Maternity HESI 1 Test Bank (2020)

1. A 38-week primigravida who works as a secretary and sits at a computer for 8 hours each day tells the nurse that her feet have begun to swell. Which instruction would be most effective in preventing pooling of blood in the lower extremities?

Move about every hour

Pooling of blood in the lower extremities results from the enlarged uterus exerting pressure on the pelvic veins. Moving about every hour will straighten out the pelvic veins and increase venous return.

2. A 26-year-old, gravida 2, para 1 client is admitted to the hospital at 28-weeks gestation in preterm labor. She is given 3 doses of terbutaline sulfate (Brethine) 0.25 mg subcutaneously to stop her labor contractions. The nurse plans to monitor for which primary side effect of terbutaline sulfate?

Tachycardia and a feeling of nervousness

Terbutaline sulfate (Brethine), a beta-sympathomimetic drug, stimulates beta-adrenergic receptors in the uterine muscle to stop contractions. The beta-adrenergic agonist properties of the drug may cause tachycardia, increased cardiac output, restlessness, headache, and a feeling of "nervousness".

3. When do the anterior and posterior fontanels close?

anterior fontanel closes at 12 to 18 months and the posterior by the end of the second month.

4. When assessing a client who is at 12-weeks gestation, the nurse recommends that she and her husband consider attending childbirth preparation classes. When is the best time for the couple to attend these classes?

30 weeks gestation

at 30 weeks gestation is closest (of the options) to the time parents would be ready for such classes. Learning is facilitated by an interested pupil! The couple is most interested in childbirth toward the end of the pregnancy when they are psychologically ready for the termination of the pregnancy, and the birth of their child is an immediate concern.

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

the cervix is completely dilated.

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 the cervix

can become edematous and may never completely dilate, necessitating an operative delivery. Many primigravida's begin active labor 100% effaced and then proceed to dilate.

6. The nurse instructs a laboring client to use accelerated-blow breathing. The client begins to complain of tingling fingers and dizziness. What action should the nurse take?

Have the client breathe into her cupped hands

Tingling fingers and dizziness are signs of hyperventilation (blowing off too much carbon dioxide). Hyperventilation is treated by retaining carbon dioxide. This can be facilitated by breathing into a paper bag or cupped hands.

7. Twenty-four hours after admission to the newborn nursery, a full-term male infant develops localized edema on the right side of his head. The nurse knows that, in the newborn, an accumulation of blood between the periosteum and skull which does not cross the suture line is a newborn variation known as...

a cephalohematoma, caused by forceps trauma and may last up to 8 weeks.

Cephalohematoma, a slight abnormal variation of the newborn, usually arises within the first 24 hours after delivery. Trauma from delivery causes capillary bleeding between the periosteum and the skull.

8. When does the head return to its normal shape?

7-10 days

9. What did Nurse theorist Reva Rubin describe?

The initial postpartum period as the "taking-in phase," which is characterized by maternal reliance on others to satisfy the needs for comfort, rest, nourishment, and closeness to families and the newborn.

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

Shoulder pain

If the tubes are patent (open), pain is referred to the shoulder from a sub diaphragmatic collection of peritoneal dye/gas.

11. Which nursing intervention is most helpful in relieving postpartum uterine contractions or "afterpains?"

Lying prone with a pillow on the abdomen

Lying prone keeps the fundus contracted and is especially useful with multiparas, who commonly experience afterpains due to lack of uterine tone.

12. Which maternal behavior is the nurse most likely to see when a new mother receives her infant for the first time?

Her arms and hands receive the infant and she then traces the infant's profile with her fingertips.

Attachment/bonding theory indicates that most mothers will demonstrate behaviors described in during the first visit with the newborn, which may be at delivery or later.

13. A client at 32-weeks gestation is hospitalized with severe pregnancy-induced hypertension (PIH), and magnesium sulfate is prescribed to control the symptoms. Which assessment finding indicates the therapeutic drug level has been achieved?

A decreased in respiratory rate from 24 to 16

Magnesium sulfate, a CNS depressant, helps prevent seizures. A decreased respiratory rate indicates that the drug is effective. (Respiratory rate below 12 indicates toxic effects.)

14. Urinary output must be monitored when administering magnesium sulfate and should be at least 30 ml per hour. (The therapeutic level of magnesium sulfate for a PIH client is 4.8 to 9.6 mg/dl.) What is the therapeutic level of magnesium sulfate?

The therapeutic level of magnesium sulfate for a PIH client is 4.8 to 9.6 mg/dl.
What does it help prevent? helps prevent seizures
What indicates toxic levels? 3

Respiratory rate below 12 indicates toxic effects.
Urine output of less than 100 ml/4 hours
Absent DTRs

15. Twenty minutes after a continuous epidural anesthetic is administered, a laboring client's blood pressure drops from 120/80 to 90/60. What action should the nurse take?

Place woman in a lateral position

The nurse should immediately turn the woman to a lateral position, place a pillow or wedge under the right hip to deflect the uterus, increase the rate of the main line IV infusion, and administer oxygen by face mask at 10-12 L/min. If the blood pressure remains low, especially if it further decreases, the anesthesiologist/healthcare provider should be notified immediately.

16. A client at 28-weeks gestation calls the antepartum clinic and states that she is experiencing a small amount of vaginal bleeding which she describes as bright red. She further states that she is not experiencing any uterine contractions or abdominal pain. What instruction should the nurse provide?

Come to the clinic today for an ultrasound

Third trimester painless bleeding is characteristic of a placenta previa. Bright red bleeding may be intermittent, occur in gushes, or be continuous. Rarely is the first incidence life-threatening, nor cause for hypovolemic shock. Diagnosis is confirmed by transabdominal ultrasound.

17. An off-duty nurse finds a woman in a supermarket parking lot delivering an infant while her husband is screaming for someone to help his wife. Which intervention has the highest priority?

Put the newborn to breast

Putting the newborn to breast will help contract the uterus and prevent a postpartum hemorrhage--this intervention has the highest priority.

18. A pregnant client with mitral stenosis Class III is prescribed complete bedrest. The client asks the nurse, "Why must I stay in bed all the time?" Which response is best for the nurse to provide this client?

Complete bedrest decreases oxygen needs and demands on the heart muscle tissue.

To help preserve cardiac reserves, the woman may need to restrict her activities and complete bedrest is often prescribed.

19. The nurse is teaching care of the newborn to a group of prospective parents and describes the need for administering antibiotic ointment into the eyes of the newborn. Which infectious organism will this treatment prevent from harming the infant?

Gonorrhea

Erythromycin ointment is instilled into the lower conjunctiva of each eye within 2 hours after birth to prevent ophthalmic neonatorum, an infection caused by gonorrhea, and inclusion conjunctivitis, an infection caused by chlamydia. The infant may be exposed to these bacteria when passing through the birth canal.

20. The nurse is teaching a woman how to use her basal body temperature (BBT) pattern as a tool to assist her in conceiving a child. Which temperature pattern indicates the occurrence of ovulation, and therefore, the best time for intercourse to ensure conception?

Between the time the temperature falls and rises.

In most women, the BBT drops slightly 24 to 36 hours before ovulation and rises 24 to 72 hours after ovulation, when the corpus luteum of the ruptured ovary produces progesterone. Therefore, intercourse between the time of the temperature fall and rise is the best time for conception. The human ovum can be fertilized 16 to 24 hours after ovulation.

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

Edema, basilar rales, and an irregular pulse

This indicates cardiac decompensation and requires immediate intervention.

22. A woman with Type 2 diabetes mellitus becomes pregnant, and her oral hypoglycemic agents are discontinued. Which intervention is most important for the nurse to implement?

Describe diet changes that can improve the management of her diabetes

Diet modifications are effective in managing Type 2 diabetes during pregnancy and describing the necessary diet changes is the most important intervention for the nurse to implement with this client.

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

Raise the foot of the bed

These symptoms are suggestive of hypotension which is a side effect of epidural anesthesia. Raising the foot of the bed will increase venous return and provide blood to the vital areas. Increasing the IV fluid rate using a balanced non-dextrose solution and ensuring that the client is in a lateral position are also appropriate interventions, and then checking the patient's blood pressure.

24. What is the normal bilirubin at 1 day old?

A. The normal total bilirubin level is 6 to 12 mg/dl after Day 1 of life.

25. How do we lower the levels if they are not severe?

This infant's bilirubin is beginning to climb, and the infant should be monitored to prevent further complications. Breast milk provides calories and enhances GI motility, which will assist the bowel in eliminating bilirubin.

26. A 30-year-old gravida 2, para 1 client is admitted to the hospital at 26-weeks' gestation in preterm labor. She is given a dose of terbutaline sulfate (Brethine) 0.25 mg subcutaneous. Which assessment is the highest priority for the nurse to monitor during the administration of this drug?

Monitoring maternal and fetal heart rates is most important when terbutaline is being administered.

Terbutaline acts as a sympathomimetic agent that stimulates both beta 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).

27. 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?

Choking, coughing, and cyanosis.

the "3 Cs" of esophageal atresia caused by the overflow of secretions into the trachea.

28. What does a child in respiratory distress look like?

Apneic spells and grunting with prematurity or sepsis

29. What does a diaphragmatic hernia look like?

Scaphoid abdomen and anorexia

30. A new mother is afraid to touch her baby's head for fear of hurting the "large soft spot." Which explanation should the nurse give to this anxious client?

There's a strong, tough membrane there to protect the baby so you need not be afraid to wash or comb his/her hair.

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

It is difficult to consume 18 mg of additional iron by diet alone.

Consuming enough iron-containing foods to facilitate adequate fetal storage of iron and to meet the demands of pregnancy is difficult so iron supplements are often recommended.

32. What is megaloblastic anemia caused by?

folic acid deficiency

33. A woman who thinks she could be pregnant calls her neighbor, a nurse, to ask when she could use a home pregnancy test to diagnose pregnancy. Which response is best?

A home pregnancy test can be used right after your first missed period.

Home urine tests are based on the chemical detection of human chorionic gonadotrophin, which begins to increase 6 to 8 days after conception and is best detected at 2 weeks' gestation or immediately after the first missed period.

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

Extend the leg and dorsiflex the foot

Dorsiflexing the foot by pushing the sole of the foot forward or by standing (if the client is capable) and putting the heel of the foot on the floor is the best means of relieving leg cramps.

35. A client at 30-weeks' gestation, complaining of pressure over the pubic area, is admitted for observation. She is contracting irregularly and demonstrates underlying uterine irritability. Vaginal examination reveals that her cervix is closed, thick, and high. Based on these data, which intervention should the nurse implement first?

Obtaining a urine analysis should be done first because preterm clients with uterine irritability and contractions are often suffering from a urinary tract infection, and this should be ruled out first.

36. A client in active labor is admitted with preeclampsia. Which assessment finding is most significant in planning this client's care?

A 4+ reflex in a client with pregnancy-induced hypertension indicates hyperreflexia, which is an indication of an impending seizure.

37. What is Epogen for?

Changes an apical heart rate from the 180s to the 140s.

Epogen, given to prevent or treat anemia, stimulates erythropoietin production, resulting in an increase in RBCs. Since the body has not had to compensate for anemia with an increased heart rate, changes in heart rate from high to normal is one indicator that Epogen is effective

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

Gestational diabetes.

The nurse should evaluate the client for gestational diabetes because terbutaline (Brethine) increases blood glucose levels.

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

Date of last normal menstrual period.

Evaluating the gestation of the pregnancy takes priority. If the fetus is preterm and the

fetal heart pattern is reassuring, the healthcare provider may attempt to prolong the pregnancy and administer corticosteroids to mature the lungs of the fetus.

40. The nurse assesses a client admitted to the labor and delivery unit and obtains the following data: dark red vaginal bleeding, uterus slightly tense between contractions, BP 110/68, FHR 110 beats/minute, cervix 1 cm dilated and uneffaced. Based on these assessment findings, what intervention should the nurse implement?

Monitoring bleeding from IV sites

Monitoring bleeding from peripheral sites is the priority intervention. This client is presenting with signs of placental abruption. Disseminated intravascular coagulation (DIC) is a complication of placental abruptio, characterized by abnormal bleeding.

41. Immediately after birth a newborn infant is suctioned, dried, and placed under a radiant warmer. The infant has spontaneous respirations and the nurse assesses an apical heart rate of 80 beats/minute and respirations of 20 breaths/minute. What action should the nurse perform next?

Initiate positive pressure ventilation

The nurse should immediately begin positive pressure ventilation because this infant's vital signs are not within the normal range, and oxygen deprivation leads to cardiac depression in infants. (The normal newborn pulse is 100 to 160 beats/minute and respirations are 40 to 60 breaths/minute.)

42. The nurse is preparing to give an enema to a laboring client. Which client requires the most caution when carrying out this procedure?

A 40-week primigravida who is at 6 cm cervical dilatation and the presenting part is not engaged.

When the presenting part is ballotable, it is floating out of the pelvis. In such a situation, the cord can descend before the fetus causing a prolapsed cord, which is an emergency situation.

43. The nurse is providing discharge teaching for a client who is 24 hours postpartum. The nurse explains to the client that her vaginal discharge will change from red to pink and then to white. The client asks, "What if I start having red bleeding AFTER it changes?" What should the nurse instruct the client to do?

Reduce activity level and notify the healthcare provider.

Lochia should progress in stages from rubra (red) to serosa (pinkish) to alba (whitish), and not return to red. The return to rubra usually indicates subinvolution or infection. If such a sign occurs, the mother should notify the clinic/healthcare provider and reduce her activity to conserve energy

44. One hour after giving birth to an 8-pound infant, a client's lochia rubra has increased from small to large and her fundus is boggy despite massage. The client's pulse is 84 beats/minute and blood pressure is 156/96. The healthcare provider prescribes Methergine 0.2 mg IM × 1. What action should the nurse take immediately?

Contact the healthcare provider and question the prescription

Methergine is contraindicated for clients with elevated blood pressure, so the nurse should contact the healthcare provider and question the prescription

45. A client at 32-weeks' gestation is diagnosed with preeclampsia. Which assessment finding is most indicative of an impending convulsion?

3+ deep tendon reflexes and hyper clonus

46. A client at 32-weeks' gestation comes to the prenatal clinic with complaints of pedal edema, dyspnea, fatigue, and a moist cough. Which question is most important for the nurse to ask this client?

Do you have a history of rheumatic fever?

Clients with a history of rheumatic fever may develop mitral valve prolapse, which increases the risk for cardiac decompensation due to the increased blood volume that occurs during pregnancy, so obtaining information about this client's health history is a priority.

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

Similac® Soy Isomil® Formula is a soy protein-based formula that contains sucrose

The nurse should explain that the newborn's feeding intolerance may be related to the lactose found in cow's milk formula and is being replaced with the soy-based formula that contains sucrose, which is well-tolerated in infants with milk allergies and lactose intolerance.

48. The nurse is performing a gestational age assessment on a full-term newborn during the first hour of transition using the Ballard (Dubowitz) scale. Based on this assessment, the nurse determines that the neonate has a maturity rating of 40-weeks. What findings should the nurse identify to determine if the neonate is small for gestational age (SGA)? (Select all that apply.)

Frontal occipital circumference of 12.5 inches (31.25 cm)
Head to heel length of 17 inches (42.5 cm)
Admission weight of 4 pounds, 15 ounces (2244 grams)

The normal full-term, appropriate for gestational age (AGA) newborn should fall between the measurement ranges of weight, 6-9 pounds (2700-4000 grams); length, 19-21 inches (48-53 cm); FOC, 13-14 inches (33-35 cm). This neonate's parameters plot below the 10% percentile, which indicate that the infant is SGA.

49. 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 fetal heart rate (FHR) baseline is 144 bpm, and no FHR accelerations are occurring. What action should the nurse take?

The client should be asked if she has felt the fetus move.

An NST is used to determine fetal well-being and is often implemented when post maturity is suspected. A "reactive" NST occurs if the FHR accelerates 15 bpm for 15 seconds in response to the fetus' own movement and is "nonreactive" if no FHR acceleration occurs in response to fetal movement.

50. A vaginally delivered infant of an HIV positive mother is admitted to the newborn nursery. What intervention should the nurse perform first?

To reduce direct contact with the human immuno-virus in blood and body fluids on the newborn's skin, a bath with an antimicrobial soap should be administered first.

51. A client who is in the second trimester of pregnancy tells the nurse that she wants to use herbal therapy. Which response is best for the nurse to provide?

It is important that you want to take part in your care.

The emphasis of alternative and complementary therapies, such as herbal therapy, is that the client is viewed as a whole being, capable of decision-making and an integral part of the health care team, so recognizes the client's request.

52. A primigravida client who is 5 cm dilated, 90% effaced, and at 0 station is requesting an epidural for pain relief. Which assessment finding is most important for the nurse to report to the healthcare provider?

A platelet count of 67,000/mm3.

Thrombocytopenia (low platelet count) should be reported to the healthcare provider because it places the client at risk for bleeding when an epidural is administered.

53. A 24-hour-old newborn has a pink papular rash with vesicles superimposed on the thorax, back, and abdomen. What action should the nurse implement?
documented the findings in the infant's record

Erythema toxicum (or erythema neonatorum) is a newborn rash that is commonly referred to as "flea bites," but is a normal finding that is documented in the infant's record.

54. When explaining "postpartum blues" to a client who is 1 day postpartum, which symptoms should the nurse include in the teaching plan? (Select all that apply.)

Mood swings
Tearfulness

"Postpartum blues" is a common emotional response related to the rapid decrease in placental hormones after delivery and include mood swings, tearfulness, feeling low, emotional, and fatigued.

55. The nurse should explain to a 30-year-old gravid client that alpha fetoprotein testing is recommended for which purpose?

Assess for maternal pre-eclampsia

Alpha-fetoprotein (AFP) is a screening test used in pregnancy. Elevated AFP may indicate an increased risk of neural tube defects such as anencephaly and spinal bifida.

56. The nurse identifies crepitus when examining the chest of a newborn who was delivered vaginally. Which further assessment should the nurse perform?
Observe for an asymmetrical Moro (startle) reflex

The most common neonatal birth trauma due to a vaginal delivery is fracture of the clavicle. Although an infant may be asymptomatic, a fractured clavicle should be suspected if an infant has limited use of the affected arm, malposition of the arm, an asymmetric Moro reflex, crepitus over the clavicle, focal swelling or tenderness, or cries when the arm is moved.

57. A primigravida at 40-weeks gestation is receiving oxytocin (Pitocin) to augment labor. Which adverse effect should the nurse monitor for during the infusion of Pitocin?

Fetal tachycardia

Pitocin causes the uterine myofibril to contract, so unless the infusion is closely monitored, the client is at risk for hyperstimulation which can lead to tetanic contractions, uterine rupture, and fetal distress or demise.

58. A multigravida client at 41-weeks gestation presents in the labor and delivery unit after a non-stress test indicated that the fetus is experiencing some difficulties in utero. Which diagnostic test should the nurse prepare the client for additional information about fetal status?
Biophysical profile (BPP)

BPP provides data regarding fetal risk surveillance by examining 5 areas: fetal breathing movements, fetal movements, amniotic fluid volume, and fetal tone and heart

rate. The client's gestation has progressed past the estimated date of confinement, so the major concern is fetal well-being related to an aging placenta, not screening for fetal anomalies.

59. While breastfeeding, a new mother strokes the top of her baby's head and asks the nurse about the baby's swollen scalp. The nurse responds that the swelling is caput succedaneum. Which additional information should the nurse provide this new mother?

The scalp edema will subside in a few days after birth

Caput succedaneum is edema of the fetal scalp that crosses over the suture lines and is caused by pressure on the fetal head against the cervix during labor; it subsides in a few days after birth without treatment.

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

dark red vaginal bleeding
increased uterine irritability
rigid abdomen.

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

The antidote for magnesium sulfate is calcium gluconate, which should be readily available if the client manifest signs of toxicity.

62. A 42-week gestational client is receiving an intravenous infusion of oxytocin (Pitocin) to augment early labor. The nurse should discontinue the oxytocin infusion for which pattern of contractions?

Transition labor with contractions every 2 minutes, lasting 90 seconds each.

Contraction pattern describes hyperstimulation and an inadequate resting time between contractions to allow for placental perfusion.

63. The nurse is preparing a client with a term pregnancy who is in active labor for an amniotomy. What equipment should the nurse have available at the client's bedside?

A single sterile glove, an amniotic hook, and Doppler to check fetal heart tones are the necessary equipment for performing an amniotomy.

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

Three plus deep tendon reflexes and hyper clonus are indicative of an impending convulsion and requires immediate attention.

65. During labor, the nurse determines that a full-term client is demonstrating late decelerations. In which sequence should the nurse implement these nursing actions? (Arrange in order.)

1. Reposition the client
2. Increase IV fluids
3. Provide oxygen via face mask
4. Call the healthcare provider

To stabilize the fetus, intrauterine resuscitation is the first priority, and to enhance fetal blood supply, the laboring client should be repositioned (1) to displace the gravid uterus and improve fetal perfusion. Secondly, to optimize oxygenation of the circulatory blood volume, oxygen via face mask (2) should be applied to the mother. Next, the IV fluids should be increased (3) to expand the maternal circulating blood volume. Then, the primary healthcare provider should be notified (4) for additional interventions to resolve the fetal stress.

66. What is the Silverman-Anderson Index?

A Silverman-Anderson Index has five categories with scores of 0, 1, or 2. The total score ranges from 0 to 10. A total score of 0 means the infant has no dyspnea, a total score of 10 indicates maximum respiratory distress.

67. Define Milia

Milia are tiny white bumps that appear across a baby's nose, chin or cheeks.

Milia are common in newborns but can occur at any age.

68. Define Pseudo strabismus

The false appearance of crossed eyes.

When the eyes are actually crossed or not completely aligned with one another it is called strabismus. Pseudo strabismus generally occurs in infants and toddlers whose facial features are not fully developed.

69. Define Subarachnoid hematoma

When blood leaks into the space between two of the membranes that surround the brain.

It is usually caused by a ruptured aneurysm..... The bleeding occurs in the arteries just below the arachnoid membrane and above the pia mater, just below the surface of the skull. Do nothing, it will most likely re-absorb on its own over time or they become brain damaged.

70. Hysterosalpingography (HSG) AKA uterosalpingography

a radiologic procedure to investigate the patency of the fallopian tubes. It entails the injection of a radio-opaque material into the cervical canal and usually fluoroscopy with image intensification.

71. Define amniotomy

AROM: may be performed by a midwife or obstetrician to induce or accelerate labor. The membranes may be ruptured using a specialized tool, such as an amnihook or amnicot, or they may be ruptured by the proceduralist's finger.

72. Define hyper clonus

Hyperactive reflexes

73. Total placental previa

If you have placenta previa, it means that your placenta is lying unusually low in your uterus, next to or covering your cervix...

.. (You may also hear the term "partial previa," which refers to a placenta that covers part of the cervical opening once the cervix starts to dilate.) The egg implants near the bottom of the cervix, the placenta forms around it and the placenta blocks the opening so the baby cannot come out without a C-section unless the placenta moves on its own.

74. What is Methergine for?

It helps reduce blood loss by contracting the uterus. It is an ergot alkaloid uterine stimulant.

Do not give if mom has a high BP

75. How many wet diapers per day?

At least 6-8

76. Define Terbutaline sulfate (Brethine)

A beta-antagonist used for lung issues, but it also works (non-FDA approved) to slow preterm labor. Do not give if HR is high.

a beta-sympathomimetic drug, stimulates beta-adrenergic receptors in the uterine muscle to stop contractions. The beta-adrenergic agonist properties of the drug may cause tachycardia, increased cardiac output, restlessness, headache, and a feeling of "nervousness".

77. Procardia (Nifedipine) what is it used for?

To stop preterm labor

78. non-stress test (NST) - how to pass?

Must have fetal heart rate of 15 beats above normal heart rate for 15 seconds two times or more over 20 minutes. If the baby is asleep, wake it up. A Fetal acoustic stimulator works best. (FAST)

79. What is Alpha-fetoprotein (AFP)?
High levels of this in the amniotic fluid help confirm the diagnosis of NTD such as spina bifida, anencephaly, or an abdominal wall defect

80. Define Biophysical profile (BPP)

a prenatal ultrasound evaluation of fetal well-being involving a scoring system, with the score being termed Manning's score.

It scores the fetuses responses to stimuli, is non-invasive, and based on acute and chronic markers of fetal disease.

Measures:

- *Fetal breathing movements*
- *Fetal movements*
- *Fetal tone*
- *Amniotic fluid index (AFI)*

81. Define Preeclampsia:

a pregnancy complication characterized by high blood pressure and signs of damage to another organ system, often the kidneys. It usually begins after 20 weeks of pregnancy in a woman whose blood pressure had been normal.

Characterized by:

- *Hypertension*
- *Pulmonary edema*
- *Proteinuria*
- *Renal insufficiency*
- *Visual disturbances*
- *Thrombocytopenia*
- *Impaired liver function*

Use magnesium sulfate for treatment

Maternity HESI 2

1. Which nursing intervention is most helpful in relieving postpartum uterine contractions or "afterpains?"

a. Lying prone with a pillow on the abdomen
b. Using a breast pump
c. Massaging the abdomen
d. Giving oxytocic medications

Lying prone (A) keeps the fundus contracted and is especially useful with multiparas, who commonly experience afterpains due to lack of uterine tone.

2. A multigravida client arrives at the labor and delivery unit and tells the nurse that her bag of water has broken. The nurse identifies the presence of meconium fluid on the perineum and determines the fetal heart rate is between 140 to 150 beats/minute. What action should the nurse implement next?

a. Complete a sterile vaginal exam
b. Take maternal temperature every 2 hours
c. Prepare for an immediate cesarean birth
d. Obtain sterile suction equipment

A vaginal exam (A) should be performed after the rupture of membranes to determine the presence of a prolapsed cord.

3. When explaining "postpartum blues" to a client who is 1 day postpartum, which symptoms should the nurse include in the teaching plan? (Select all that apply.)

a. Mood swings
b. Panic attacks
c. Tearfulness
d. Decreased need for sleep
e. Disinterest in the infant

"Postpartum blues" is a common emotional response related to the rapid decrease in placental hormones after delivery and include mood swings (A), tearfulness (C), feeling low, emotional, and fatigued.

4. A client at 30-weeks gestation, complaining of pressure over the pubic area, is admitted for observation. She is contracting irregularly and demonstrates underlying uterine irritability. Vaginal examination reveals that her cervix is closed, thick, and high. Based on these data, which intervention should the nurse implement first?

a. Provide oral hydration
b. Have a complete blood count (CBC) drawn

c. Obtain a specimen for urine analysis
d. Place the client on strict bedrest

Obtaining a urine analysis (C) should be done first because preterm clients with uterine irritability and contractions are often suffering from a urinary tract infection, and this should be ruled out first.

5. A client in active labor complains of cramps in her leg. What intervention should the nurse implement?

a. Ask the client if she takes a daily calcium tablet
b. Extend the leg and dorsiflex the foot
c. Lower the leg off the side of the bed
d. Elevate the leg above the heart
b. Extend the leg and dorsiflex the foot

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 of relieving leg cramps.

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

a. edema, basilar rales, and an irregular pulse
b. Increased urinary output, and tachycardia
c. Shortness of breath, bradycardia, and hypertension
d. Regular heart rate, and hypertension

Edema, basilar rales, and an irregular pulse (A) indicate cardiac decompensation and require immediate intervention.

7. The nurse is teaching a woman how to use her basal body temperature (BBT) pattern as a tool to assist her in conceiving a child. Which temperature pattern indicates the occurrence of ovulation, and there for, the best time for intercourse to ensure conception?

a. Between the time the temperature falls and rises
b. Between 36 and 48 hours after the temperature rises
c. When the temperature falls and remains low for 36 hours
d. Within 72 hours before the temperature falls

I*n most women, the BBT drops slightly 24 to 36 hours before ovulation and rises 24 to 72 hours after ovulation, when the corpus luteum of the ruptured ovary produces progesterone. Therefore, intercourse between the time of the temperature fall and rise (A) is the best time for conception*.

8. A client who is in the second trimester of pregnancy tells the nurse that she wants to use herbal therapy. Which response is best for the nurse to provide?

a. Herbs are a corner stone of good health to include in your treatment
b. Touch is also therapeutic in relieving discomfort and anxiety
c. Your healthcare provider should direct treatment options for herbal therapy
d. It is important that you want to take part in your care

The emphasis of alternative and complementary therapies, such as herbal therapy, is that the client is viewed as a whole being, capable of decision-making and an integral part of the health care team, so (D) recognizes the client's request.

9. A mother who is breastfeeding her baby receives instructions from the nurse. Which instruction is most effective to prevent nipple soreness?

a. Wear a cotton bra
b. Increase nursing time gradually
c. Correctly place the infant on the breast
d. Manually express a small amount of milk before nursing

The most common cause of nipple soreness is incorrect positioning (C) of the infant on the breast, e.g., grasping too little of the areola or grasping on the nipple.

10. The nurse is counseling a woman who wants to become pregnant. The woman tells the nurse that she has a 36-day menstrual cycle and the first day of her menstrual period was January *. The nurse correctly calculates that the woman's next fertile period is

a. January 14-15
b. January 22-23
c. January 30-31
d. February 6-7

This woman can expect her next period to begin 36 days from the first day of her last menstrual period - the cycle begins at the first day of the cycle and continues to the first day of the next cycle. Her next period would, therefore, begin on February 13. Ovulation occurs 14 days before the first day of the menstrual period. Therefore, ovulation for this woman would occur January 31 (C).

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

a. there is only an anterior or posterior lip of cervix left
b. the client describes the need to have a bowel movement
c. the cervix is completely dilated
d. the cervix is completely effaced

Pushing begins with the second stage of labor, i.e., when the cervix is completely dilated (A, B, and D), the cervix can become edematous and may never completely dilate, necessitating an operative delivery. Many primigravida's begin active labor 100% effaced and then proceed to dilate.

12. One hour after giving birth to an 8-pound infant, a client's lochia rubra has increased from small to large and her fundus is boggy despite massage. The client's pulse is 84 beats/minute and blood pressure is 156/96. The healthcare provider prescribes Methergine 0.2 mg IM x 1. What action should the nurse take immediately?

a. Give the medication as prescribed and monitor for efficacy
b. Encourage the client to breastfeed rather than bottle feed
c. Have the client empty her bladder and massage the fundus
d. Call the healthcare provider to question the prescription

Methergine is contraindicated for clients with elevated blood pressure, so the nurse should contact the healthcare provider and question the prescription (D).

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

a. shortness of breath
b. joint pain
c. a persistent cold
d. organomegaly

Respiratory tract infections commonly occur in the pediatric population. However, the child 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).

14.A A healthcare provider informs the charge nurse of a labor and delivery unit that a client 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

The symptoms of abruptio placentae include dark red vaginal bleeding (A), increased uterine irritability (D), and a rigid abdomen (F).

15. The nurse assesses a client admitted to the labor and delivery unit and obtains the following data: dark red vaginal bleeding, uterus slightly tense between contractions, BP 110/68, FHR 110 beats/minute, cervix 1 cm dilated and uneffaced. Based on these assessment findings, what intervention should the nurse implement?

a. Insert an internal fetal monitor
b. Assess for cervical changes q1h
c. Monitor bleeding from IV sites
d. Perform Leopold's maneuvers

Monitoring bleeding from peripheral sites (C) is the priority intervention. This client is presenting with signs of placental abruption. Disseminated intravascular coagulation (DIC) is a complication of placental abruption, characterized by abnormal bleeding.

16A A client who is attending antepartum classes asks the nurse why her healthcare provider has prescribed iron tablets. The nurse's response is based on what knowledge?

a. Supplementary iron is more efficiently utilized during pregnancy
b. It difficult to consume 18 mg of additional iron by diet alone
c. Iron absorption is decreased in the GI tract during pregnancy
d. Iron is needed to prevent megaloblastic anemia in the last trimester

Consuming enough iron-containing foods to facilitate adequate fetal storage of iron and to meet the demands of pregnancy is difficult (B) so iron supplements are often recommended.

17A A 42-week gestational client is receiving an intravenous infusion of oxytocin (Pitocin) to augment early labor. The nurse should discontinue the oxytocin infusion for which pattern of contractions?

a. Transition labor with contractions every 2 minutes, lasting 90 seconds each
a. Early labor with contractions every 5 minutes, lasting 40 seconds each
c. Active labor with contractions every 31 minutes, lasting 60 seconds each
d. Active labor with contractions every 2 to 3 minutes, lasting 70 to 80 seconds each

Contractions pattern (A) describes hyperstimulation and an inadequate resting time between contractions to allow for placental perfusion. The oxytocin infusion should be discontinued.

18. Which maternal behavior is the nurse most likely to see when a new mother receives her infant for the first time?

a. She eagerly reaches for the infant, undresses the infants, and examines the infant completely
b. Her arms and hands receive the infant and she then traces the infant's profile with her fingertips
c. Her arms and hands receive the infant and she then cuddles the infant to her own body
d. She eagerly reaches for the infant and then holds the infant close to her own body

Attachment/bonding theory indicates that most mothers will demonstrate behaviors described in (B) during the first visit with the newborn, which may be at delivery of later.

19. Client teaching is an important part of the maternity nurse's role. Which factor has the greatest influence on successful teaching on the gravid client?