcutaneous fat pockets. A postmature newborn, greater than 42 weeks of gestation, will have dry, cracked skin with a wrinkled appearance.

A nurse is assessing a 2 day old newborn and notes an egg-shaped, edematous, bluish discoloration that does not cross the suture line. What pieces of info should the nurse provide to the mother when she inquires about the finding?

a. this will resolve within 3-6 wks without treatment

b. this will resolve on its own within 3-4 days

c. this is expected at birth so you don't need to worry about it

d. the provider might drain this area with a syringe - CORRECT ANSWER a. this will resolve within 3-6 wks without treatment

A nurse is assessing a client who is postpartum following a vacuum-assisted birth. For what finding should the nurse monitor to identify a cervical laceration?

a. a gush of rubra lochia when the nurse massages the uterus

b. continuous lochia flow and flaccid uterus

c. slow trickle of bright vaginal bleeding and a firm fundus

d. report of increasing pain and pressure in the perineal area - CORRECT ANSWER c. slow trickle of bright vaginal bleeding and a firm fundus

The nurse should monitor for bright red bleeding as a slow trickle, oozing or outright bleeding,and a firm fundus to identify a cervical laceration.

A nurse is planning care for a client who is postpartum and has cardiac disease. For what script should the nurse seek clarification?

a. initiate bedrest with HOB elevated

b. initiate high-fiber diet for client

c. monitor clients wt wkly

d. monitor client's I&O - CORRECT ANSWER c. monitor clients wt wkly