PrepU: Chapter 16: Nursing Management During the Postpartum Period

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1.	**When palpating for fundal height on a postpartal woman, which technique is preferable?**	Placing one hand at the base of the uterus, one on the fundus
2.	**A woman who gave birth 10 hours ago is ambulating to the bathroom and calls for assistance with perineal care. When the nurse touches her skin, the nurse notices that she is excessively warm. After reinforcing the woman's self-care, the nurse encourages increased oral intake. Why was this the appropriate instruction to give to this client?**	Increased intake will rehydrate the patient and decrease her skin temperature.
3.	**A client who gave birth to twins 6 hours ago becomes restless and nervous. Her blood pressure falls from 130/80 mm Hg to 96/50 mm Hg. Her pulse drops from 80 to 56 bpm. She was induced earlier in the day and experienced abruptio placentae. Based on this information, what postpartum complication would the nurse expect is happening?**	hemorrhage
4.	**A client who gave birth vaginally 16 hours ago states she does not need to void at this time. The nurse reviews the documentation and finds that the client has not voided for 7 hours. Which response by the nurse is indicated?**	"It's not uncommon after birth for you to have a full bladder even though you can't sense the fullness."
5.	**A nursing student learns that a certain condition occurring in up to 3 in every 1,000 births is a major cause of death. What is this condition?**	pulmonary embolism
6.	**Inspection of a woman's perineal pad reveals a 5-inch stain. How should the nurse document this amount?**	Moderate
7.	**A postpartum client who had a cesarean birth reports right calf pain to the nurse. The nurse observes that the client has nonpitting edema from her right knee**	Venous duplex ultrasound of the right leg

	to her foot. The nurse knows to prepare the client for which test first?	
8.	**Elevation of a client's temperature is a crucial first sign of infection. However, when is elevated temperature not a warning sign of impending infection?**	During the first 24 hours after delivery owing to dehydration from exertion
9.	**The nurse who works on a postpartum floor is mentoring a new graduate. She informs the new nurse that a postpartum assessment of the mother includes which assessments? Select all that apply.**	• vital signs of mother • pain level • head-to-toe assessment
10.	**A nurse is conducting a class on various issues that might develop after going home with a new infant. After discussing how to care for hemorrhoids, the nurse understands that which statement by the class would indicate the need for more information?**	"I only eat a low-fiber diet."
11.	**A woman who is two days postpartum has painful hemorrhoids postpartally. Which of the following positions would you suggest she use for resting?**	Sims' position
12.	**A nurse is providing care to a postpartum woman and is completing the assessment. Which finding would indicate to the nurse that a postpartum woman is experiencing bladder distention?**	Percussion reveals dullness
13.	**When completing the morning postpartum data collection, the nurse notices the client's perineal pad is completely saturated. Which action should be the nurse's first response?**	Ask the client when she last changed her perineal pad.
14.	**A client gave birth 2 days ago and is preparing for discharge. The nurse assesses respirations to be 26 rpm and labored, and the client was short of breath ambulating from the bathroom this morning. Lung sounds are clear. The nurse alerts the primary care**	pulmonary embolism.

	provider and the nurse-midwife to her concern that the client may be experiencing:	
15.	**A client is Rh-negative and has given birth to her newborn. What should the nurse do next?**	Determine the newborn's blood type and rhesus.
16.	**A client who has given birth is being discharged from the health care facility. She wants to know how safe it would be for her to have intercourse. Which instructions should the nurse provide to the client regarding intercourse after birth?**	Resume intercourse if bright-red bleeding stops.
17.	**When teaching the new mother about breastfeeding, the nurse is correct when providing what instructions? Select all that apply.**	• Help the mother initiate breastfeeding within 30 minutes of birth. • Encourage breastfeeding of the newborn infant on demand. • Place baby in uninterrupted skin-to-skin contact with the mother.
18.	**A client who is 12 hours postbirth is reporting perineal pain. After the assessment reveals no signs of an infection, which measure could the nurse offer the client?**	an ice pack applied to the perineum
19.	**On a routine home visit, the nurse is asking the new mother about her breastfeeding and personal eating habits. How many additional calories should the nurse encourage the new mother to eat daily?**	500 additional calories per day
20.	**A nurse is conducting a in-service education program for a group of nurses working in the postpartum unit about postpartal infection. The nurse determines that**	placenta removed via manual extraction

	the teaching was successful when the group identifies which factor as contributing to the risk for infection postpartally?	
21.	**Two days ago, a woman gave birth to her third infant; she is now preparing for discharge home. After the birth of her second child, she developed an endometrial infection. Nursing goals for this discharge include all of the following except:**	maintain previous household routines to prevent infection.
22.	**A nurse finds the uterus of a postpartum woman to be boggy and somewhat relaxed. This a sign of which condition?**	atony
23.	**The birth center recognizes that attachment is very important in the early stages after birth. Which policy would be inappropriate for the birth center to implement when assisting new parents in this process?**	policies that discourage unwrapping and exploring the infant
24.	**In a class for expectant parents, the nurse may discuss the various benefits of breastfeeding. However, the nurse also describes that there are situations involving certain women who should not breastfeed. Which examples would the nurse cite? Select all that apply.**	-women on antithyroid medications -women on antineoplastic medications -women using street drugs
25.	**A nurse is assessing a woman during the first 24 hours after birth. Which assessment finding would the nurse determine as acceptable during this time? Select all that apply.**	-Fundus one fingerbreadth below the umbilicus -Moderate saturation of peripad every 3 hours
26.	**A nurse is applying ice packs to the perineal area of a client who has had a vaginal birth. Which intervention should the nurse perform to ensure that the client gets the optimum benefits of the procedure?**	Ensure ice pack is changed frequently.

27.	**The client is preparing to go home after a cesarean birth. The nurse giving discharge instructions stresses to the family that the client should be seen by her primary care provider within what time interval?**	2 weeks
28.	**A new mother has been reluctant to hold her newborn. Which action by the nurse would help promote this mother's attachment to her newborn?**	Bringing the newborn into the room
29.	**A new mother who is breastfeeding reports that her right breast is very hard, tender, and painful. Upon examination the nurse notices several nodules and the breast feels very warm to the touch. What do these findings indicate to the nurse?**	mastitis
30.	**A nurse is caring for a client who has just received an episiotomy. The nurse observes that the laceration extends through the perineal area and continues through the anterior rectal wall. How does the nurse classify the laceration?**	Fourth degree
31.	**The nurse who is working with parents and their newborn encourages which action to assist the bonding and attachment between them?**	touching
32.	**The LVN/LPN will be assessing a postpartum client for danger signs after a vaginal birth. What assessment finding would the nurse assess as a danger sign for this client?**	fever more than 100.4° F (38° C)
33.	**It has been 8 hours since a woman gave birth vaginally to a healthy newborn. When assessing the woman's fundus, the nurse would expect to find it at:**	the level of the umbilicus
34.	**A nurse is caring for a postpartum woman who is Muslim. When developing the woman's plan of care, the nurse would make which action a priority?**	Assign a female nurse to care for her.
35.	**Seven hours ago, a multigravida woman gave birth to a 4133-g male infant. She has voided once and calls**	assess and massage the fundus.

	for a nurse to check because she states that she feels "really wet" now. Upon examination, her perineal pad is saturated. The immediate nursing action is to:	
36.	**A nurse is instructing a woman that it is important to lose pregnancy weight gain within 6 months of birth because studies show that keeping extra weight longer is a predictor of which condition?**	long-term obesity
37.	**A nurse is providing care to a postpartum woman who gave birth about 2 days ago. The client asks the nurse, "I haven't moved my bowels yet. Is this a problem?" Which response by the nurse would be most appropriate?**	"It might take up to a week for your bowels return to their normal pattern."
38.	**A new mother talking to a friend states, "I wish my baby was more like yours. You are so lucky. My baby has not slept straight through the night even once. It seems like all she wants to do is breastfeed. I am so tired of her." This is an example of which behavior?**	negative attachment
39.	**A client who gave birth by cesarean birth 3 days ago is bottle-feeding her neonate. While collecting data the nurse notes that vital signs are stable, the fundus is four fingerbreadths below the umbilicus, lochia are small and red, and the client reports discomfort in her breasts, which are hard and warm to touch. The best nursing intervention based on this data would be:**	encouraging the client to wear a supportive bra.
40.	**The client, who has just been walking around her room, sits down and reports leg tightness and achiness. After resting, she states she is feeling much better. The nurse recognizes that this discomfort could be due to which cause?**	thromboembolic disorder of the lower extremities
41.	**A nurse is providing care to a postpartum woman. The woman gave birth vaginally at 2 a.m. The nurse would anticipate the need to catheterize the client if she does not void by which time?**	9:00 a.m.