ATI COMPREHENSIVE HESI MATERNITY QUESTION AND ANSWERS | REAL EXAMS

1. **A full-term infant is admitted to the newborn nursery and, after careful assessment, the nurse suspects that the infant may have an esophageal atresia. Which symptoms is this newborn likely to have exhibited?**

A) Choking, coughing, and cyanosis.
Feedback: CORRECT

B) Projectile vomiting and cyanosis.
Feedback: INCORRECT

C) Apneic spells and grunting.
Feedback: INCORRECT

D) Scaphoid abdomen and anorexia.
Feedback: INCORRECT

Feedback: INCORRECT
(A) includes the "3 Cs" of esophageal atresia caused by the overflow of secretions intothe trachea. (B) is characteristic of pyloric stenosis in the infant. (C) could be due to prematurity or sepsis, and grunting is a sign of respiratory distress. (D) is characteristicof diaphragmatic hernia.

Correct Answer(s): A

2.
A female client with insulin-dependent diabetes arrives at the clinic seeking a planto get pregnant in approximately 6 months. She tells the nurse that she want to have an uncomplicated pregnancy and a healthy baby. What information should the nurse share with the client?

A) Your current dose of Insulin should be maintained throughout your pregnancy.
B) Maintain blood sugar levels in a constant range within normal limitsduring pregnancy.

C) The course and outcome of your pregnancy is not an achievable goal with diabetes.
D) Expect an increase in insulin dosages by 5 units/week during the first trimester.

Feedback: INCORRECT
Maintaining blood sugar within a normal range during pregnancy has a strong correlation with a good outcome (B). Insulin requirements normally change duringpregnancy (A).
Active participation of the client with her diabetes management during pregnancy is associated with better outcomes, not (C). Insulin needs are individually determined byblood glucose values, not a set schedule, not (D).

Correct Answer(s): B

3.
The nurse observes a new mother avoiding eye contact with her newborn. Whichaction should the nurse take?
A) Ask the mother why she won't look at the infant.

Feedback: INCORRECT

B) Observe the mother for other attachment behaviors.
Feedback: CORRECT

C) Examine the newborn's eyes for the ability to focus.
Feedback: INCORRECT

D) Recognize this as a common reaction in new mothers.
Feedback: INCORRECT

Feedback: INCORRECT
Parent-infant bonding or attachment is based on a mutual relationship between parentand infant and is commonly established by the "enface

position," which is demonstrated by the mother's and infant's eyes meeting in the same plane. To assessfor other attachment behaviors, continued observation of the new mother's interactions with her infant (B) helps the nurse determine problems in attachment.
(A) may cause undue confusion, stress, or impact the mother's self-confidence. (C) is not indicated. The "enface position" is a significant, early behavior that leads to theformation of affectional ties and should be encouraged (D).

Correct Answer(s): B

4.
A client who is attending antepartum classes asks the nurse why her healthcareprovider has prescribed iron tablets. The nurse's response is based on what knowledge?

A) Supplementary iron is more efficiently utilized during pregnancy.
Feedback: INCORRECT

B) It is difficult to consume 18 mg of additional iron by diet alone.
Feedback: CORRECT

C) Iron absorption is decreased in the GI tract during pregnancy.
Feedback: INCORRECT

D) Iron is needed to prevent megaloblastic anemia in the last trimester.
Feedback: INCORRECT

Feedback: INCORRECT
Consuming enough iron-containing foods to facilitate adequate fetal storage of ironand to meet the demands of pregnancy is difficult (B) so iron supplements are oftenrecommended. Dietary iron (A) is just as "good" as iron in tablet form. Iron absorption occurs readily during pregnancy, and is not decreased within the GI tract(C).
Megaloblastic anemia (D) is caused by folic acid deficiency.

Correct Answer(s): B

5.
Just after delivery, a new mother tells the nurse, "I was unsuccessful breastfeeding my first child, but I would like to try with this baby." Which intervention is best for the nurse to implement first?

A) Assess the husband's feelings about his wife's decision to breastfeed their baby.
Feedback: INCORRECT

B) Ask the client to describe why she was unsuccessful with breastfeeding her last child.
Feedback: INCORRECT

C) Encourage the client to develop a positive attitude about breastfeeding to helpensure success.
Feedback: INCORRECT

D) Provide assistance to the mother to begin breastfeeding as soon as possibleafter delivery.
Feedback: CORRECT

Feedback: INCORRECT
Infants respond to breastfeeding best when feeding is initiated in the active phase soon after delivery (D). (A and B) might provide interesting data, but gathering this information is not as important as providing support and instructions to the new mother.While (C) is also true, this response by the nurse might seem judgmental to a new mother.

Correct Answer(s): D

6.
The nurse is caring for a woman with a previously diagnosed heart disease who isin the second stage of labor. Which assessment findings are of greatest concern?

A) Edema, basilar rales, and an irregular pulse.
Feedback: CORRECT

B) Increased urinary output and tachycardia.
Feedback: INCORRECT

C) Shortness of breath, bradycardia, and hypertension.
Feedback: INCORRECT

D) Regular heart rate and hypertension.
Feedback: INCORRECT

Feedback: INCORRECT
Edema, basilar rales, and an irregular pulse (A) indicate cardiac decompensation andrequire immediate intervention. Though (B, C, and D) are cardiac symptoms, they require less emergency intervention than (A).

Correct Answer(s): A

7.
Which assessment finding should the nursery nurse report to the pediatrichealthcare provider?

A) Blood glucose level of 45 mg/dl.
B) Blood pressure of 82/45 mmHg.
C) Non-bulging anterior fontanel.
D) Central cyanosis when crying.

Feedback: INCORRECT
An infant who demonstrates central cyanosis when crying (D) is manifesting poor adaptation to extrauterine life which should be reported to the healthcare provider fordetermination of a possible underlying cardiovascular problem. (A, B, and C) are expected findings.

Correct Answer(s): D

8.
A client at 32-weeks gestation is diagnosed with preeclampsia. Which assessmentfinding is most indicative of an impending convulsion?

A) 3+ deep tendon reflexes.
Feedback: INCORRECT

B) Periorbital edema.
Feedback: INCORRECT

C) Epigastric pain.
Feedback: CORRECT

D) Decreased urine output.
Feedback: INCORRECT

Feedback: INCORRECT
Epigastric pain (C) is indicative of an edematous liver or pancreas which is an earlywarning sign of an impending convulsion (eclampsia) and requires immediate attention. (A, B and D)are pathological changes that occur with preeclampsia, but
(C) is often an early indicator of an impending seizure.

Correct CAnswer (s):

9.
A client receiving epidural anesthesia begins to experience nausea and becomespale and clammy. What intervention should the nurse implement first?

A) Raise the foot of the bed.
Feedback: CORRECT

B) Assess for vaginal bleeding.
Feedback: INCORRECT

C) Evaluate the fetal heart rate.
Feedback: INCORRECT

D) Take the client's blood pressure.
Feedback: INCORRECT

Feedback: INCORRECT
These symptoms are suggestive of hypotension which is a side effect of epidural anesthesia. Raising the foot of the bed (A) will increase venous return and provideblood to the vital areas. Increasing the IV fluid rate using a balanced non-dextrosesolution and ensuring that the client is in a lateral position are also appropriate interventions. (B and C) will not raise the maternal blood pressure. Since the symptoms are common sideeffects of epidural anesthesia and suggest hypotension, (D) can wait until (A) is implemented.

Correct Answer(s): A

10.

The healthcare provider prescribes terbutaline (Brethine) for a client in pretermlabor. Before initiating this prescription, it is most important for the nurse to assess the client for which condition?

A) Gestational diabetes.
Feedback: CORRECT

B) Elevated blood pressure.
Feedback: INCORRECT

C) Urinary tract infection.
Feedback: INCORRECT

D) Swelling in lower extremities.
Feedback: INCORRECT

Feedback: INCORRECT
The nurse should evaluate the client for gestational diabetes (A) because terbutaline (Brethine) increases blood glucose levels. (B) could be related to the client being in preterm labor, however, terbutaline (Brethine) can cause a decrease in blood pressure.
(C) can cause uterine irritability, which can result in preterm labor that should be treated by first resolving the infection rather than by administering a tocolytic agentsuch as terbutaline (Brethine). (D) is a common pregnancy complaint.

Correct
A**Answer**
(s):

11.

During a prenatal visit, the nurse discusses with a client the effects of

smokingon the fetus. When compared with nonsmokers, mothers who smoke during pregnancy tend to produce infants who have

A) lower Apgar scores.
Feedback: INCORRECT

B) lower birth weights.
Feedback: CORRECT

C) respiratory distress.
Feedback: INCORRECT

D) a higher rate of congenital anomalies.
Feedback: INCORRECT

Feedback: INCORRECT
Smoking is associated with low-birth-weight infants (B). Mothers are encouraged not to smoke during pregnancy. To date, significant relationships have not been found between smoking and options (A, C, or D).

Correct Answer(s): B

12.
A 30-year-old gravida 2, para 1 client is admitted to the hospital at 26-weeksgestation in preterm labor. She is started on an IV solution of terbutaline (Brethine). Which assessment is the highest priority for the nurse to monitorduring the administration of this drug?

A) Maternal blood pressure and respirations.

B) Maternal and fetal heart rates.
Feedback: CORRECT

C) Hourly urinary output.
Feedback: INCORRECT

D) Deep tendon reflexes.

Feedback: INCORRECT
Monitoring maternal and fetal heart rates (B) is most important when terbutaline is being administered. Terbutaline acts as a sympathomimetic agent that stimulates bothbeta 1 receptors (causing tachycardia, a side effect of the drug) and stimulation of beta 2 receptors (causing uterine relaxation, a desired effect of the drug). While monitoring (A, C, and D) is helpful, these do not have the priority of monitoring (B) when a beta- adrenergic agonists is administered.

Correct Answer(s): B

13.
A newborn, whose mother is HIV positive, is scheduled for follow-up assessments. The nurse knows that the most likely presenting symptom for apediatric client with AIDS is:

A) shortness of breath.
Feedback: INCORRECT

B) joint pain.
Feedback: INCORRECT

C) a persistent cold.
Feedback: CORRECT

D) organomegaly.
Feedback: INCORRECT

Feedback: INCORRECT
Respiratory tract infections commonly occur in the pediatric population. However, thechild with AIDS has a decreased ability to defend the body against these infections and often the presenting symptom of a child with AIDS is a persistent cold (C). (A, B,and D) are symptoms of complications which may occur later in the disease process.

Correct Answer(s): C

14.
A 28-year-old client in active labor complains of cramps in her leg. Whatintervention should the nurse implement?

A) Massage the calf and foot.
Feedback: INCORRECT

B) Extend the leg and dorsiflex the foot.
Feedback: CORRECT

C) Lower the leg off the side of the bed.
Feedback: INCORRECT

D) Elevate the leg above the heart.
Feedback: INCORRECT

Feedback: INCORRECT
Dorsiflexing the foot by pushing the sole of the foot forward or by standing (if the client is capable) (B), and putting the heel of the foot on the floor is the best means ofrelieving leg cramps. (A) is ineffective for leg cramps caused by phosphorous/calcium imbalances and may dislodge small

thrombus. (C) would not be helpful. (D) is used to promote venous return, but is not indicated for leg cramps.

Correct Answer(s): B

15.

A client with gestational hypertension is in active labor and receiving an infusion of magnesium sulfate. Which drug should the nurse have available forsigns of potential toxicity?

A) Oxytocin (Pitocin).
B) Calcium gluconate.
C) Terbutaline (Brethine).
D) Naloxone (Narcan).

Feedback: INCORRECT
The antidote for magnesium sulfate is calcium gluconate (B), which should be readilyavailable if the client manifest signs of toxicity. (A, C, and D) are not effective in the reversal of magnesium sulfate.

Correct Answer(s): B

16.
A full term infant is transferred to the nursery from labor and delivery. Whichinformation is most important for the nurse to receive when planning immediate care for the newborn?

A) Length of labor and method of delivery.
Feedback: INCORRECT

B) Infant's condition at birth and treatment received.
Feedback: CORRECT

C) Feeding method chosen by the parents.
Feedback: INCORRECT

D) History of drugs given to the mother during labor.
Feedback: INCORRECT

Feedback: INCORRECT
Immediate care is most dependent on the infant's current status (i.e., Apgar scores at 1 and 5 minutes) and any treatment or resuscitation that was indicated. The transitional care nurse needs the information listed in the choices (A, C, and D), but the priority is(B).

Correct Answer(s): B

17.
Which nursing intervention is helpful in relieving "afterpains" (postpartum uterinecontractions)?

A) Using relaxation breathing techniques.
Feedback: CORRECT

B) Using a breast pump.
Feedback: INCORRECT

C) Massaging the abdomen.
Feedback: INCORRECT

D) Giving oxytocic medications.
Feedback: INCORRECT

Feedback: INCORRECT

Periodic contraction and relaxation of the uterus causes "afterpains." Relaxation breathing techniques (A) provide distraction, reducing the perception of pain. (B) stimulates uterine contractions. (C) may contract the uterus temporarily and then encourage more afterpains later. (D) stimulates afterpains/uterine contractions.

Correct Answer(s): A

18.
A client with no prenatal care arrives at the labor unit screaming, "The baby iscoming!" The nurse performs a vaginal examination that reveals the cervix is 3centimeters dilated and 75% effaced. What additional information is most important for the nurse to obtain?

A) Gravidity and parity.

Feedback: INCORRECT

B) Time and amount of last oral intake.
Feedback: INCORRECT

C) Date of last normal menstrual period.
Feedback: CORRECT

D) Frequency and intensity of contractions.
Feedback: INCORRECT

Feedback: INCORRECT
Evaluating the gestation of the pregnancy (C) takes priority. If the fetus is preterm andthe fetal heart pattern is reassuring, the healthcare provider may attempt to prolong thepregnancy and administer corticosteroids to mature the lungs of the fetus. (A, B, and D) are all important to evaluate and incorporate into the plan of care, but establishing gestation takes priority.

Correct Answer(s): C

19.
What action should the nurse implement to decrease the client's risk forhemorrhage after a cesarean section?

A) Monitor urinary output via an indwelling catheter.
B) Assess the abdominal dressings for drainage.
C) Give the Ringer's Lactated infusion at 125 ml/hr.
D) Check the firmness of the uterus every 15 minutes.

Feedback: INCORRECT
A client's risk of postpartal hemorrhage is deceased when the uterus is firm after delivery of the infant. Assessment of fundus consistency q15 minutes

(D) provides frequent intervals to stimulate the fundus to contract and prevent bleeding. (A, B, andC) are interventions that do not decrease a postpartal client's risk for hemorrhage.

Correct Answer(s): D

20.

In evaluating the respiratory effort of a one-hour-old infant using the Silverman-Anderson Index, the nurse determines the infant has synchronized chest and abdominal movement, just visible lower chest retractions, just visible xiphoid retractions, minimal and transient nasal flaring, and an expiratory grunt heard only on auscultation. What Silverman-Anderson score should the nurse assign tothis infant? (Enter numeral value only.)

4

Feedback: CORRECT

Feedback: INCORRECT

A Silverman-Anderson Index has five categories with scores of 0, 1, or 2. The totalscore ranges from 0 to 10. Four of the these assessment findings should receive a score of 1, and the 5th finding (synchronized chest and abdominal movement) receives a score of 0. Therefore, the total score is 4. A total score of 0 means the infant has no dyspnea, a total score of 10 indicates maximum respiratory distress.

Correct Answer(s): 4

21.

An expectant father tells the nurse he fears that his wife "is losing her mind."He states she is constantly rubbing her abdomen and talking to the baby, andthat she actually reprimands the baby when it moves too much. What recommendation should the nurse make to this expectant father?

A) Reassure him that these are normal reactions to pregnancy and suggest that hediscuss his concerns with the childbirth education nurse.
Feedback: INCORRECT

B) Help him to understand that his wife is experiencing normal symptomsof ambivalence about the pregnancy and no action is needed.
Feedback: INCORRECT

C) Ask him to observe his wife's behavior carefully for the next few weeks and reportany similar behavior to the nurse at the next prenatal visit.
Feedback: INCORRECT

D) Let him know that these behaviors are part of normal maternal/fetal bondingwhich occur once the mother feels fetal movement.
Feedback: CORRECT

Feedback: INCORRECT
These behaviors are positive signs of maternal/fetal bonding (D) and do not reflect ambivalence (B). No intervention is needed. Quickening, the first perception of fetalmovement, occurs at 17 to 20 weeks gestation and begins a new phase of prenatal bonding during the second trimester. Although (A) is not wrong, it dismisses the father's concerns. (C) is not indicated.

Correct Answer(s): D

22.
The nurse should encourage the laboring client to begin pushing when

A) there is only an anterior or posterior lip of cervix left.
Feedback: INCORRECT

B) the client describes the need to have a bowel movement.
Feedback: INCORRECT

C) the cervix is completely dilated.
Feedback: CORRECT

D) the cervix is completely effaced.
Feedback: INCORRECT

Feedback: INCORRECT
Pushing begins with the second stage of labor, i.e., when the cervix is completely dilated at 10 cm (C). If pushing begins before the cervix is completely dilated (A, B,and D), the cervix can become edematous and may never completely dilate, necessitating an operative delivery. Many primigravidas begin active labor 100% effaced and then proceed to dilate.

Correct Answer(s): C

23.
The nurse attempts to help an unmarried teenager deal with her feelings following a spontaneous abortion at 8-weeks gestation. What type of emotional response should the nurse anticipate?

A) Grief related to her perceptions about the loss of this child.
Feedback: CORRECT

B) Relief of ambivalent feelings experienced with this pregnancy.
Feedback: INCORRECT

C) Shock because she may not have realized that she was pregnant.

Feedback: INCORRECT

D) Guilt because she had not followed her healthcare provider's instructions.
Feedback: INCORRECT

Feedback: INCORRECT
Grief/loss response occurs at all stages of pregnancy loss (A). Ambivalence toward the pregnancy normally occurs up to 20-weeks and contributes to guilt experienced following pregnancy loss (B). Shock due to denial of pregnancy might be a factor with this client, but it is not likely to influence the grieving process (C). Although data was not provided to support (D), compliance with medical instructions does notprevent guilt that can be associated with other behaviors the client may have exhibited(such as smoking) during the first trimester.

Correct Answer(s): A

24.
The nurse caring for a laboring client encourages her to void at least q2h, and records each time the client empties her bladder. What is the primary reason forimplementing this nursing intervention?

A) Emptying the bladder during delivery is difficult because of the position ofthe presenting fetal part.
Feedback: INCORRECT

B) An over-distended bladder could be traumatized during labor as well as prolongthe progress of labor.
Feedback: CORRECT

C) Urine specimens for glucose and protein must be obtained at certainintervals throughout labor.
Feedback: INCORRECT

D) Frequent voiding minimizes the need for catheterization which increases the chanceof bladder infection.
Feedback: INCORRECT

Feedback: INCORRECT
A full bladder can impair the efficiency of the uterine contractions and impede descent of the fetus during labor (B). Also, because of the close proximity of the bladder to the uterus, the bladder can be traumatized by the descent of the fetus. It is not difficult to empty the bladder during delivery (A). Urine specimens are obtained only by special order (C). There is danger of infection due to catheterization (D), butthis is not the primary reason for encouraging the client to void during labor.

Correct Answer(s): B

25.
After each feeding, a 3-day-old newborn is spitting up large amounts of EnfamilÂ® Newborn Formula, a nonfat cow's milk formula. The pediatric healthcare provider changes the neonate's formula to SimilacÂ® Soy IsomilÂ® Formula, a soy protein isolate based infant formula. What information should thenurse provide to the mother about the newly prescribed formula?

A) The new formula is a coconut milk formula used with babies with impairedfat absorption.

Feedback: INCORRECT

B) EnfamilÂ® Formula is a demineralized whey formula that is needed with diarrhea.
Feedback: INCORRECT

C) The new formula is a casein protein source that is low in phenylalanine.
Feedback: INCORRECT

D) SimilacÂ® Soy IsomilÂ® Formula is a soy-based formula that contains sucrose.
Feedback: CORRECT

Feedback: INCORRECT
The nurse should explain that the newborn's feeding intolerance may be related to thelactose found in cow's milk formula and is being replaced with the soy-based formulathat contains sucrose (D), which is well-tolerated in infants with milk allergies and lactose intolerance. (A) describes PortagenÂ® Formula, a formula prescribed for malabsorption syndromes. (B) does not explain that cow's milk intolerance is the reason for the formula change. (C) describes LofenalacÂ® Formula, a formula prescribed for phenylketonuria (PKU).

Correct Answer(s): D

26.
A couple, concerned because the woman has not been able to conceive, is referredto a healthcare provider for a fertility workup and a hysterosalpingography is scheduled. Which postprocedure complaint indicates that the fallopian tubes are patent?

A) Back pain.
Feedback: INCORRECT

B) Abdominal pain.
Feedback: INCORRECT

C) Shoulder pain.

Feedback: CORRECT

D) Leg cramps.
Feedback: INCORRECT

Feedback: INCORRECT
If the tubes are patent (open), pain is referred to the shoulder (C) from a subdiaphragmatic collection of peritoneal dye/gas. (B) could be caused from uterinecramping, but might also be indicative of gas/dye collecting in the uterus due to occluded tubes. Abdominal pain should be further evaluated; it would not be normalafter hysterosalpingography. (A and D) are not related to the procedure.

Correct Answer(s): C

27.
A new mother who has just had her first baby says to the nurse, "I saw the babyin the recovery room. She sure has a funny looking head." Which response by the nurse is best?

A) This is not an unusual shaped head, especially for a first baby.
Feedback: INCORRECT

B) It may look funny to you, but newborn babies are often born with heads likeyour baby's.
Feedback: INCORRECT

C) That is normal; the head will return to a round shape within 7 to 10 days.
Feedback: CORRECT

D) Your pelvis was too small, so the baby's head had to adjust to the birth canal.
Feedback: INCORRECT

Feedback: INCORRECT
(C) reassures the mother that this is normal in the newborn and provides correct information regarding the return to a "normal" shape. Although (A) is correct, it implies

that the client should "not worry." Any implied or spoken "don't worry" is usually thewrong answer! (B) is condescending and dismissing--the mother is seeking reassurance and information. (D) is a negative statement and implies that molding is the mother's "fault."

Correct Answer(s): C

28.
When preparing a class on newborn care for expectant parents, what content should the nurse teach concerning the newborn infant born at term gestation?

A) Milia are red marks made by forceps and will disappear within 7 to 10 days.
Feedback: INCORRECT

B) Meconium is the first stool and is usually yellow gold in color.
Feedback: INCORRECT

C) Vernix is a white, cheesy substance, predominantly located in the skin folds.
Feedback: CORRECT

D) Pseudostrabismus found in newborns is treated by minor surgery.
Feedback: INCORRECT

Feedback: INCORRECT
(C) is correct. Vernix, found in the folds of the skin, is a characteristic of term infants.
(A) is white, pinpoint spots usually found over the nose and chin which represent blockage of the sebaceous glands. (B) is tarry-black. (D) (crossed eyes) is normal atbirth but should be corrected if it persists after 6 to 9 months of age.

Correct Answer(s): C

29.
Which action should the nurse implement when preparing to measure the fundalheight of a pregnant client?

A) Have the client empty her bladder.
B) Request the client lie on her left side.
C) Perform Leopold's maneuvers first.
D) Give the client some cold juice to drink.

Feedback: INCORRECT
To accurately measure the fundal height, the bladder must be empty (A) to avoid elevation of the uterus. Fundal height is not measured with the client lying on her side(B). Leopold's maneuvers are performed to assess fetal position and the expected location of the point of maximal impulse (PMI) for fetal heart rate (C). Cold juice (D)does not affect the fundal height measurement, but may be given to arouse the fetus ifthe fetus appears to be sleeping during a non-stress test.

Correct Answer(s): A

30.
A newborn infant is brought to the nursery from the birthing suite. The nursenotices that the infant is breathing satisfactorily but appears dusky. What action should the nurse take first?

A) Notify the pediatrician immediately.
Feedback: INCORRECT

B) Suction the infant's nares, then the oral cavity.
Feedback: INCORRECT

C) Check the infant's oxygen saturation rate.
Feedback: CORRECT

D) Position the infant on the right side.
Feedback: INCORRECT

Feedback: INCORRECT
When possible, the nurse should first obtain measurable objective data; an oxygen saturation rate provides such information (C). The pediatrician should be notified if the

oxygen saturation rate is below 90% (A). The infant is not demonstrating signs of anobstructed airway, but if suctioning was required, the oral cavity should be suctionedfirst to prevent the infant from aspirating pharyngeal secretions (B). (D) facilitates drainage from the mouth and promotes emptying into the small intestine, but at this time, this intervention is not as high a priority as (C).

Correct Answer(s): C

31.

A healthcare provider informs the charge nurse of a labor and delivery unit that aclient is coming to the unit with suspected abruptio placentae. What findings should the charge nurse expect the client to demonstrate? (Select all that apply.)

A) Dark, red vaginal bleeding.
B) Lower back pain.
C) Premature rupture of membranes.
D) Increased uterine irritability.
E) Bilateral pitting edema.
F) A rigid abdomen.

Feedback: INCORRECT
The symptoms of abruptio placentae include dark red vaginal bleeding (A), increaseduterine irritability (D), and a rigid abdomen (F). (B, C, and E) are findings not associated with abruptio placentae.

Correct Answer(s): A, D, F

32.

The nurse is assessing a client who is having a non-stress test (NST) at 41-weeks gestation. The nurse determines that the client is not having contractions, the fetalheart rate (FHR) baseline is 144 bpm, and no FHR

accelerations are occurring.
What action should the nurse take?

A) Check the client for urinary bladder distention.
Feedback: INCORRECT

B) Notify the healthcare provider of the nonreactive results.