Submission Details

Submission Date: 1/31/2014

Submission Time: 1:28 AM

Points Awarded: 101

Points Missed: 1

Number of Attempts Allowed: Unlimited

Not Scored: 0

Percentage: 99%

Maternity A

1.ID: 310993981

Which action should the nurse implement when preparing to measure the fundal height of a pregnant client?

- (•) Have the client empty her bladder. Correct
- ( ) Request the client lie on her left side.
- ( ) Perform Leopold’s maneuvers first.
- ( ) Give the client some cold juice to drink.

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 if the fetus appears to be sleeping during a non-stress test.

Awarded 1.0 points out of 1.0 possible points.

2.ID: 311028927

The nurse identifies crepitus when examining the chest of a newborn who was delivered vaginally. Which further assessment should the nurse perform?

- Elicit a positive scarf sign on the affected side.
- Observe for an asymmetrical Moro (startle) reflex. Correct
- Watch for swelling of fingers on the affected side.
- Note paralysis of affected extremity and muscles.

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 (B), crepitus over the clavicle, focal swelling or tenderness, or cries when the arm is moved. Eliciting (A) (extending arm across the chest toward the opposite shoulder) is contraindicated if a fractured clavicle is present. (C and D) on the affected side require follow-up, but are not indicative of a fractured clavicle.

Awarded 1.0 points out of 1.0 possible points.

3.ID: 310955049

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?

- Give the medication as prescribed and monitor for efficacy.
- Encourage the client to breastfeed rather than bottle feed.
- Have the client empty her bladder and massage the fundus.

Call the healthcare provider to question the prescription. Correct

Methergine is contraindicated for clients with elevated blood pressure, so the nurse should contact the healthcare provider and question the prescription (D). (A) compromises patient safety. While (B) releases endogenous oxytocin, and (C) promotes uterine contraction, questioning the administration of Methergine is a higher priority because it concerns medication safety.

Awarded 1.0 points out of 1.0 possible points.

4.ID: 311013689

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

A gravida 6, para 5 who is 38 years of age and in early labor.

A 37-week primigravida who presents at 100% effacement, 3 cm cervical dilatation, and a -1 station.

A gravida 2, para 1 who is at 1 cm cervical dilatation and a 0 station admitted for induction of labor due to post dates.

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

Correct

When the presenting part is ballottable (D), 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. (A, B, and C) do not present problems with administration of an enema.

Awarded 1.0 points out of 1.0 possible points.

5.ID: 310945203

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 to this infant? (Enter numeral value only.)

Correct

4

Awarded 1.0 out of 1.0 possible points.

6.ID: 310951930

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?

Which symptom did you experience first?

Are you eating large amounts of salty foods?

Have you visited a foreign country recently?

Do you have a history of rheumatic fever? Correct

Clients with a history of rheumatic fever (D) 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. (A) is not important. Salty foods (B) sometimes cause edema, but this client is experiencing additional cardiac symptoms. (C) assesses for possible exposure to microorganisms, but these symptoms are more indicative of a cardiovascular etiology.

Awarded 1.0 points out of 1.0 possible points.

7.ID: 310974981

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?

Check the client for urinary bladder distention.

Notify the healthcare provider of the nonreactive results.

Have the mother stimulate the fetus to move.

Ask the client if she has felt any fetal movement. Correct

The client should be asked if she has felt the fetus move (D). An NST is used to determine fetal well-being, and is often implemented when postmaturity 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. The client should empty her bladder before starting the test, but bladder distention does not impede fetal movement (A). The client should be quizzed about fetal movement before determining that the NST is nonreactive (B). If no movement has occurred in the last 20 to 30 minutes, it is likely that the fetus is sleeping--providing the mother with orange juice often wakes the infant, and then the NST should be conducted again.

Awarded 1.0 points out of 1.0 possible points.

8.ID: 310955099

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

Patellar reflex 4+. Correct

Blood pressure 158/80.

Four-hour urine output 240 ml.

Respiration 12/minute.

A 4+ reflex in a client with pregnancy-induced hypertension (A) indicates hyperreflexia, which is an indication of an impending seizure. Although (B) is significant, some individuals have preeclampsia superimposed on chronic hypertension, and an elevated blood pressure alone is not as significant a finding as (A). (C and D) are important, but these findings are within normal range.

Awarded 1.0 points out of 1.0 possible points.

9.ID: 311008995

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?

- Insert an internal fetal monitor.
- Assess for cervical changes q1h.
- Monitor bleeding from IV sites. Correct
- 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 abruptio, characterized by abnormal bleeding. Invasive vaginal procedures (A and B) or (D) can increase the abruption and bleeding, so these interventions are contraindicated.

Awarded 1.0 points out of 1.0 possible points.

10.ID: 310947644

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 hyperclonus. Correct
- Periorbital edema, flashing lights, and aura.

Epigastric pain in the third trimester.

Recent decreased urinary output.

Three plus deep tendon reflexes and hyperclonus (A) are indicative of an impending convulsion and requires immediate attention. Epigastric pain (C) in the third trimester is indicative of HELLP Syndrome leading to impaired hepatic functioning. (B and D) are pathological changes that occur with preeclampsia.

Awarded 1.0 points out of 1.0 possible points.

11.ID: 311013637

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. Correct

Intervene after the one minute Apgar is assessed.

Initiate CPR on the infant.

Assess the infant's blood glucose level.

The nurse should immediately begin positive pressure ventilation (A) 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.) Waiting until the infant is 1 minute old to intervene may worsen the infant's condition. According to neonatal resuscitation guidelines, CPR is not begun until the heart rate is 60 or below or between 60 and 80 and not increasing after 20 to 30 seconds of PPV. (D) can be checked after treating the respiratory rate.

Awarded 1.0 points out of 1.0 possible points.

12.ID: 311013687

A pregnant woman comes to the prenatal clinic for an initial visit. In reviewing her childbearing history, the client indicates that she has delivered premature twins, one full-term baby, and has had no abortions. Which GTPAL should the nurse document in this client's record?

- 3-1-2-0-3.
- 4-1-2-0-3.
- 2-1-2-1-2.
- 3-1-1-0-3. Correct

(D) describes the correct GTPAL. The client has been pregnant 3 times including the current pregnancy (G-3). She had one full-term infant (T-1). She also had a preterm (P-1) twin pregnancy (a multifetal gestation is considered one birth when calculating parity). There were no abortions (A-0), so this client has a total of 3 living children. (A, B, and C) are inaccurate.

Awarded 1.0 points out of 1.0 possible points.

13.ID: 310949422

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. Correct
- Elevated blood pressure.
- Urinary tract infection.

Swelling in lower extremities.

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 agent such as terbutaline (Brethine). (D) is a common pregnancy complaint.

Awarded 1.0 points out of 1.0 possible points.

14.ID: 310945764

A 4-week-old premature infant has been receiving epoetin alfa (Epogen) for the last three weeks. Which assessment finding indicates to the nurse that the drug is effective?

Slowly increasing urinary output over the last week.

Respiratory rate changes from the 40s to the 60s.

Changes in apical heart rate from the 180s to the 140s. Correct

Change in indirect bilirubin from 12 mg/dl to 8 mg/dl.

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 (C) is one indicator that Epogen is effective. (A) is not related to Epogen administration. Respiratory rate should decrease rather than increase (B) with Epogen administration. (D) is usually related to resolution of hyperbilirubinemia, treated with phototherapy or increased oral intake in the infant.

Awarded 1.0 points out of 1.0 possible points.

15.ID: 310985673

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. Correct

Go to bed and assume a knee-chest position.

Massage the uterus and go to the emergency room.

Do not worry as this is a normal occurrence.

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 (A). Going to bed, or resting might be helpful, but (B) is not indicated. (C) would be an over-reaction and the uterus might not be palpable at that time. This is not a normal occurrence (D).

Awarded 1.0 points out of 1.0 possible points.

16.ID: 310945726

A couple has been trying to conceive for nine months without success. Which information obtained from the clients is most likely to have an impact on the couple's ability to conceive a child?

Exercise regimen of both partners includes running four miles each morning.

History of having sexual intercourse 2 to 3 times per week.

The woman's menstrual period occurs every 35 days.

They use lubricants with each sexual encounter to decrease friction. Correct

The use of lubricants (D) has the potential to affect fertility because some lubricants interfere with sperm motility. While excessive heat can affect sperm production, bicycling, rather than running (A) is more likely to concentrate heat in the groin area. While having intercourse too frequently has been implicated

as a cause for decreased numbers of sperm, 2 to 3 times per week (B) is not considered excessive. (C) should not affect fertility.

Awarded 1.0 points out of 1.0 possible points.

17.ID: 310974967

A pregnant client tells the nurse that the first day of her last menstrual period was August 2, 2006. Based on Nägele's rule, what is the estimated date of delivery?

April 25, 2007.

May 9, 2007. Correct

May 29, 2007.

June 2, 2007.

Since this woman's first day of her last normal menstrual period occurred on August 2, 2006, the estimated date of delivery is May 9, 2007 (B). Nägele's rule is used to calculate the expected date of delivery, and is obtained by subtracting 3 months and adding 7 days beginning from the first day of the last normal menstrual period. (A, C, and D) are incorrect calculations.

Awarded 1.0 points out of 1.0 possible points.

18.ID: 310985611

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?

Gravidity and parity.

Time and amount of last oral intake.

Date of last normal menstrual period. Correct

Frequency and intensity of contractions.

Evaluating the gestation of the pregnancy (C) 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. (A, B, and D) are all important to evaluate and incorporate into the plan of care, but establishing gestation takes priority.

Awarded 1.0 points out of 1.0 possible points.

19.ID: 311008973

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? (Select all that apply.)

Litmus paper.

Fetal scalp electrode.

A sterile glove. Correct

An amniotic hook. Correct

Sterile vaginal speculum.

A Doppler. Correct

A single sterile glove (C), an amniotic hook (D), and Doppler (F) to check fetal heart tones are the necessary equipment for performing an amniotomy. Litmus paper (A) is used to assess for the presence of amniotic fluid. A fetal scalp probe (B) is used to assess fetal heart rates but is not indicated with the information provided. A sterile vaginal speculum (E) is used to visualize the cervix and is not indicated with the information provided.

Awarded 1.0 points out of 1.0 possible points.

20.ID: 311002969

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

- Detect cardiovascular disorders.
- Screen for neural tube defects. Correct
- Monitor the placental functioning.
- Assess for maternal pre-eclampsia.

Alpha-fetoprotein (AFP) is a screening test used in pregnancy. Elevated AFP may indicate an increased rish of neural tube defects (B) such as anencephaly and spinal bifida. AFP does not apply in (A, C, or D).

Awarded 1.0 points out of 1.0 possible points.

21.ID: 310969495

A woman who gave birth 48 hours ago is bottle-feeding her infant. During assessment, the nurse determines that both breasts are swollen, warm, and tender upon palpation. What action should the nurse take?

- Apply cold compresses to both breasts for comfort. Correct
- Instruct the client run warm water on her breasts.

Wear a loose-fitting bra to prevent nipple irritation.

Express small amounts of milk to relieve pressure.

The client is experiencing engorgement even though she is bottle-feeding her infant, and cold compresses (A) may help reduce discomfort. Lactation begins about the third day after delivery, so the mother should avoid any breast stimulation, such as (B or D), which further stimulates milk production. To aid in suppressing lactation, a well-fitting bra, not (C), should be worn to support and bind the breasts.

Awarded 1.0 points out of 1.0 possible points.

22.ID: 310946626

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.)

Correct

Reposition the client.

Provide oxygen via face mask.

Increase IV fluid.

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.

Awarded 1.0 points out of 1.0 possible points.

23.ID: 311008979

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

Bathe the infant with an antimicrobial soap. Correct

Measure the head and chest circumference.

Obtain the infant's footprints.

Administer vitamin K (AquaMEPHYTON).

To reduce direct contact with the human immuno-virus in blood and body fluids on the newborn's skin, a bath (A) with an antimicrobial soap should be administered first. (B, C, and D) should be implemented after the neonate's skin is cleansed of blood and body fluids.

Awarded 1.0 points out of 1.0 possible points.

24.ID: 310949408

At 14-weeks gestation, a client arrives at the Emergency Center complaining of a dull pain in the right lower quadrant of her abdomen. The nurse obtains a blood sample and initiates an IV. Thirty minutes after admission, the client reports feeling a sharp abdominal pain and a shoulder pain. Assessment findings include diaphoresis, a heart rate of 120 beats/minute, and a blood pressure of 86/48. Which action should the nurse implement next?

Check the hematocrit results.

Administer pain medication.

Increase the rate of IV fluids. Correct

Monitor client for contractions.

The client is demonstrating symptoms of blood loss, probably the result of an ectopic pregnancy, which occurs at approximately 14-weeks gestation when embryonic growth expands the fallopian tube causing its rupture, and can result in hemorrage and hypovolemic shock. Increasing the IV infusion rate (C) provides intravascular fluid to maintain blood pressure. (A, B, and D) can be implemented after fluid replacement is increased.

Awarded 1.0 points out of 1.0 possible points.

25.ID: 311008991

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

- The client's readiness to learn. Correct
- The client's educational background.
- The order in which the information is presented.
- The extent to which the pregnancy was planned.

When teaching any client, readiness to learn (A) is the most important criterion. For example, the client with severe morning sickness in the first trimester may not be "ready to learn" about labor and delivery, but is probably very "ready to learn" about ways to relieve morning sickness. (B and C) are factors that may influence learning, but they are not as influential as (A). Even if a pregnancy is planned and very desirable (D), the client must be ready to learn the content presented.

Awarded 1.0 points out of 1.0 possible points.

26.ID: 310949464

A 38-week primigravida who works as a secretary and sits at a computer 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?

- Wear support stockings.
- Reduce salt in her diet.
- Move about every hour. Correct

Avoid constrictive clothing.

Pooling of blood in the lower extremities results from the enlarged uterus exerting pressure on the pelvic veins. Moving about every hour (C) will straighten out the pelvic veins and increase venous return. (A) increase venous return from varicose veins in the lower extremities, but are little help with swelling. (B) might be helpful with generalized edema (which could be an indication of PIH) but is not specific for edematous lower extremities. (D) does not specifically address venous return in this particular case.

Awarded 1.0 points out of 1.0 possible points.

27.ID: 310945766

During a prenatal visit, the nurse discusses with a client the effects of smoking on the fetus. When compared with nonsmokers, mothers who smoke during pregnancy tend to produce infants who have

lower Apgar scores.

lower birth weights. Correct

respiratory distress.

a higher rate of congenital anomalies.

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).

Awarded 1.0 points out of 1.0 possible points.

28.ID: 310944500

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. Correct

These tests are most accurate after you have missed your second period.

Home pregnancy tests often give false positives and should not be trusted.

The test can provide accurate information when used right after ovulation.

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 (A). (B and D) provide inaccurate information. Although home tests are accurate, they have more false negatives than false positives (C), usually because they are used too early.

Awarded 1.0 points out of 1.0 possible points.

29.ID: 310969423

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?

Drowsiness and bradycardia.

Depressed reflexes and increased respirations.

Tachycardia and a feeling of nervousness. Correct

A flushed, warm feeling and a dry mouth.

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" (C). Hypotension, hypertension, and/or drowsiness may occur, but tachycardia, not (A), is a primary side effect. (B and D) are side effects of magnesium sulfate.

Awarded 1.0 points out of 1.0 possible points.

30.ID: 311008955

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

- Wear a cotton bra.
- Increase nursing time gradually.
- Correctly place the infant on the breast. Correct
- 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 only the nipple. (A) helps prevent chafing. (B) is important, but is not necessary for all women. (D) helps soften an engorged breast and encourages correct infant attachment, but is not the BEST answer.

Awarded 1.0 points out of 1.0 possible points.

31.ID: 310989315

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

- Length of labor and method of delivery. Incorrect
- Infant's condition at birth and treatment received. Correct
- Feeding method chosen by the parents.
- History of drugs given to the mother during labor.

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).

Awarded 0.0 points out of 1.0 possible points.

32.ID: 310950750

In developing a teaching plan for expectant parents, the nurse plans to include information about when the parents can expect the infant's fontanels to close. The nurse bases the explanation on knowledge that for the normal newborn, the

- anterior fontanel closes at 2 to 4 months and the posterior by the end of the first week.
- anterior fontanel closes at 5 to 7 months and the posterior by the end of the second week.
- anterior fontanel closes at 8 to 11 months and the posterior by the end of the first month.
- anterior fontanel closes at 12 to 18 months and the posterior by the end of the second month.

Correct

In the normal infant the anterior fontanel closes at 12 to 18 months of age and the posterior fontanel by the end of the second month (D). These growth and development milestones should be memorized to prepare for the NCLEX.

Awarded 1.0 points out of 1.0 possible points.

33.ID: 310959879

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?

- At 16-weeks gestation.
- At 20-weeks gestation.

At 24-weeks gestation.

At 30-weeks gestation. Correct

(D) is closest 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. (A, B, and C) are not the best times during a pregnancy for the couple to attend childbirth education classes--they will have other teaching needs.

Awarded 1.0 points out of 1.0 possible points.

34.ID: 310989329

The nurse should encourage the laboring client to begin pushing when

there is only an anterior or posterior lip of cervix left.

the client describes the need to have a bowel movement.

the cervix is completely dilated. Correct

the cervix is completely effaced.

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.

Awarded 1.0 points out of 1.0 possible points.

35.ID: 310972797

The nurse is counseling a couple who has sought information about conceiving. For teaching purposes, the nurse should know that ovulation usually occurs

two weeks before menstruation. Correct

immediately after menstruation.

immediately before menstruation.

three weeks before menstruation.

Ovulation occurs 14 days before the first day of the menstrual period (A). While ovulation can occur in the middle of the cycle, or 2 weeks after menstruation, this is only true for a woman who has a perfect 28-day cycle. For many women, the length of their menstrual cycle varies.

Awarded 1.0 points out of 1.0 possible points.

36.ID: 311008967

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 for implementing this nursing intervention?

Emptying the bladder during delivery is difficult because of the position of the presenting fetal part.

An over-distended bladder could be traumatized during labor as well as prolong the progress of

labor. Correct

Urine specimens for glucose and protein must be obtained at certain intervals throughout labor.

Frequent voiding minimizes the need for catheterization which increases the chance of bladder

infection.

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), but this is not the primary reason for encouraging the client to void during labor.

Awarded 1.0 points out of 1.0 possible points.

37.ID: 310949428

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?

- Administer oxygen by face mask.
- Notify the healthcare provider of the client's symptoms.
- Have the client breathe into her cupped hands. Correct
- Check the client's blood pressure and fetal heart rate.

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 (C). (A) is inappropriate since the CO2 level is low, not O2. (B and D) are not specific for this situation.

Awarded 1.0 points out of 1.0 possible points.

38.ID: 310965929

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

- Massage the calf and foot.
- Extend the leg and dorsiflex the foot. Correct
- Lower the leg off the side of the bed.

Elevate the leg above the heart.

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. (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.

Awarded 1.0 points out of 1.0 possible points.

39.ID: 310972711

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

Milia are red marks made by forceps and will disappear within 7 to 10 days.

Meconium is the first stool and is usually yellow gold in color.

Vernix is a white, cheesy substance, predominantly located in the skin folds. Correct

Pseudostrabismus found in newborns is treated by minor surgery.

(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 at birth but should be corrected if it persists after 6 to 9 months of age.

Awarded 1.0 points out of 1.0 possible points.

40.ID: 310945796

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 cephalhematoma, caused by forceps trauma and may last up to 8 weeks. Correct

a subarachnoid hematoma, which requires immediate drainage to prevent further complications.

molding, caused by pressure during labor and will disappear within 2 to 3 days.

a subdural hematoma which can result in lifelong damage.

Cephalhematoma (A), 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. (C) is a cranial distortion lasting 5 to 7 days and is caused by pressure on the cranium during vaginal delivery--it is a normal finding, or a common variation of the newborn. (B and D) both involve intracranial bleeding, and could not be detected by physical assessment alone.

Awarded 1.0 points out of 1.0 possible points.

41.ID: 310999021

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, and that she actually reprimands the baby when it moves too much. What recommendation should the nurse make to this expectant father?

Reassure him that these are normal reactions to pregnancy and suggest that he discuss his concerns

with the childbirth education nurse.

Help him to understand that his wife is experiencing normal symptoms of ambivalence about the

pregnancy and no action is needed.

Ask him to observe his wife's behavior carefully for the next few weeks and report any similar

behavior to the nurse at the next prenatal visit.

Let him know that these behaviors are part of normal maternal/fetal bonding which occur once the

mother feels fetal movement. Correct

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 fetal movement, 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.

Awarded 1.0 points out of 1.0 possible points.

42.ID: 310946660

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

- This is not an unusual shaped head, especially for a first baby.
- It may look funny to you, but newborn babies are often born with heads like your baby's.
- That is normal; the head will return to a round shape within 7 to 10 days. Correct
- Your pelvis was too small, so the baby's head had to adjust to the birth canal.

(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 the wrong 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."

Awarded 1.0 points out of 1.0 possible points.

43.ID: 310985681

A new mother asks the nurse, "How do I know that my daughter is getting enough breast milk?" Which explanation should the nurse provide?

- Weigh the baby daily, and if she is gaining weight, she is eating enough.
- Your milk is sufficient if the baby is voiding pale straw-colored urine 6 to 10 times a day. Correct

Offer the baby extra bottle milk after her feeding, and see if she is still hungry.

If you're concerned, you might consider bottle feeding so that you can monitor her intake.

The urine will be dilute (straw-colored) and frequent (>6 to 10 times/day) (B), if the infant is adequately hydrated. Although a weight gain (A) of 30 grams/day is indicative of adequate nutrition, most home scales do not measure this accurately and this suggestion is likely to make the mother very anxious! (C) causes nipple confusion and diminishes the mother's milk production. (D) does not answer the client's question.

Awarded 1.0 points out of 1.0 possible points.

44.ID: 310962735

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?

The new formula is a coconut milk formula used with babies with impaired fat absorption.

Enfamil® Formula is a demineralized whey formula that is needed with diarrhea.

The new formula is a casein protein source that is low in phenylalanine.

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

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 (D), which is well-tolerated in infants with milk allergies and lactose intolerance. (A) describes Portagen® 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 Lofenalac® Formula, a formula prescribed for phenylketonuria (PKU).

Awarded 1.0 points out of 1.0 possible points.

45.ID: 310962737

A client who gave birth to a healthy 8 pound infant 3 hours ago is admitted to the postpartum unit. Which nursing plan is best in assisting this mother to bond with her newborn infant?

- Encourage the mother to provide total care for her infant.
- Provide privacy so the mother can develop a relationship with the infant.
- Encourage the father to provide most of the infant's care during hospitalization.
- Meet the mother's physical needs and demonstrate warmth toward the infant. Correct

It is most important to meet the mother's requirement for attention to her needs so that she can begin infant care-taking (D). Nurse theorist Reva Rubin describes the initial postpartal 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. (A) could impede development of maternal bonding. (B) is important but not the priority. (C) might encourage paternal bonding, but does not specifically encourage maternal bonding.

Awarded 1.0 points out of 1.0 possible points.

46.ID: 310955095

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

- Lying prone with a pillow on the abdomen. Correct
- Using a breast pump.
- Massaging the abdomen.
- 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. (B and D) stimulate uterine contractions. (C) may contract the uterus temporarily and then encourage more afterpains later.

Awarded 1.0 points out of 1.0 possible points.

47.ID: 310957471

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

- She eagerly reaches for the infant, undresses the infant, and examines the infant completely.
- Her arms and hands receive the infant and she then traces the infant's profile with her fingertips.

Correct

- Her arms and hands receive the infant and she then cuddles the infant to her own body.
- 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 or later. After the first visit, the mother may exhibit greater affection such as eagerly reaching, hugging, etc. (A, C, and D).

Awarded 1.0 points out of 1.0 possible points.

48.ID: 310950754

On admission to the prenatal clinic, a 23-year-old woman tells the nurse that her last menstrual period began on February 15, and that previously her periods were regular. Her pregnancy test is positive. This client's expected date of delivery (EDD) is

- November 22. Correct
- November 8.

December 22.

October 22.

(A) correctly applies Nägele’s rule for estimating the due date by counting back 3 months from the first day of the last menstrual period (January, December, November) and adding 7 days (15+7=22).

Awarded 1.0 points out of 1.0 possible points.

49.ID: 311002965

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 last menstrual period was January 8. The nurse correctly calculates that the woman's next fertile period is

January 14-15.

January 22-23.

January 30-31. Correct

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).

Awarded 1.0 points out of 1.0 possible points.

50.ID: 311008957

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?

4+ reflexes.

Urinary output of 50 ml per hour.

A decrease in respiratory rate from 24 to 16. Correct

A decreased body temperature.

Magnesium sulfate, a CNS depressant, helps prevent seizures. A decreased respiratory rate (C) indicates that the drug is effective. (Respiratory rate below 12 indicates toxic effects.) (A) indicates high CNS irritability. Urinary output must be monitored when administering magnesium sulfate and should be at least 30 ml per hour. (B) indicates that the magnesium sulfate is not at a toxic level, but does not indicate that a therapeutic level has been achieved. (D) is not specifically related to magnesium sulfate. (The therapeutic level of magnesium sulfate for a PIH client is 4.8 to 9.6 mg/dl.)

Awarded 1.0 points out of 1.0 possible points.

51.ID: 310969427

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?

Notify the healthcare provider or anesthesiologist immediately.

Continue to assess the blood pressure q5 minutes.

Place the woman in a lateral position. Correct

Turn off the continuous epidural.

The nurse should immediately turn the woman to a lateral position (C), 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 (A). Continued assessment of (B), without taking any further action would constitute malpractice. (D) may also be warranted, but such action is based on hospital protocol.

Awarded 1.0 points out of 1.0 possible points.

52.ID: 310969485

A client at 28-weeks gestation calls the antepartal 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. Correct
- Go immediately to the emergency room.
- Lie on your left side for about one hour and see if the bleeding stops.
- Bring a urine specimen to the lab tomorrow to determine if you have a urinary tract infection.

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 (A). Bleeding that has a sudden onset and is accompanied by intense uterine pain indicates abruptio placenta, which is life-threatening to the mother and fetus, then (B) would be appropriate. (C) does not take the symptoms seriously. The woman is not describing symptoms of a UTI (D).

Awarded 1.0 points out of 1.0 possible points.

53.ID: 310949486

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?

- Use a thread to tie off the umbilical cord.

Provide as much privacy as possible for the woman.

Reassure the husband and try to keep him calm.

Put the newborn to breast. Correct

Putting the newborn to breast (D) will help contract the uterus and prevent a postpartum hemorrhage--this intervention has the highest priority. It is not necessary to tie off the umbilical cord (A), the infant can be transported attached to the placenta. Providing privacy (B) is an important psychosocial need, but does not have the priority of (D). Although the husband is an important part of family-centered care, he is not the most important concern at this time (C).

Awarded 1.0 points out of 1.0 possible points.

54.ID: 310972701

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. Correct

We want your baby to be healthy, and this is the only way we can make sure that will happen.

I know you're upset. Would you like to talk about some things you could do while in bed?

Labor is difficult and you need to use this time to rest before you have to assume all child-caring

duties.

To help preserve cardiac reserves, the woman may need to restrict her activities and complete bedrest is often prescribed (A). (B) offers false reassurance. (C) does not answer the woman's question. While (D) may be true, it is not the most important reason for bedrest.

Awarded 1.0 points out of 1.0 possible points.

55.ID: 310951928

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

- Notify the pediatrician immediately.
- Suction the infant's nares, then the oral cavity.
- Check the infant's oxygen saturation rate. Correct
- Position the infant on the right side.

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 an obstructed airway, but if suctioning was required, the oral cavity should be suctioned first 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).

Awarded 1.0 points out of 1.0 possible points.

56.ID: 310962791

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?

- Assess the husband's feelings about his wife's decision to breastfeed their baby.
- Ask the client to describe why she was unsuccessful with breastfeeding her last child.
- Encourage the client to develop a positive attitude about breastfeeding to help ensure success.
- Provide assistance to the mother to begin breastfeeding as soon as possible after delivery. Correct

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.

Awarded 1.0 points out of 1.0 possible points.

57.ID: 311002949

The nurse is assessing the umbilical cord of a newborn. Which finding constitutes a normal finding?

- Two vessels: one artery and one vein.
- Two vessels: two arteries and no veins.
- Three vessels: two arteries and one vein. Correct
- Three vessels: two veins and one artery.

The normal umbilical cord contains three vessels--two arteries and one vein (C). Fewer than three vessels correlates with various congenital anomalies, such as cardiac and renal anomalies. (A, B, and D) would constitute abnormal findings.

Awarded 1.0 points out of 1.0 possible points.

58.ID: 310949452

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. Correct
- Between 36 and 48 hours after the temperature rises.

When the temperature falls and remains low for 36 hours.

Within 72 hours before the temperature falls.

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 (A) is the best time for conception. The human ovum can be fertilized 16 to 24 hours after ovulation, so (B) is beyond the fertile period. (C) indicates that ovulation has not occurred. (D) would occur before ovulation.

Awarded 1.0 points out of 1.0 possible points.

59.ID: 310945238

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. Correct

Increased urinary output and tachycardia.

Shortness of breath, bradycardia, and hypertension.

Regular heart rate and hypertension.

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

Awarded 1.0 points out of 1.0 possible points.

60.ID: 310974939

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. Correct

Assess for vaginal bleeding.

Evaluate the fetal heart rate.

Take the client's blood pressure.

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 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. (B and C) will not raise the maternal blood pressure. Since the symptoms are common side effects of epidural anesthesia and suggest hypotension, (D) can wait until (A) is implemented.

Awarded 1.0 points out of 1.0 possible points.

61.ID: 310965997

The total bilirubin level of a 36-hour, breastfeeding newborn is 14 mg/dl. Based on this finding, which intervention should the nurse implement?

Provide phototherapy for 30 minutes q8h.

Feed the newborn sterile water hourly.

Encourage the mother to breastfeed frequently. Correct

Assess the newborn's blood glucose level.

The normal total bilirubin level is 6 to 12 mg/dl after Day 1 of life. 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 (C). (A) is not indicated at

this level. (B) would limit caloric intake, which is essential in preventing jaundice. (D) is not related to bilirubin levels.

Awarded 1.0 points out of 1.0 possible points.

62.ID: 310951972

A 35-year-old primigravida client with severe preeclampsia is receiving magnesium sulfate via continuous IV infusion. Which assessment data indicates to the nurse that the client is experiencing magnesium sulfate toxicity?

- Deep tendon reflexes 2+.
- Blood pressure 140/90.
- Respiratory rate 18/minute.
- Urine output 90 ml/4 hours. Correct

Urine outputs of less than 100 ml/4 hours (D), absent DTRs, and a respiratory rate of less than 12 breaths/minute are cardinal signs of magnesium sulfate toxicity. (A, B, and C) do not indicate a magnesium sulfate toxicity.

Awarded 1.0 points out of 1.0 possible points.

63.ID: 310969447

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?

- Maternal blood pressure and respirations.
- Maternal and fetal heart rates. Correct

Hourly urinary output.

Deep tendon reflexes.

Monitoring maternal and fetal heart rates (B) 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). While monitoring (A, C, and D) is helpful, these do not have the priority of monitoring (B) when a beta-adrenergic agonists is administered.

Awarded 1.0 points out of 1.0 possible points.

64.ID: 310993929

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?

Grief related to her perceptions about the loss of this child. Correct

Relief of ambivalent feelings experienced with this pregnancy.

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

Guilt because she had not followed her healthcare provider's instructions.

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 not prevent guilt that can be associated with other behaviors the client may have exhibited (such as smoking) during the first trimester.

Awarded 1.0 points out of 1.0 possible points.

65.ID: 311002981

The nurse is teaching breastfeeding to prospective parents in a childbirth education class. Which instruction should the nurse include as content in the class?

Begin as soon as your baby is born to establish a four-hour feeding schedule.

Resting helps with milk production. Ask that your baby be fed at night in the nursery.

Feed your baby every 2 to 3 hours or on demand, whichever comes first. Correct

Do not allow your baby to nurse any longer than the prescribed number of minutes.

Breastfeeding infants should be kept in the room with the mother and fed every 2 to 3 hours or on demand--whichever comes first (C). Rigid scheduling (A) can be detrimental to breastfeeding and impede milk production. While (B) does promote milk production, not feeding at night will decrease the amount of milk produced. The infant should be allowed to decide when to stop breastfeeding rather than breaking suction and pulling the infant off the breast (D) after a set number of minutes since the infant tells the breast how much milk to produce by sucking at the breast.

Awarded 1.0 points out of 1.0 possible points.

66.ID: 311018717

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?

Some care is required when touching the large soft area on top of your baby's head until the bones

fuse together.

That's just an 'old wives' tale' so don't worry, you can't harm your baby's head by touching the soft

spot.

The soft spot will disappear within 6 weeks and is very unlikely to cause any problems for your baby.

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

(D) provides correct information and attempts to alleviate anxiety related to knowledge deficit. The anterior fontanel or "large soft spot" has a strong epidermal membrane present, which can be touched (A). (B) dismisses the client's concerns. The anterior fontanel normally closes at 12 to 18 months of age, not 6 weeks (C). The posterior fontanel closes at 8 to 12 weeks of age.

Awarded 1.0 points out of 1.0 possible points.

67.ID: 310989377

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 postprocedure complaint indicates that the fallopian tubes are patent?

Back pain.

Abdominal pain.

Shoulder pain. Correct

Leg cramps.

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 uterine cramping, 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 normal after hysterosalpingography. (A and D) are not related to the procedure.

Awarded 1.0 points out of 1.0 possible points.

68.ID: 311023609

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?

Supplementary iron is more efficiently utilized during pregnancy.

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

Iron absorption is decreased in the GI tract during pregnancy.

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. 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.

Awarded 1.0 points out of 1.0 possible points.

69.ID: 310947652

Which nursing intervention is helpful in relieving "afterpains" (postpartum uterine contractions)?

Using relaxation breathing techniques. Correct

Using a breast pump.

Massaging the abdomen.

Giving oxytocic medications.

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.

Awarded 1.0 points out of 1.0 possible points.

70.ID: 310999031

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

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

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. (A) is not related to leg cramps caused by reduced circulation to the foot. (C) is not likely to be helpful. (D) is used to promote venous return, but is not indicated for leg cramps.

Awarded 1.0 points out of 1.0 possible points.

71.ID: 310944538

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?

- Provide oral hydration.
- Have a complete blood count (CBC) drawn.
- Obtain a specimen for urine analysis. Correct
- 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. (A) is important, but gathering objective data through a urine analysis has a higher priority. (B) would be indicated if the client's temperature was elevated. (D) is indicated only if the client is in preterm labor which would be determined by vaginal examination.

Awarded 1.0 points out of 1.0 possible points.

72.ID: 311018719

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.)

- [x] Admission weight of 4 pounds, 15 ounces (2244 grams). Correct
- [x] Head to heel length of 17 inches (42.5 cm). Correct
- [x] Frontal occipital circumference of 12.5 inches (31.25 cm). Correct
- [ ] Skin smooth with visible veins and abundant vernix.
- [ ] Anterior plantar crease and smooth heel surfaces.
- [ ] Full flexion of all extremities in resting supine position.

Correct choices are (A, B, and C). 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 (A, B, and C) plot below the 10% percentile, which indicate that the infant is SGA. (D and E) are criteria for a pre-term neonate. (F) is a criteria for physical maturity score (full-term, 40-weeks) on the Ballard (Dubowitz) scale.

Awarded 1.0002 points out of 1.0002 possible points.

73.ID: 310962701

A woman who had a miscarriage 6 months ago becomes pregnant. Which instruction is most important for the nurse to provide this client?

- Elevate lower legs while resting.
- Increase caloric intake by 200 to 300 calories per day.
- Increase water intake to 8 full glasses per day.
- Take prescribed multivitamin and mineral supplements. Correct

A client who has had a spontaneous abortion or still birth in the last 1½ years should take multivitamin and mineral supplements (D) and maintain a balanced diet because the previous pregnancy may have left her nutritionally depleted. (A, B, and C) are sound instructions to provide any pregnant client, but do not have the priority of (D) for this particular client who had a miscarriage 6 months ago.

Awarded 1.0 points out of 1.0 possible points.

74.ID: 310953431

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. Correct
- Projectile vomiting and cyanosis.
- Apneic spells and grunting.
- Scaphoid abdomen and anorexia.

(A) includes the "3 Cs" of esophageal atresia caused by the overflow of secretions into the 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 characteristic of diaphragmatic hernia.

Awarded 1.0 points out of 1.0 possible points.

75.ID: 310953423

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:

- shortness of breath.
- joint pain.
- a persistent cold. Correct
- 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). (A, B, and D) are symptoms of complications which may occur later in the disease process.

Awarded 1.0 points out of 1.0 possible points.

76.ID: 310974963

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?

- Herpes.
- Staphylococcus.

Gonorrhea. Correct

Syphilis.

Erythromycin ointment is instilled into the lower conjunctiva of each eye within 2 hours after birth to prevent ophthalmica neonatorum, an infection caused by gonorrhea, and inclusion conjunctivitis, an infection caused by chlamydia (C). The infant may be exposed to these bacteria when passing through the birth canal. Ophthalmic ointment is not effective against (A, B, and D).

Awarded 1.0 points out of 1.0 possible points.

77.ID: 310957459

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?

Cervical dilation of 5 cm with 90% effacement.

White blood cell count of 12,000/mm3.

Hemoglobin of 12 mg/dl and hematocrit of 38%.

A platelet count of 67,000/mm3. Correct

Thrombocytopenia (low platelet count) (D) should be reported to the healthcare provider because it places the client at risk for bleeding when an epidural is administred. (A, B, and C) are within the normal parameters for a client in active labor and is not contraindicated for the placement of an epidural.

Awarded 1.0 points out of 1.0 possible points.

78.ID: 310951932

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?

- [x] Describe diet changes that can improve the management of her diabetes. Correct
- [ ] Inform the client that oral hypoglycemic agents are teratogenic during pregnancy.
- [ ] Demonstrate self-administration of insulin.
- [ ] Evaluate the client's ability to do glucose monitoring.

Diet modifications (A) 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. (B, C, and D) are interventions that should also be implemented, but do not have the priority of (A).

Awarded 1.0 points out of 1.0 possible points.

79.ID: 310955091

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?

- [ ] Notify the healthcare provider.
- [ ] Move the newborn to an isolation nursery.
- [x] Document the finding in the infant's record. Correct
- [ ] Obtain a culture of the vesicles.

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 (C), and requires no further action (A, B, and D).

Awarded 1.0 points out of 1.0 possible points.

80.ID: 310953443

The nurse is planning preconception care for a new female client. Which information should the nurse provide the client?

- Discuss various contraceptive methods to use until pregnancy is desired.
- Provide written or verbal information about prenatal care.
- Ask the client about risk factors associated with complications of pregnancy.
- Encourage healthy lifestyles for families desiring pregnancy. Correct

Planning for pregnancy begins with healthy lifestyles in the family (D) which is an intervention in preconception care that targets an overall goal for a client preparing for pregnancy. Although (A and B) may be useful for the client, preconception care should focus on measures to assist the client in reducing lifestyle variables that may increase the risk for problems in pregnancy. (C) is important, but not the main objective of maintaining healthy living.

Awarded 1.0 points out of 1.0 possible points.

81.ID: 310965925

The nurse is calculating the estimated date of confinement (EDC) using Nägele's rule for a client whose last menstrual period started on December 1. Which date is most accurate?

- August 1.
- August 10.
- September 3.
- September 8. Correct

Calculation of a client's EDC provides baseline data to monitor fetal gestation. Nägele's rule uses the formula: subtract 3 months and add 7 days to the first day of the last normal menstrual period, so December 1 minus 3 months + 7 days is September 8 (D). (A, B, and C) are incorrect use of this formula.

Awarded 1.0 points out of 1.0 possible points.

82.ID: 310985683

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?

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

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. (A and B) provide little support for the client's comment about herbal therapy. Although the healthcare provider should address the client's request, (C) dismisses the discussion and assumes the client is not an integral part of the healthcare team.

Awarded 1.0 points out of 1.0 possible points.

83.ID: 310955079

The nurse observes a new mother is rooming-in and caring for her newborn infant. Which observation indicates the need for further teaching?

- Cuddles the baby close to her.
- Rocks and soothes the infant in her arms.

Places the infant prone in the bassinet. Correct

Wraps the baby in a warm blanket after bathing.

The mother should be instructed to avoid placing the infant prone (C) which is associated with an increased incidence of sudden infant death syndrome (SIDS). (A, B, and D) are bonding and nurturing behaviors.

Awarded 1.0 points out of 1.0 possible points.

84.ID: 311018733

A client who has an autosomal dominant inherited disorder is exploring family planning options and the risk of transmission of the disorder to an infant. The nurse's response should be based on what information?

Males inherit the disorder with a greater frequency than females.

Each pregnancy carries a 50% chance of inheriting the disorder. Correct

The disorder occurs in 25% of pregnancies.

All children will be carriers of the disorder.

According to the laws of inheritance, an autosomal dominant disorder has a 50% chance of being transmitted with each pregnancy (B), and if transmitted, the disorder will appear in the child. Males do not inherit autosomal dominant disorders more frequently than females (A). There is a 25% chance of receiving an affected gene in autosomal recessive (C), not autosomal dominant disorders. (D) is incorrect.

Awarded 1.0 points out of 1.0 possible points.

85.ID: 310959871

A 30-year-old multiparous woman who has a 3-year-old boy and an newborn girl tells the nurse, "My son is so jealous of my daughter, I don't know how I'll ever manage both children when I get home." How should the nurse respond?

Tell the older child that he is a big boy now and should love his new sister.

Ask friends and relatives not to bring gifts to the older sibling because you do not want to spoil him.

Let the older child stay with his grandparents for the first six weeks to allow him to adjust to the newborn.

Regression in behaviors in the older child is a typical reaction so he needs attention at this time.

Correct

Preschool-aged children frequently regress in habits or behaviors, such as toileting and sleep habits, as a method of seeking attention (D), so the parents should distribute their attention between the children and include the preschooler during infant care. (A) is a negative approach. Providing small gifts to give to the preschooler (B) is a strategy that can facilitate sibling acceptance of the new infant. Removing the preschooler from the home when the new infant arrives may enhance his negative behaviors (C) when he is separated from his mother.

Awarded 1.0 points out of 1.0 possible points.

86.ID: 310953439

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. Correct

Panic attacks.

Tearfulness. Correct

Decreased need for sleep.

Disinterest in the infant.

Correct choices are (A and C). "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. (B, D, and E) are more characteristic of postpartum depression that typically occurs 3 to 7 days later than postpartum blues.

Awarded 1.0 points out of 1.0 possible points.

87.ID: 310974965

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?

Dehydration.

Hyperstimulation. Correct

Galactorrhea.

Fetal tachycardia.

Pitocin causes the uterine myofibril to contract, so unless the infusion is closely monitored, the client is at risk for hyperstimulation (B) which can lead to tetanic contractions, uterine rupture, and fetal distress or demise. Dehydration (A) and galactorrhea (C) are not adverse effects associated with the administration of Pitocin. Fetal tachycardia (D) is an initial response to any stressor, including an increase in maternal temperature or intrauterine infection, but fetal decelerations indicate distress following tetanic contractions.

Awarded 1.0 points out of 1.0 possible points.

88.ID: 310993999

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 infant should be positioned to reduce the swelling.
- The swelling is a subperiosteal collection of blood.
- The pediatrician will aspirate the blood if it gets larger.
- The scalp edema will subside in a few days after birth. Correct

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 subside in a few days after birth without treatment (D). (B) describes a cephalohematoma, a subperiosteal collection of blood that does not cross the suture lines and is a common benign birth injury. (A and C) are not necessary for caput or cephalohematoma.

Awarded 1.0 points out of 1.0 possible points.

89.ID: 310950712

The nurse observes a new mother avoiding eye contact with her newborn. Which action should the nurse take?

- Ask the mother why she won't look at the infant.
- Observe the mother for other attachment behaviors. Correct
- Examine the newborn's eyes for the ability to focus.
- Recognize this as a common reaction in new mothers.

Parent-infant bonding or attachment is based on a mutual relationship between parent and 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 assess for 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 the formation of affectional ties and should be encouraged (D).

Awarded 1.0 points out of 1.0 possible points.

90.ID: 311031905

A 23-year-old client who is receiving Medicaid benefits is pregnant with her first child. Based on knowledge of the statistics related to infant mortality, which plan should the nurse implement with this client?

- Refer the client to a social worker to arrange for home care.
- Recommend perinatal care from an obstetrician, not a nurse-midwife.
- Teach the client why keeping prenatal care appointments is important. Correct
- Advise the client that neonatal intensive care may be needed.

Regular prenatal visits should begin early in pregnancy to monitor health of the mother and development of the fetus (C). Based on the client's information, (A, B, and D) are not indicated.

Awarded 1.0 points out of 1.0 possible points.

91.ID: 311031913

A female client with insulin-dependent diabetes arrives at the clinic seeking a plan to 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?

- Your current dose of Insulin should be maintained throughout your pregnancy.

Maintain blood sugar levels in a constant range within normal limits during pregnancy. Correct

The course and outcome of your pregnancy is not an achievable goal with diabetes.

Expect an increase in insulin dosages by 5 units/week during the first trimester.

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

Awarded 1.0 points out of 1.0 possible points.

92.ID: 311031903

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). Correct

Ultrasound for fetal anomalies.

Maternal serum alpha-fetoprotein (AF) screening.

Percutaneous umbilical blood sampling (PUBS).

BPP (A) 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 (B). Maternal serum AF screening is generally checked between 15 and 22 weeks to detect neural tube defects (C). Although PUBS is performed to determine a number of at-risk fetal conditions, the BPP determines current fetal risk (D).

Awarded 1.0 points out of 1.0 possible points.

93.ID: 311031919

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?

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

A vaginal exam (A) should be performed after the rupture of membranes to determine the presence of a prolapsed cord. (B and D) can be implemented after the completion of (A). (C) is not indicated at this time since the fetal heart rate is within normal limits.

Awarded 1.0 points out of 1.0 possible points.

94.ID: 311028997

A client is admitted with the diagnosis of total placenta previa. Which finding is most important for the nurse to report to the healthcare provider immediately?

- Heart rate of 100 beats/minute.
- Variable fetal heart rate.
- Onset of uterine contractions. Correct

Burning on urination.

Total (complete) placenta previa involves the placenta covering the entire cervical os (opening). The onset of uterine contractions (C) places the client at risk for dilation and placental separation, which causes painless hemorrhaging. Although (A, B, and D) should be reported, the risk of hemorrhage is the priority.

Awarded 1.0 points out of 1.0 possible points.

95.ID: 311031917

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.)

- [x] Dark, red vaginal bleeding. Correct
- [ ] Lower back pain.
- [ ] Premature rupture of membranes.
- [x] Increased uterine irritability. Correct
- [ ] Bilateral pitting edema.
- [x] A rigid abdomen. Correct

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

Awarded 1.0002 points out of 1.0002 possible points.

96.ID: 311031911

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?

- Oxytocin (Pitocin).
- Calcium gluconate. Correct
- Terbutaline (Brethine).
- Naloxone (Narcan).

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

Awarded 1.0 points out of 1.0 possible points.

97.ID: 311028999

A 40-week gestation primigravida client is being induced with an oxytocin (Pitocin) secondary infusion and complains of pain in her lower back. Which intervention should the nurse implement?

- Discontinue the oxytocin (Pitocin) infusion.
- Place the client in a semi-Fowler's position.
- Inform the healthcare provider.
- Apply firm pressure to sacral area. Correct

The discomfort of back labor can be minimized by the application of firm pressure to the sacral area (D). (A and C) are not indicated at this time. (B) does not help to alleviate the client's pain.

Awarded 1.0 points out of 1.0 possible points.

98.ID: 311031907

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. Correct
- Early labor with contractions every 5 minutes, lasting 40 seconds each.
- Active labor with contractions every 31 minutes, lasting 60 seconds each.
- Active labor with contractions every 2 to 3 minutes, lasting 70 to 80 seconds each.

Contraction pattern (A) describes hyperstimulation and an inadequate resting time between contractions to allow for placental perfusion. The oxytocin infusion should be discontinued. There is an appropriate resting period between contractions for clients who are experiencing contraction patterns (B and D). Oxytocin can benefit the client in contraction pattern (C) by causing the contractions to come closer together and to become more efficient.

Awarded 1.0 points out of 1.0 possible points.

99.ID: 311028995

What action should the nurse implement to decrease the client's risk for hemorrhage after a cesarean section?

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

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, and C) are interventions that do not decrease a postpartal client's risk for hemorrhage.

Awarded 1.0 points out of 1.0 possible points.

100.ID: 311031909

Which assessment finding should the nursery nurse report to the pediatric healthcare provider?

- Blood glucose level of 45 mg/dl.
- Blood pressure of 82/45 mmHg.
- Non-bulging anterior fontanel.
- Central cyanosis when crying. Correct

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

Awarded 1.0 points out of 1.0 possible points.

101.ID: 311031915

The nurse is assessing a 3-day old infant with a cephalohematoma in the newborn nursery. Which assessment finding should the nurse report to the healthcare provider?

- Yellowish tinge to the skin. Correct
- Babinski reflex present bilaterally.
- Pink papular rash on the face.

Moro reflex noted after a loud noise.

Cephalohematomas are characterized by bleeding between the bone and its covering, the periosteum. Due to the breakdown of the red blood cells within a hematoma, the infant is at a greater risk for jaundice, so (A) should be reported. (B, C, and D) are expected assessment findings in a newborn.

Awarded 1.0 points out of 1.0 possible points.

102.ID: 311031901

A client who delivered an infant an hour ago tells the nurse that she feels wet underneath her buttock. The nurse notes that both perineal pads are completely saturated and the client is lying in a 6-inch diameter pool of blood. Which action should the nurse implement next?

Cleanse the perineum.

Obtain a blood pressure.

Palpate the firmness of the fundus. Correct

Inspect the perineum for lacerations.

A firm uterus is needed to control bleeding from the placental site of attachment on the uterine wall. The nurse should first assess for firmness (C) and massage the fundus as indicated. (A, B, and D) can be implemented after (C).

Awarded 1.0 points out of 1.0 possible points.

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