Maternity & Women's Health Care 12th Edition Lowdermilk Test Bank

Chapter 1: 21st Century Maternity and Women's Health Nursing

MULTIPLE CHOICE

1. In evaluating the level of a pregnant womans risk of having a low-birth-weight (LBW) infant, which factor is the most important for the nurse to consider?

a. African-American race
b. Cigarette smoking
c. Poor nutritional status
d. Limited maternal education

ANS: A

For African-American births, the incidence of LBW infants is twice that of Caucasian births. Race is a nonmodifiable risk factor. Cigarette smoking is an important factor in potential infant mortality rates, but it is not the most important. Additionally, smoking is a modifiable risk factor. Poor nutrition is an important factor in potential infant mortality rates, but it is not the most important. Additionally, nutritional status is a modifiable risk factor. Maternal education is an important factor in potential infant mortality rates, but it is not the most important. Additionally, maternal education is a modifiable risk factor.

DIF: Cognitive Level: Understand REF: IM:

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance, Antepartum Care

2. What is the primary role of practicing nurses in the research process?

a. Designing research studies
b. Collecting data for other researchers
c. Identifying researchable problems

d. Seeking funding to support research studies

ANS: C

When problems are identified, research can be properly conducted. Research of health care issues leads to evidence-based practice guidelines. Designing research studies is only one factor of the research process. Data collection is another factor of research. Financial support is necessary to conduct research, but it is not the primary role of the nurse in the research process.

DIF: Cognitive Level: Understand REF: im: 14 TOP: Nursing Process: N/A

MSC: Client Needs: Safe and Effective Care Environment

3. A 23-year-old African-American woman is pregnant with her first child. Based on the statistics for infant mortality, which plan is most important for the nurse to implement?

a. Perform a nutrition assessment.
b. Refer the woman to a social worker.
c. Advise the woman to see an obstetrician, not a midwife.
d. Explain to the woman the importance of keeping her prenatal care appointments.

ANS: D

Consistent prenatal care is the best method of preventing or controlling risk factors associated with infant mortality. Nutritional status is an important modifiable risk factor, but it is not the most important action a nurse should take in this situation. The client may need assistance from a social worker at some time during her pregnancy, but a referral to a social worker is not the most important aspect the nurse should address at this time. If the woman has identifiable high-risk problems, then her health care may need to be provided by a physician. However, it cannot be assumed that all African-American women have high-risk issues. In addition, advising the woman to see an obstetrician is not the most important aspect on which the nurse should focus at this time, and it is not appropriate for a nurse to advise or manage the type of care a client is to receive.

DIF: Cognitive Level: Understand REF: IM: TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

4. During a prenatal intake interview, the nurse is in the process of obtaining an initial assessment of a 21-year-old Hispanic client with limited English proficiency. Which action is the most important for the nurse to perform?

a. Use maternity jargon to enable the client to become familiar with these terms.
b. Speak quickly and efficiently to expedite the visit.
c. Provide the client with handouts.
d. Assess whether the client understands the discussion.

ANS: D

Nurses contribute to health literacy by using simple, common words, avoiding jargon, and evaluating whether the client understands the discussion. Speaking slowly and clearly and focusing on what is important will increase understanding. Most client education materials are written at a level too high for the average adult and may not be useful for a client with limited English proficiency.

DIF: Cognitive Level: Apply REF: im: 5 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

5. The nurses working at a newly established birthing center have begun to compare their performance in providing maternal-newborn care against clinical standards. This comparison process is most commonly known as what?

a. Best practices network
b. Clinical benchmarking
c. Outcomes-oriented practice
d. Evidence-based practice

ANS: C

Outcomes-oriented practice measures the effectiveness of the interventions and quality of care against benchmarks or standards. The term *best practice* refers to a program or service that has been recognized for its excellence. Clinical benchmarking is a process used to compare ones own performance against the performance of the best in an area of service. The term *evidence-based practice* refers to the provision of care based on evidence gained through research and clinical trials.

DIF: Cognitive Level: Understand REF: im: 11 TOP: Nursing Process: Evaluation

MSC: Client Needs: Safe and Effective Care Environment

6. Which statement best exemplifies contemporary maternity nursing?

a. Use of midwives for all vaginal deliveries
b. Family-centered care
c. Free-standing birth clinics
d. Physician-driven care

ANS: B

Contemporary maternity nursing focuses on the familys needs and desires. Fathers, partners, grandparents, and siblings may be present for the birth and participate in activities such as cutting the babys umbilical cord. Both midwives and physicians perform vaginal deliveries. Free-standing clinics are an example of alternative birth options. Contemporary maternity nursing is driven by the relationship between nurses and their clients.

DIF: Cognitive Level: Understand REF: pp. 8-9 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. A 38-year-old Hispanic woman vaginally delivered a 9-pound, 6-ounce baby girl after being in labor for 43 hours. The baby died 3 days later from sepsis. On what grounds could the woman have a legitimate legal case for negligence?

a. Inexperienced maternity nurse was assigned to care for the client.

b. Client was past her due date by 3 days.
c. Standard of care was not met.
d. Client refused electronic fetal monitoring.

ANS: C

Not meeting the standard of care is a legitimate factor for a case of negligence. An inexperienced maternity nurse would need to display competency before being assigned to care for clients on his or her own. This client may have been past her due date; however, a term pregnancy often goes beyond 40 weeks of gestation. Although fetal monitoring is the standard of care, the client has the right to refuse treatment. This refusal is not a case for negligence, but informed consent should be properly obtained, and the client should have signed an *against medical advice* form when refusing any treatment that is within the standard of care.

DIF: Cognitive Level: Analyze REF: im: 13

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

8. When the nurse is unsure how to perform a client care procedure that is high risk and low volume, his or her best action in this situation would be what?

a. Ask another nurse.
b. Discuss the procedure with the clients physician.
c. Look up the procedure in a nursing textbook.
d. Consult the agency procedure manual, and follow the guidelines for the procedure.

ANS: D

Following the agencys policies and procedures manual is always best when seeking information on correct client procedures. These policies should reflect the current standards of care and the individual states guidelines. Each nurse is responsible for his or her own practice. Relying on another nurse may not always be a safe practice. Each nurse is obligated to follow the standards

of care for safe client care delivery. Physicians are responsible for their own client care activity. Nurses may follow safe orders from physicians, but they are also responsible for the activities that they, as nurses, are to carry out. Information provided in a nursing textbook is basic information for general knowledge. Furthermore, the information in a textbook may not reflect the current standard of care or the individual state or hospital policies.

DIF: Cognitive Level: Understand REF: im: 13

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

9. The National Quality Forum has issued a list of never events specifically pertaining to maternal and child health. These include all of the following *except*:

a. infant discharged to the wrong person.
b. kernicterus associated with the failure to identify and treat hyperbilirubinemia.
c. artificial insemination with the wrong donor sperm or egg.
d. foreign object retained after surgery.

ANS: D

Although a foreign object retained after surgery is a never event, it does not specifically pertain to obstetric clients. A client undergoing any type of surgery may be at risk for this event. An infant discharged to the wrong person specifically pertains to postpartum care. Death or serious disability as a result of kernicterus pertains to newborn assessment and care. Artificial insemination affects families seeking care for infertility.

DIF: Cognitive Level: Remember REF: im: 4

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

10. A nurse caring for a pregnant client should be aware that the U.S. birth rate shows what trend?

a. Births to unmarried women are more likely to have less favorable outcomes.
b. Birth rates for women 40 to 44 years of age are declining.
c. Cigarette smoking among pregnant women continues to increase.
d. Rates of pregnancy and abortion among teenagers are lower in the United States than in any other industrialized country.

ANS: A

LBW infants and preterm births are more likely because of the large number of teenagers in the unmarried group. Birth rates for women in their early 40s continue to increase. Fewer pregnant women smoke. Teen pregnancy and abortion rates are higher in the United States than in any other industrial country.

DIF: Cognitive Level: Understand REF: IM:

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. A recently graduated nurse is attempting to understand the reason for increasing health care spending in the United States. Which information gathered from her research best explains the rationale for these higher costs compared with other developed countries?

a. Higher rate of obesity among pregnant women
b. Limited access to technology
c. Increased use of health care services along with lower prices
d. Homogeneity of the population

ANS: A

Health care is one of the fastest growing sectors of the U.S. economy. Currently, 17.4% of the gross domestic product is spent on health care. Higher spending in the United States, as compared with 12 other industrialized countries, is related to higher prices and readily accessible technology along with greater obesity rates among women. More than one third of women in the United States are obese. In the population in the United States, 16% are uninsured and have

limited access to health care. Maternal morbidity and mortality are directly related to racial disparities.

DIF: Cognitive Level: Understand REF: im: 5 TOP: Nursing Process: N/A

MSC: Client Needs: Safe and Effective Care Environment

12. Which statement best describes maternity nursing care that is based on knowledge gained through research and clinical trials?

a. Maternity nursing care is derived from the Nursing Intervention Classification.
b. Maternity nursing care is known as evidence-based practice.
c. Maternity nursing care is at odds with the Cochrane School of traditional nursing.
d. Maternity nursing care is an outgrowth of telemedicine.

ANS: B

Evidence-based practice is based on knowledge gained from research and clinical trials. The Nursing Intervention Classification is a method of standardizing language and categorizing care. Dr. Cochrane systematically reviewed research trials and is part of the evidence-based practice movement. Telemedicine uses communication technologies to support health care.

DIF: Cognitive Level: Understand REF: pp. 10-11 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Safe and Effective Care Environment

13. What is the minimum level of practice that a reasonably prudent nurse is expected to provide?

a. Standard of care
b. Risk management
c. Sentinel event
d. Failure to rescue

ANS: A

Guidelines for standards of care are published by various professional nursing organizations. Risk management identifies risks and establishes preventive practices, but it does not define the standard of care. Sentinel events are unexpected negative occurrences. They do not establish the standard of care. Failure to rescue is an evaluative process for nursing, but it does not define the standard of care.

DIF: Cognitive Level: Remember REF: im: 13

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

14. Through the use of social media technology, nurses can link with other nurses who may share similar interests, insights about practice, and advocate for clients. Which factor is the most concerning pitfall for nurses using this technology?

a. Violation of client privacy and confidentiality
b. Institutions and colleagues who may be cast in an unfavorable light
c. Unintended negative consequences for using social media
d. Lack of institutional policy governing online contact

ANS: A

The most significant pitfall for nurses using this technology is the violation of client privacy and confidentiality. Furthermore, institutions and colleagues can be cast in an unfavorable light with negative consequences for those posting information. Nursing students have been expelled from school and nurses have been fired or reprimanded by their Board of Nursing for injudicious posts. The American Nurses Association has published six principles for social networking and the nurse. All institutions should have policies guiding the use of social media, and the nurse should be familiar with these guidelines.

DIF: Cognitive Level: Analyze REF: im: 8

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

15. During a prenatal intake interview, the client informs the nurse that she would prefer a midwife to provide both her care during pregnancy and deliver her infant. Which information is most appropriate for the nurse to share with this client?

a. Midwifery care is only available to clients who are uninsured because their services are less expensive than an obstetrician.
b. She will receive fewer interventions during the birth process.
c. She should be aware that midwives are not certified.
d. Her delivery can take place only at home or in a birth center.

ANS: B

This client will be able to participate actively in all decisions related to the birth process and is likely to receive fewer interventions during the birth process. Midwifery services are available to all low-risk pregnant women, regardless of the type of insurance they have. Midwifery care in all developed countries is strictly regulated by a governing body to ensure that core competencies are met. In the United States, this body is the American College of Nurse-Midwives (ACNM). Midwives can provide care and delivery at home, in freestanding birth centers, and in community and teaching hospitals.

DIF: Cognitive Level: Understand REF: im: 8 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

16. While obtaining a detailed history from a woman who has recently immigrated from Somalia, the nurse realizes that the client has undergone female genital mutilation. What is the nurses most appropriate response in this situation?

a. This is a very abnormal practice and rarely seen in the United States.
b. Are you aware of who performed this mutilation so that it can be reported to the authorities?
c. We will be able to restore fully your circumcision after delivery.
d. The extent of your circumcision will affect the potential for complications.

ANS: D

The extent of the circumcision is important. The client may experience pain, bleeding, scarring, or infection and may require surgery before childbirth. Although this practice is not prevalent in the United States, it is very common in many African and Middle Eastern countries for religious reasons. Mentioning that the practice is abnormal and rarely seen in the United States is culturally insensitive. The infibulation may have occurred during infancy or childhood; consequently, the client will have little to no recollection of the event. She would have considered this to be a normal milestone during her growth and development. The International Council of Nurses has spoken out against this procedure as harmful to a womans health.

DIF: Cognitive Level: Analyze REF: im: 9

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. To ensure client safety, the practicing nurse must have knowledge of The Joint Commissions current Do Not Use list of abbreviations. Which term is acceptable for use regarding medication administration?

a. q.o.d. or Q.O.D.
b. MSO_4 or $MgSO_4$
c. International Unit
d. Lack of a leading zero

ANS: C

I.U. and i.u. are no longer acceptable because they could be misread as I.V. or the number 10. Q.O.D. should be written out as every other day. The period after the Q could be mistaken for an I and the o could also be mistaken for an i. Confusing one medication for another is too easy. Medications are used for very different purposes and could place a client at risk for an adverse outcome. For example, these medications should be written as *morphine sulfate* and *magnesium sulfate*. The decimal point should never be missed before a number (e.g., 0.4 rather than .4). A leading zero is the preferred form.

DIF: Cognitive Level: Remember REF: im: 13

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

18. Maternity nurses can enhance communication among health care providers by using the SBAR technique. The acronym SBAR stands for what?

a. Situation, background, assessment, recommendation
b. Situation, baseline, assessment, recommendation
c. Subjective, background, analysis, recommendation
d. Subjective, background, analysis, review

ANS: A

SBAR is an easy-to-remember, useful, and concrete mechanism for communicating important information that requires a clinicians immediate attention. *Baseline* is not discussed as part of SBAR. *Subjective* and *analysis*are not specific to the SBAR acronym. *Subjective, analysis,* and *review* are not specific to the SBAR acronym.

DIF: Cognitive Level: Apply REF: im: 14

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

19. *Healthy People 2020* has established national health priorities that focus on a number of maternal-child health indicators. Nurses are assuming greater roles in assessing family health and are providing care across the perinatal continuum. Which of these priorities has made the most significant progress?

a. Reduction of fetal deaths and use of prenatal care
b. LBW infants and preterm births
c. Elimination of health disparities based on race
d. Infant mortality and the prevention of birth defects

ANS: A

Trends in maternal child health indicate that progress has been made in relation to reduced infant and fetal deaths and increased prenatal care. Notable gaps remain in the rates of LBW infants and preterm births. According to the March of Dimes, persistent disparities still exist between African-Americans and non-Hispanic Caucasians. Many of these negative outcomes are preventable through access to prenatal care and the use of preventive health practices. These preventable negative outcomes demonstrate the need for comprehensive community-based care for all mothers, infants, and families.

DIF: Cognitive Level: Remember REF: pp. 3, 4

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. Greater than one third of women in the United States are now obese (body mass index [BMI] of 30 or greater). Less than one quarter of women in Canada exhibit the same BMI. Obesity in the pregnant woman increases both maternal medical risk factors and negative outcomes for the infant. The nurse is about to perform an assessment on a client who is 28 weeks pregnant and has a BMI of 35. What are the most frequently reported complications for which the nurse must be alert while assessing this client? (*Select all that apply.)*

a. Potential miscarriage
b. Diabetes
c. Fetal death in utero
d. Decreased fertility
e. Hypertension

ANS: B, E

The two most frequently reported maternal medical risk factors associated with obesity are hypertension associated with pregnancy and diabetes. Decreased fertility, miscarriage, fetal

death, and congenital anomalies are also associated with obesity. These clients often experience longer hospital stays and increased use of health services.

DIF: Cognitive Level: Apply REF: im: 7

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. The Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama in early 2010. The Act provides some immediate benefits, and other provisions will take place over the next several years. The practicing nurse should have a thorough understanding of how these changes will benefit his or her clients. Which outcomes are goals of the ACA? (*Select all that apply.)*

a. Insurance affordability
b. Improve public health
c. Treatment of illness
d. Elimination of Medicare and Medicaid
e. Cost containment

ANS: A, B, E

The ACA goals are to make insurance more affordable, contain costs, and strengthen Medicare and Medicaid. The Act contains provisions that promote the prevention of illness and improve access to public health. The ultimate goal of the Act is to improve the quality of care for all Americans while reducing waste, fraud, and abuse of the current system.

DIF: Cognitive Level: Comprehend REF: im: 5 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

3. Which statements indicate that the nurse is practicing appropriate family-centered care techniques? (*Select all that apply.)*

a. The nurse commands the pregnant woman to do as she is told.
b. The nurse allows time for the partner to ask questions.

c. The nurse allows the mother and father to make choices when possible.

d. The nurse informs the family about what is going to happen.

e. The nurse tells the clients sister, who is a nurse, that she cannot be in the room during the delivery.

ANS: B, C

Including the partner in the care process and allowing the couple to make choices are important elements of family-centered care. The nurse should never tell the client what to do. Family-centered care involves collaboration between the health care team and the client. Unless an institutional policy limits the number of attendants at a delivery, the client should be allowed to have whomever she wants present (except when the situation is an emergency and guests are asked to leave).

DIF: Cognitive Level: Analyze REF: pp. 8-9

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. Which methods help alleviate the problems associated with access to health care for the maternity client? (*Select all that apply.)*

a. Provide transportation to prenatal visits.

b. Provide child care to enable a pregnant woman to keep prenatal visits.

c. Increase the number of providers that will care for Medicaid clients.

d. Provide low-cost or no-cost health care insurance.

e. Provide job training.

ANS: A, B, C, D

Lack of transportation to prenatal visits, child care, access to skilled obstetric providers, and affordable health insurance are prohibitive factors associated with the lack of prenatal care. Although job training may result in employment and income, the likelihood of significant changes during the time frame of the pregnancy is remote.

Chapter 2: Community Care: The Family and Culture

MULTIPLE CHOICE

1. A married couple lives in a single-family house with their newborn son and the husbands daughter from a previous marriage. Based on this information, what family form best describes this family?

a. Married-blended family
b. Extended family
c. Nuclear family
d. Same-sex family

ANS: A

Married-blended families are formed as the result of divorce and remarriage. Unrelated family members join to create a new household. Members of an extended family are kin or family members related by blood, such as grandparents, aunts, and uncles. A nuclear family is a traditional family with male and female partners along with the children resulting from that union. A same-sex family is a family with homosexual partners who cohabit with or without children.

DIF: Cognitive Level: Remember REF: im: 19

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. Which key factors play the most powerful role in the behaviors of individuals and families?

a. Rituals and customs
b. Beliefs and values
c. Boundaries and channels
d. Socialization processes

ANS: B

Beliefs and values are the most prevalent factors in the decision-making and problem-solving behaviors of individuals and families. This prevalence is particularly true during times of stress and illness. Although culture may play a part in the decision-making process of a family, ultimately, values and beliefs dictate the course of action taken by family members. Boundaries and channels affect the relationship between the family members and the health care team, not the decisions within the family. Socialization processes may help families with interactions within the community, but they are not the criteria used for decision making within the family.

DIF: Cognitive Level: Understand REF: pp. 21-22 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. Using the family stress theory as an interventional approach for working with families experiencing parenting challenges, the nurse can assist the family in selecting and altering internal context factors. Which statement best describes the components of an *internal context*?

a. Biologic and genetic makeup
b. Maturation of family members
c. Familys perception of the event
d. Prevailing cultural beliefs of society

ANS: C

The family stress theory is concerned with the familys reaction to stressful events. Internal context factors include elements that a family can control such as psychologic defenses, family structure, and philosophic beliefs and values. The family stress theory focuses on ways that families react to stressful events. Maturation of family members is more relevant to the family life-cycle theory. The family stress theory focuses on internal elements that a family might be able to alter.

DIF: Cognitive Level: Understand REF: im: 21 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

4. The nurse is developing a plan of care for a Hispanic client who just delivered a newborn. Which cultural variation is most important to include in the care plan?

a. Breastfeeding is encouraged immediately after birth.
b. Male infants are typically circumcised.
c. Maternal grandmother participates in the care of the mother and her infant.
d. Bathing is encouraged immediately after delivery.

ANS: C

In the Hispanic family, the expectant mother is strongly influenced by her mother or mother-in-law. Breastfeeding is often delayed until the third postpartum day. Hispanic male infants are not usually circumcised. Bathing after delivery is most often delayed.

DIF: Cognitive Level: Apply REF: im: 26 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

5. Which health care service represents a primary level of prevention?

a. Immunizations
b. Breast self-examination (BSE)
c. Home care for high-risk pregnancies
d. Blood pressure screening

ANS: A

Primary prevention involves health promotion and disease prevention activities to reduce the occurrence of illness and enhance the general health and quality of life. This level of care includes, for example, immunizations, using infant car seats, and providing health education to prevent tobacco use. BSE is an example of secondary prevention that involves early detection of health problems. Home care for a high-risk pregnancy is an example of tertiary prevention. This level of care follows the occurrence of a defect or disability. Blood pressure screening is an

example of secondary prevention and is a screening tool for early detection of a health care problem.

DIF: Cognitive Level: Understand REF: im: 34

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

6. What is the primary difference between hospital care and home health care?

a. Home care is routinely and continuously delivered by professional staff.
b. Home care is delivered on an intermittent basis by professional staff.
c. Home care is delivered for emergency conditions.
d. Home care is not available 24 hours a day.

ANS: B

Home care is generally delivered on an intermittent basis by professional staff members. The primary difference between health care in a hospital and home care is the absence of the continuous presence of professional health care providers in a clients home. In a true emergency, the client should be directed to call 9-1-1 or to report to the nearest hospitals emergency department. Generally, home health care entails intermittent care by a professional who visits the clients home for a particular reason and provides on-site care for periods shorter than 4 hours at a time.

DIF: Cognitive Level: Understand REF: pp. 34-35

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

7. To provide culturally competent care to an Asian-American family, which question should the nurse include during the assessment interview?

a. Do you prefer hot or cold beverages?
b. Do you want some milk to drink?

c. Do you want music playing while you are in labor?

d. Do you have a name selected for the baby?

ANS: A

Asian-Americans often prefer warm beverages. Milk is usually excluded from the diet of this population. Asian-American women typically labor in a quiet environment. Delaying naming the child is not uncommon for Asian-American families.

DIF: Cognitive Level: Apply REF: im: 27

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

8. The womans family members are present when the nurse arrives for a postpartum and newborn visit. What should the nurse do?

a. Observe the family members interactions with the newborn and one another.

b. Ask the woman to meet with her and the baby alone.

c. Perform a brief assessment on all family members who are present.

d. Reschedule the visit for another time so that the mother and infant can be privately assessed.

ANS: A

The nurse should introduce her or himself to the client and to the other family members who are present. Family members in the home may be providing care and assistance to the mother and infant. However, this care may not be based on sound health practices. Nurses should take the opportunity to dispel myths while family members are present. The responsibility of the home care maternal-child nurse is to provide care to the new postpartum mother and to her infant, not to all family members. The nurse can politely ask about the other people in the home and their relationships with the mother. Unless an indication is given that the woman would prefer privacy, the visit may continue.

DIF: Cognitive Level: Analyze REF: im: 35

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. What is a limitation of a home postpartum visit?

a. Distractions limit the nurses ability to teach.
b. Identified problems cannot be resolved in the home setting.
c. Necessary items for infant care are not available.
d. Home visits to different families may require the nurse to travel a great distance.

ANS: D

One limitation of home health visits is the distance the nurse must travel between clients. Driving directions should be obtained by telephone before the visit. The home care nurse is accustomed to distractions but may request that the television be turned off so that attention can be focused on the client and her family. Problems cannot always be resolved; however, appropriate referrals may be arranged by the nurse. The nurse is required to bring any necessary equipment, such as a thermometer, baby scale, or laptop computer, for documentation.

DIF: Cognitive Level: Understand REF: im: 35 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

10. During the childbearing experience, which behavior might the nurse expect from an African-American client?

a. Seeking prenatal care early in her pregnancy
b. Avoiding self-treatment of pregnancy-related discomfort
c. Requesting liver in the postpartum period to prevent anemia
d. Arriving at the hospital in advanced labor

ANS: D

African-American women often arrive at the hospital in far-advanced labor and may view pregnancy as a state of wellness, which is often the reason for the delay in seeking prenatal care. African-American women practice many self-treatment options for various discomforts of

pregnancy. African-American women may also request liver in the postpartum period, which is based on a belief that liver has a higher blood content.

DIF: Cognitive Level: Understand REF: im: 26

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

11. Which resource best describes a health care service representing the tertiary level of prevention?

a. Stress management seminars
b. Childbirth education classes for single parents
c. BSE pamphlet and teaching
d. Premenstrual syndrome (PMS) support group

ANS: D

A PMS support group is an example of tertiary prevention, which follows the occurrence of a defect or disability (e.g., PMS). Stress management seminars are a primary prevention technique for preventing health care issues associated with stress. Childbirth education is a form of primary prevention. BSE information is a form of secondary prevention, which is aimed toward early detection of health problems.

DIF: Cognitive Level: Understand REF: im: 28

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. When the services of an interpreter are needed, which is the most important factor for the nurse to consider?

a. Using a family member who is fluent in both languages
b. Using an interpreter who is certified, and documenting the persons name in the nursing notes
c. Directing questions only to the interpreter
d. Using an interpreter only in an emergency

ANS: B

Using a certified interpreter ensures that the standards of care are met and that the information exchanged is reliable and unaltered. The name of the interpreter should be documented for legal purposes. Asking a family member to interpret may not be appropriate, although many health care personnel must adopt this approach in an emergency. Furthermore, most states require that certified interpreters be used when possible. When using an interpreter, the nurse should direct questions to the client. The interpreter is simply a means by which the nurse communicates with the client. Every attempt should be made to contact an interpreter whenever one is needed. During an emergency, health care workers often rely on information interpreted by family members. This information may be private and should be protected under the rules established by the Health Insurance Portability and Accountability Act (HIPAA). Furthermore, family members may skew information or may not be able to interpret the exact information the nurse is trying to obtain.

DIF: Cognitive Level: Apply REF: pp. 24, 25

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

13. Which traditional family structure is decreasing in numbers and attributable to societal changes?

a. Extended family
b. Binuclear family
c. Nuclear family
d. Blended family

ANS: C

The nuclear family has long represented the traditional American family in which husband, wife, and children live as an independent unit. As a result of rapid changes in society, this number is steadily decreasing as other family configurations are socially recognized. Extended families involve additional blood relatives other than the parents. A binuclear family involves two households. A blended family is reconstructed after divorce and involves the merger of two families.

DIF: Cognitive Level: Understand REF: im: 18

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. Which statement regarding the Family Systems Theory is *inaccurate*?

a. Family system is part of a larger suprasystem.
b. Family, as a whole, is equal to the sum of the individual members.
c. Changes in one family member affect all family members.
d. Family is able to create a balance between change and stability.

ANS: B

A family, as a whole, is greater than the sum of its individual members. The other statements are accurate and can be attributed to the Family Systems Theory.

DIF: Cognitive Level: Understand REF: im: 21

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. Which pictorial tool can assist the nurse in assessing the aspects of family life related to health care?

a. Genogram
b. Ecomap
c. Life-cycle model
d. Human development wheel

ANS: A

A genogram depicts the relationships of the family members over generations. An ecomap is a graphic portrayal of the social relationships of the woman and her family. The life-cycle model, in no way, illustrates a family genogram; rather, it focuses on the stages that a person reaches throughout life. The human development wheel describes various stages of growth and development rather than the family members relationships to each other.

DIF: Cognitive Level: Remember REF: pp. 20-21

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. When attempting to communicate with a client who speaks a different language, which action is the most appropriate?

a. Promptly and positively respond to project authority.
b. Never use a family member as an interpreter.
c. Talk to the interpreter to avoid confusing the client.
d. Provide as much privacy as possible.

ANS: D

Providing privacy creates an atmosphere of respect and puts the client at ease. The nurse should not rush to judgment and should ensure she or he clearly understands the clients message. In crisis situations, the nurse may need to use a family member or neighbor as a translator. The nurse should speak directly to the client to create an atmosphere of respect.

DIF: Cognitive Level: Apply REF: im: 24

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

17. The secondary level of prevention is best illustrated by which example?

a. Approved infant car seats
b. BSE
c. Immunizations
d. Support groups for parents of children with Down syndrome

ANS: B

Infant car seats are an example of primary prevention. BSE is an example of the secondary level of prevention, which includes health-screening measures for early detection of health problems. Immunizations are an example of the primary level of prevention. Support groups are an

example of tertiary prevention, which follows the occurrence of a defect or disability (e.g., Down syndrome).

DIF: Cognitive Level: Understand REF: im: 28 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

18. Which key point is important for the nurse to understand regarding the perinatal continuum of care?

a. Begins with conception and ends with the birth
b. Begins with family planning and continues until the infant is 1 year old
c. Begins with prenatal care and continues until the newborn is 24 weeks old
d. Refers to home care only

ANS: B

The perinatal continuum of care begins with family planning and continues until the infant is 1 year old. It takes place both at home and in health care facilities. The perinatal continuum does not end with the birth. The perinatal continuum begins before conception and continues after the birth. Home care is one delivery component; health care facilities are another.

DIF: Cognitive Level: Remember REF: im: 17 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. What information should the nurse be aware of regarding telephonic nursing care such as *warm lines*?

a. Were developed as a reaction to impersonal telephonic nursing care
b. Were set up to take complaints concerning health maintenance organizations (HMOs)
c. Are the second option when 9-1-1 hotlines are busy
d. Refer to community service telephone lines designed to provide new parents with encouragement and basic information

ANS: D

Warm lines are one aspect of telephonic nursing care specifically designed to provide new parents with encouragement and basic information. Warm lines and similar services sometimes are set up by HMOs to provide new parents with encouragement and basic information. The name, *warm lines*, may have been suggested by the term *hotlines,* but these are not emergency numbers but are designed to provide new parents with encouragement and basic information.

DIF: Cognitive Level: Remember REF: im: 34

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. When weighing the advantages and disadvantages of planning home care for perinatal services, what information should the nurse use in making the decision?

a. Home care for perinatal services is more dangerous for vulnerable neonates at risk of acquiring an infection from the nurse.
b. Home care for perinatal services is more cost-effective for the nurse than office visits.
c. Home care for perinatal services allows the nurse to interact with and include family members in teaching.
d. Home care for perinatal services is made possible by the ready supply of nurses with expertise in maternity care.

ANS: C

Treating the whole family is an advantage of home care. Forcing neonates out in inclement weather and in public is more risky. Office visits are more cost-effective for the providers such as nurses because less travel time is involved. Unfortunately, home care options are limited by the lack of nurses with expertise in maternity care.

DIF: Cognitive Level: Apply REF: im: 35

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

21. In what form do families tend to be the most socially vulnerable?

a. Married-blended family
b. Extended family
c. Nuclear family
d. Single-parent family

ANS: D

The single-parent family tends to be economically and socially vulnerable, creating an unstable and deprived environment for the growth potential of children. The married-blended family, the extended family, and the nuclear family are not the most socially vulnerable.

DIF: Cognitive Level: Understand REF: im: 19 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

22. While working in the prenatal clinic, nurses care for a very diverse group of clients. Which cultural factor related to health is most likely to drive acceptance of planned interventions?

a. Educational achievement
b. Income level
c. Subcultural group
d. Individual beliefs

ANS: D

The clients beliefs are ultimately the key to the acceptance of health care interventions. However, these beliefs may be influenced by factors such as educational level, income level, and ethnic background. Educational achievement, income level, and being part of a subcultural group all are important factors. However, the nurse must understand that a womans concerns from her own point of view will have the most influence on her compliance and acceptance of health care interventions.

DIF: Cognitive Level: Apply REF: pp. 21-22 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

23. A clients household consists of her husband, his mother, and another child. To which family configuration does this client belong?

a. Multigenerational family
b. Single-parent family
c. Married-blended family
d. Nuclear family

ANS: A

A multigenerational family includes three or more generations living together. Both parents and a grandparent are living in this extended family. Single-parent families comprise an unmarried biologic or adoptive parent who may or may not be living with other adults. Married-blended families refer to those who are reconstructed after divorce. A nuclear family comprises male and female partners and their children living together as an independent unit.

DIF: Cognitive Level: Apply REF: IMS: 19

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

24. Which term is an accurate description of the process by which people retain some of their own culture while adopting the practices of the dominant society?

a. Acculturation
b. Assimilation
c. Ethnocentrism
d. Cultural relativism

ANS: A

Acculturation is the process by which people retain some of their own culture while adopting the practices of the dominant society. This process takes place over the course of generations. Assimilation is a loss of cultural identity. Ethnocentrism is the belief in the superiority of ones

own culture over the cultures of others. Cultural relativism recognizes the roles of different cultures.

DIF: Cognitive Level: Understand REF: pp. 22-23 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

25. In which culture is the father more likely to be expected to participate in the labor and delivery?

a. Asian-American
b. African-American
c. European-American
d. Hispanic

ANS: C

European-Americans expect the father to take a more active role in the labor and delivery of a newborn than the other cultures.

DIF: Cognitive Level: Understand REF: IMS: 27

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

26. Which statement about the development of cultural competence is inaccurate?

a. Local health care workers and community advocates can help extend health care to underserved populations.
b. Nursing care is delivered in the context of the clients culture but not in the context of the nurses culture.
c. Nurses must develop an awareness of and a sensitivity to various cultures.
d. Cultures economic, religious, and political structures influence practices that affect childbearing.

ANS: B

Although the cultural context of the nurse affects the delivery of nursing care and is very important, the work of local health care workers and community advocates, developing sensitivity to various cultures, and the impact of economic, religious, and political structures are all parts of cultural competence.

DIF: Cognitive Level: Understand REF: pp. 27-28 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

27. Which statement accurately describes the *walking survey* as a data collection tool?

a. The walking survey determines how much exercise an expectant mother has been getting, to help her make health care decisions.
b. The walking survey usually takes place on the maternity ward but can be expanded to other areas of the hospital.
c. The walking survey is a method of observing the resources and health-related environment of the community.
d. The walking survey is performed by government census takers as part of their canvas.

ANS: C

The walking survey is a valuable tool for the nurses in the community and has nothing to do with exercise. It is an observational method used to assess the health environment of the community. A walking survey takes place in the community, not the maternity ward, and is not part of the census; it is conducted by nurses in the community.

DIF: Cognitive Level: Remember REF: IMS: 30

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

28. A Native-American woman gave birth to a baby girl 12 hours ago. The nurse notes that the woman keeps her baby in the bassinet except for bottle feeding and states that she will wait until she gets home to begin breastfeeding. The nurse recognizes that this behavior is most likely a reflection of what?

a. Delayed attachment
b. Embarrassment
c. Disappointment in the sex of the baby
d. Belief that babies should not be fed colostrum

ANS: D

Native Americans often use cradle boards and often avoid handling their newborn. They also believe that the infant should not be fed colostrum. Delayed attachment is a developmental concern, not a cultural belief. Embarrassment is not likely the cause for a delay in the initiation of breastfeeding and should be explored further by the nurse. The mother may voice her disappointment that the infant is a girl; however, this would rarely cause her to delay breastfeeding and would exhibit itself in other ways.

DIF: Cognitive Level: Understand REF: IMS: 27

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. While completing an assessment of a homeless woman, the nurse should be aware of which of the following ailments this client is at a higher risk to develop? *(Select all that apply.)*

a. Infectious diseases
b. Chronic illness
c. Anemia
d. Hyperthermia
e. Substance abuse

ANS: A, B, C, E

Poor living conditions contribute to higher rates of infectious disease. Many homeless individuals engage in sexual favors, which may expose them to sexually transmitted infections (STIs). Poor nutrition can lead to anemia. Lifestyle factors also contribute to chronic illness.

Exposure to cold temperatures and harsh environmental surroundings may lead to hypothermia. Many homeless people turn to alcohol and other substances as coping mechanisms.

Chapter 3: Nursing and Genomics

MULTIPLE CHOICE

1. A father and mother are carriers of phenylketonuria (PKU). Their 2-year-old daughter has the condition. The couple tells the nurse that they are having a second baby. Because their daughter has PKU, they are certain that this baby will not be affected. Which response by the nurse is the most accurate?

a. Good planning. You need to take advantage of the odds that are in your favor.
b. I think youd better first check with your physician.
c. You are both carriers; therefore, each baby has a 25% chance of being affected.
d. The ultrasound indicates a boy, and boys are not affected by PKU.

ANS: C

Each child conceived by this couple has a one-in-four chance of being affected with the PKU disorder. This couple still has an increased likelihood of having a child with PKU; having one child already with PKU does not guarantee that they will not have another. These parents need to discuss their options with their physician. However, an opportune time has presented itself for the couple to receive correct teaching about inherited genetic risks. No correlation exists between gender and inheritance of the disorder, because PKU is an autosomal recessive disorder.

DIF: Cognitive Level: Apply REF: IMS: 51 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. A client is 5 months pregnant. On a routine ultrasound scan, the physician discovers that the fetus has a diaphragmatic hernia. The woman becomes distraught and asks the nurse what she should do. Which response would be most suitable?

a. Talk to the client, and refer her to a genetic counselor.
b. Suggest that the client travel to a fetal treatment center for intrauterine surgery.
c. Tell her that everything is going to be fine.
d. Sit with the client, and calmly suggest that she consider terminating this pregnancy.

ANS: A

Before the client makes any decisions, she should discuss this newly discovered information with a genetic counselor. Genetic counselors can help with the diagnosis and management of families affected by genetic conditions. The discussion of potential surgery should be pursuant to genetic counseling. Telling the woman that everything is going to be fine may give her false hope and is not accurate. All options should be discussed with the genetic counselor. Furthermore, the guiding principle for genetic counseling is nondirection, which respects the right of the individual or family who are being counseled to make autonomous decisions.

DIF: Cognitive Level: Apply REF: IMS: 54 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A client who is gravida 2 and 16 weeks of gestation comes in for her prenatal appointment. Her 2-year-old daughter is with her and is wearing a sleeveless top. While interacting with her daughter, you note axillary freckling and several caf-au-lait spots (>2 cm). In reviewing her chart, the nurse should assess for documentation of which genetic disease?

a. Tay-Sachs disease
b. Galactosemia
c. Neurofibromatosis (NF)
d. PKU

ANS: C

Clinical manifestations of NF may include axillary freckling and caf-au-lait spots. Tay-Sachs disease is an incurable lipid-storage disorder and is not associated with caf-au-lait spots.

Galactosemia is an inborn error of metabolism and is also not associated with caf-au-lait spots. PKU is not associated with caf-au-lait spots. A child with PKU would have difficulty manufacturing the liver enzyme phenylalanine.

DIF: Cognitive Level: Remember REF: IMS: 51

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. A new father has just been told that his infant has trisomy 18. Which identifying physical feature is unique to an infant with this genetic disorder?

a. Microcephaly and capillary hemangiomas
b. Epicanthal folds and a simian crease
c. Oblique palpebral fissures and Cri du chat syndrome
d. Rocker-bottom feet and clenched hands with overlapping fingers

ANS: D

Rocker-bottom feet and clenched hands with overlapping fingers are associated with trisomy 18. Microcephaly and capillary hemangiomas are associated with trisomy 13. Epicanthal folds and a simian crease are associated with trisomy 21 (Down syndrome). Deletion of the short arm of chromosome number 5 is manifested by Cri du chat syndrome.

DIF: Cognitive Level: Understand REF: IMS: 49

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. A nurse is assessing the knowledge of new parents of a child born with Klinefelter syndrome. Which statement accurately describes this genetic disorder?

a. Klinefelter syndrome is a sex chromosome abnormality.
b. It affects only female children.
c. The disorder is expressed as trisomy XYY.
d. The child with this disorder will grow to be infertile.

ANS: A

Klinefelter syndrome, also known as trisomy XXY, is a sex chromosomal deviation that is expressed in males. Turner syndrome (monosomy X) is displayed in females. Most males with Klinefelter syndrome are tall, may be infertile, and are slow to learn; however, those who have mosaic Klinefelter syndrome may be fertile as adults.

DIF: Cognitive Level: Understand REF: IMS: 50

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Which factor is least likely to influence the decision to undergo genetic testing?

a. Anxiety and altered family relationships
b. Cost of testing or denial of insurance benefits
c. Imperfection of test results
d. Ethnic and socioeconomic disparity associated with genetic testing

ANS: B

Testing is not 100% accurate and has a high percentage of false-negative results. An individual may not take these results seriously and subsequently fail to have testing completed or to seek necessary follow-up consultation. Anxiety and altered family relationships are often the result of genetic testing. The results of genetic testing may be difficult to keep confidential, and family members may feel pressured to have testing performed. Decisions about genetic testing are shaped by socioeconomic status and the ability to pay for the testing. Some types of genetic testing are expensive and are not covered by insurance benefits. Caucasian middle-class families have greater access to genetic screening; therefore, this population is less at likely to decide against genetic testing.

DIF: Cognitive Level: Understand REF: IMS: 54

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

7. A 32-year-old woman is pregnant for the third time. One child was born with cystic fibrosis, and the other child is healthy. The client and her husband wonder what chance this child has of having cystic fibrosis. This type of testing is most commonly known as what?

a. Occurrence risk
b. Recurrence risk
c. Predictive testing
d. Predisposition testing

ANS: B

The couple already has a child with a genetic disease; therefore, this couple will be given a recurrence risk test. If a couple has not yet had a child but is known to be at risk for having a child with a genetic disease, then an occurrence risk test is administered. Predictive testing clarifies the genetic status of an asymptomatic family member. Predisposition testing differs from presymptomatic testing in that a positive result does not indicate 100% risk of a condition developing.

DIF: Cognitive Level: Understand REF: IMS: 54 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. Cancer is now recognized as a genetic disorder that begins with one or more genetic mutations. Which type of cancer is specifically being investigated in this regard?

a. Lung cancer
b. Liver cancer
c. Colorectal cancer
d. Oral cancer

ANS: C

Colorectal cancer usually results from one or more predisposing genes and is the third leading cause of cancer deaths in women. Although tobacco smoke is a known causative factor for lung

cancer, an acquired mutation of an oncogene may also be present. Liver cancer is not being investigated in this regard. Oral cancer may be caused by an inherited mutation of one or more oncogenes.

DIF: Cognitive Level: Remember REF: IMS: 53

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. Which statement describes a key finding of the Human Genome Project?

a. Humans produce one protein per gene.
b. All human beings are 99.9% identical at the deoxyribonucleic acid (DNA) level.
c. The Human Genome Project has not yet been able to translate the accumulating raw research into anything medically practical.
d. Humans have more genes than other species.

ANS: B

The majority of the 0.1% genetic variations are found within and not among populations. Most human genes produce at least three proteins. The projects research has been very valuable in the identification of genes involved in disease and in the development of genetic testing. There are 20,500 genes in the human genome; scientists originally estimated more than 50,000 genes. Human genes are more efficient than the genes in other species, thereby increasing the human genetic complexity.

DIF: Cognitive Level: Remember REF: IMS: 42

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. Which condition or treatment reduces the risk of morbidity in women with the inherited factor V Leiden disorder?

a. Anticoagulant therapy
b. Pregnancy
c. Oral contraceptives

d. Hormone replacement therapy

ANS: A

Factor V Leiden is the most common inherited risk factor for primary or recurrent venous thromboembolism. It is an autosomal recessive disorder that increases an individuals risk for blood clots in the legs and pulmonary emboli. This risk significantly increases if the woman is pregnant or is taking oral contraceptives or hormone replacement therapy. Prophylactic anticoagulation therapy decreases the risk of comorbidities.

DIF: Cognitive Level: Understand REF: IMS: 51 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

11. Nurses who elect to practice in the field of obstetrics must have a basic working knowledge of genetics. What is the correct term used to describe an individuals genetic makeup?

a. Genotype
b. Phenotype
c. Karyotype
d. Chromotype

ANS: A

The genotype comprises all the genes the individual can pass on to a future generation. The phenotype is the observable expression of an individuals genotype. The karyotype is a pictorial analysis of the number, form, and size of an individuals chromosomes. Genotype refers to an individuals genetic makeup.

DIF: Cognitive Level: Remember REF: IMS: 44

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. The U.S. Department of Health and Human Services has designated Thanksgiving Day as National Family History Day. The U.S. Surgeon General encourages family members to discuss

important family health information while sharing in holiday gatherings. Why is this initiative significant to nurses?

a. Few genetic tests are available that identify this information.
b. Only physicians should obtain this detailed information.
c. Clients cannot accurately complete these histories on their own.
d. Family history is the single most cost-effective source for genetic information.

ANS: D

Although more than 1000 genetic tests are available, the single most cost-effective piece of genetic information is the family history. Nurses are ideally suited to take the lead in ongoing efforts to recognize the significance of the family history as an important source of genetic information. A computerized tool called *My Family Health Portrait* is available free of charge (https://familyhistory.hhs.gov/fhh-web/home.action). Other tools designed to help the lay community in completing their family histories are available to the public.

DIF: Cognitive Level: Understand REF: pp. 42-43

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. A maternal-newborn nurse is caring for a mother who just delivered a baby born with Down syndrome. Which nursing diagnosis would be the most essential in caring for the mother of this infant?

a. Disturbed body image
b. Interrupted family processes
c. Anxiety
d. Risk for injury

ANS: B

This mother will likely experience a disruption in the family process related to the birth of a baby with an inherited disorder. Therefore, the probable nursing diagnosis for this family is

Interrupted family processes. Women commonly experience body image disturbances in the postpartum period; however, this nursing diagnosis is unrelated to giving birth to a child with Down syndrome. The mother will likely have a mix of emotions that may include anxiety, guilt, and denial, but this nursing diagnosis is not the most essential for this family. Risk for injury is not an applicable nursing diagnosis.

DIF: Cognitive Level: Apply REF: IMS: 48 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

14. A couple has been counseled for genetic anomalies. They ask you, What is karyotyping? Which description is most accurate?

a. Karyotyping will reveal if the babys lungs are mature.
b. Karyotyping will reveal if the baby will develop normally.
c. Karyotyping will provide information about the gender of the baby and the number and structure of the chromosomes.
d. Karyotyping will detect any physical deformities the baby has.

ANS: C

Karyotyping provides genetic information such as gender and chromosomal structure. The lecithin/sphingomyelin (L/S) ratio, not karyotyping, reveals lung maturity. Although karyotyping can detect genetic anomalies, the range of normal is nondescriptive, and not all such anomalies display obvious physical deformities. The term *deformities* is a nondescriptive word, and physical anomalies may be present that are not detected by genetic studies (e.g., cardiac malformations).

DIF: Cognitive Level: Analyze REF: IMS: 46

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

15. Which statement regarding genetic health care is most important to the nurse practicing in this specialty?

a. Genetic disorders equally affect people of all socioeconomic backgrounds, races, and ethnic groups.
b. Genetic health care is more concerned with populations than individuals.
c. Providing emotional support to the family during counseling is the most important of all nursing functions.
d. Taking genetic histories is the province of large universities and medical centers.

ANS: C

Perhaps the most important of all nursing functions is the ability to provide emotional support. Nurses should be prepared to help with various stress reactions from a couple facing the possibility of a genetic disorder. Although anyone may have a genetic disorder, certain disorders appear more often in certain ethnic and racial groups. Genetic health care is highly individualized because treatments are based on the phenotypic responses of the individual. Individual nurses at any facility can take a genetic history, although larger facilities may have better support services.

DIF: Cognitive Level: Understand REF: IMS: 55 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

16. Which statement most accurately describes dominant genetic disorders?

a. With a dominant disorder, the likelihood of the second child also having the condition is 100%.
b. An autosomal recessive disease carries a one-in-eight risk of the second child also having the disorder.
c. Disorders involving maternal ingestion of drugs carry a one-in-four chance of being repeated in the second child.
d. The risk factor remains the same no matter how many affected children are already in the family.

ANS: D

Each pregnancy is an independent event. The risk factor (e.g., one-in-two, one-in-four) remains the same for each child, no matter how many children are born to the family. In a dominant

disorder, the likelihood of recurrence in subsequent children is 50% (i.e., one-in-two). An autosomal recessive disease carries a one-in-four chance of recurrence. In disorders involving maternal ingestion of drugs, subsequent children would be at risk only if the mother continued to take the drugs; the rate of risk would be difficult to calculate.

DIF: Cognitive Level: Understand REF: IMS: 55 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

17. Which statement regarding chromosomal abnormalities is most accurate?

a. Chromosomal abnormalities occur in approximately 10% of newborns.
b. Abnormalities of number are the leading cause of pregnancy loss.
c. Down syndrome is a result of an abnormal chromosomal structure.
d. Unbalanced translocation results in a mild abnormality that the child will outgrow.

ANS: B

Aneuploidy is an abnormality of number that is also the leading genetic cause of mental retardation. Chromosomal abnormalities occur in fewer than 1% of newborns. Down syndrome is the most common form of a trisomal abnormality, an abnormality of chromosome number (47 chromosomes). Unbalanced translocation is an abnormality of chromosomal structure that often has serious clinical effects.

DIF: Cognitive Level: Understand REF: IMS: 46 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

18. Which type of genetic tests in clinical practice are most often offered to clients with a family history of disease?

a. Single-gene disorders
b. Carrier screening
c. Predictive value testing

d. Predispositional testing

ANS: A

Most tests now offered are tests for single-gene disorders in clients with clinical symptoms or clients who have a family history of a genetic disease. Carrier screening is used to identify individuals who have a gene mutation for a genetic condition but do not display symptoms. Predictive value testing is used only to clarify the genetic status of asymptomatic family members. Predispositional testing differs from the other types of genetic screening in that a positive result does not indicate a 100% chance of developing the condition.

DIF: Cognitive Level: Understand REF: IMS: 43 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which congenital malformations result from multifactorial inheritance? (*Select all that apply.)*

a. Cleft lip
b. Congenital heart disease
c. Cri du chat syndrome
d. Anencephaly
e. Pyloric stenosis

ANS: A, B, D, E

Cleft lip, congenital heart disease, anencephaly, and pyloric stenosis are associated with multifactorial inheritance. Cri du chat syndrome is related to a chromosomal deletion.

DIF: Cognitive Level: Analyze REF: IMS: 50 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

2. Which activities are included in the role of a nurse practicing in the field of genetics? (*Select all that apply.)*

a. Assessing the responses of family members to a genetic disorder
b. Performing genetic testing, such as amniocentesis
c. Constructing a family pedigree of three or more generations
d. Advising a pregnant mother whose fetus has a genetic disorder to have an abortion
e. Offering parents information about genetics

ANS: A, C, E

Assessing the responses of family members, constructing a family pedigree, and offering parents information about genetics are activities that a genetics nurse would carry out in caring for a family undergoing genetic counseling. Physicians perform amniocentesis, but the nurse may assist in this procedure. Being aware of their own values and beliefs and refraining from attempting to influence the family are important responsibilities for nurses. The nurse must respect the right of the individual or family to make autonomous decisions.

DIF: Cognitive Level: Understand REF: IMS: 42 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. One of the most promising clinical applications of the Human Genome Project has been pharmacogenomic testing (the use of genetic information to guide a clients drug therapy). Which conditions are potential candidates for pharmacogenomic application? (*Select all that apply.)*

a. Fragile X syndrome
b. Deep vein thrombosis (DVT)
c. Breast cancer
d. Myocardial infarction
e. Hemophilia

ANS: B, C, D

Associations between genetic variation and drug effect have been observed for a number of commonly used drugs. The conditions for which these are applicable include: DVT, breast

cancer, and myocardial infarction. Gene therapy has been unsuccessfully used in hemophilia treatment. Fragile X syndrome is the leading cause of intellectual disability and lacks effective treatment of any kind.

Chapter 4: Assessment and Health Promotion

MULTIPLE CHOICE

1. Due to the effects of cyclic ovarian changes in the breast, when is the best time for breast self-examination (BSE)?

a. Between 5 and 7 days after menses ceases
b. Day 1 of the endometrial cycle
c. Midmenstrual cycle
d. Any time during a shower or bath

ANS: A

The physiologic alterations in breast size and activity reach their minimal level approximately 5 to 7 days after menstruation ceases. Therefore, BSE is best performed during this phase of the menstrual cycle. Day 1 of the endometrial cycle is too early to perform an accurate BSE. After the midmenstrual cycle, breasts are likely to become tender and increase in size, which is not the ideal time to perform BSE. Lying down after a shower or bath with a small towel under the shoulder of the side being examined is appropriate teaching for BSE. A secondary BSE may be performed while in the shower.

DIF: Cognitive Level: Understand REF: IMS: 63 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. Individual irregularities in the ovarian (menstrual) cycle are most often caused by what?

a. Variations in the follicular (preovulatory) phase
b. Intact hypothalamic-pituitary feedback mechanism

c. Functioning corpus luteum
d. Prolonged ischemic phase

ANS: A

Almost all variations in the length of the ovarian cycle are the result of variations in the length of the follicular phase. An intact hypothalamic-pituitary feedback mechanism would be regular, not irregular. The luteal phase begins after ovulation. The corpus luteum is dependent on the ovulatory phase and fertilization. During the ischemic phase, the blood supply to the functional endometrium is blocked, and necrosis develops. The functional layer separates from the basal layer, and menstrual bleeding begins.

DIF: Cognitive Level: Understand REF: pp. 66-67

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. How would the physiologic process of the sexual response best be characterized?

a. Coitus, masturbation, and fantasy
b. Myotonia and vasocongestion
c. Erection and orgasm
d. Excitement, plateau, and orgasm

ANS: B

Physiologically, according to Masters (1992), sexual response can be analyzed in terms of two processes: vasocongestion and myotonia. Coitus, masturbation, and fantasy are forms of stimulation for the physical manifestation of the sexual response. Erection and orgasm occur in two of the four phases of the sexual response cycle. Excitement, plateau, and orgasm are three of the four phases of the sexual response cycle.

DIF: Cognitive Level: Knowledge REF: IMS: 68

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. Which action would be inappropriate for the nurse to perform before beginning the health history interview?

a. Smile and ask the client whether she has any special concerns.
b. Speak in a relaxed manner with an even, nonjudgmental tone.
c. Make the client comfortable.
d. Tell the client her questions are irrelevant.

ANS: D

The woman should be assured that all of her questions are relevant and important. Beginning any client interaction with a smile is important and assists in putting the client at ease. If the nurse speaks in a relaxed manner, then the client will likely be more relaxed during the interview. The clients comfort should always be ensured before beginning the interview.

DIF: Cognitive Level: Understand REF: pp. 78-79

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. The nurse guides a woman to the examination room and asks her to remove her clothes and put on an examination gown with the front open. The woman replies, I have special undergarments that I do not remove for religious reasons. Which is the most appropriate response from the nurse?

a. You cant have an examination without removing all your clothes.
b. Ill ask the physician to modify the examination.
c. Tell me about your undergarments. Ill explain the examination procedure, and then we can discuss how you can comfortably have your examination.
d. I have no idea how we can accommodate your beliefs.

ANS: C

Explaining the examination procedure reflects cultural competence by the nurse and shows respect for the womans religious practices. The nurse must respect the rich and unique qualities that cultural diversity brings to individuals. The examination can be modified to ensure that

modesty is maintained. In recognizing the value of cultural differences, the nurse can modify the plan of care to meet the needs of each woman. Telling the client that her religious practices are different or strange is inappropriate and disrespectful to the client.

DIF: Cognitive Level: Apply REF: pp. 79-80 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

6. A woman arrives at the clinic for her annual examination. She tells the nurse that she thinks she has a vaginal infection, and she has been using an over-the-counter cream for the past 2 days to treat it. How should the nurse initially respond?

a. Inform the woman that vaginal creams may interfere with the Papanicolaou (Pap) test for which she is scheduled.
b. Reassure the woman that using vaginal cream is not a problem for the examination.
c. Ask the woman to describe the symptoms that indicate to her that she has a vaginal infection.
d. Ask the woman to reschedule the appointment for the examination.

ANS: C

An important element of the health history and physical examination is the clients description of any symptoms she may be experiencing. The best response is for the nurse to inquire about the symptoms the woman is experiencing. Women should not douche, use vaginal medications, or have sexual intercourse for 24 to 48 hours before obtaining a Pap test. Although the woman may need to reschedule a visit for her Pap test, her current symptoms should still be addressed.

DIF: Cognitive Level: Apply REF: IMS: 79

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

7. Preconception and prenatal care have become important components of womens health. What is the guiding principal of preconception care?

a. Ensure that pregnancy complications do not occur.

b. Identify the woman who should not become pregnant.
c. Encourage healthy lifestyles for families desiring pregnancy.
d. Ensure that women know about prenatal care.

ANS: C

Preconception counseling guides couples in how to avoid unintended pregnancies, how to identify and manage risk factors in their lives and in their environment, and how to identify healthy behaviors that promote the well-being of the woman and her potential fetus. Preconception care does not ensure that pregnancy complications will not occur. In many cases, problems can be identified and treated and may not recur in subsequent pregnancies. For many women, counseling can allow behavior modification before any damage is done, or a woman can make an informed decision about her willingness to accept potential hazards. If a woman is seeking preconception care, then she is likely aware of prenatal care.

DIF: Cognitive Level: Understand REF: IMS: 69 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. Ovarian function and hormone production decline during which transitional phase?

a. Climacteric
b. Menarche
c. Menopause
d. Puberty

ANS: A

The climacteric phase is a transitional period during which ovarian function and hormone production decline. *Menarche* is the term that denotes the first menstruation. *Menopause* refers only to the last menstrual period.*Puberty* is a broad term that denotes the entire transitional period between childhood and sexual maturity.

DIF: Cognitive Level: Remember REF: IMS: 67

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

9. Which statement indicates that a client requires additional instruction regarding BSE?

a. Yellow discharge from my nipple is normal if Im having my period.
b. I should check my breasts at the same time each month, after my period.
c. I should also feel in my armpit area while performing my breast examination.
d. I should check each breast in a set way, such as in a circular motion.

ANS: A

Discharge from the nipples requires further examination from a health care provider. The breasts should be checked at the same time each month. The armpit should also be examined. A circular motion is the best method during which to ascertain any changes in the breast tissue.

DIF: Cognitive Level: Analyze REF: IMS: 63

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. A blind woman has arrived for an examination. Her guide dog assists her to the examination room. She appears nervous and says, Ive never had a pelvic examination. What response from the nurse would be most appropriate?

a. Dont worry. It will be over before you know it.
b. Try to relax. Ill be very gentle, and I wont hurt you.
c. Your anxiety is common. I was anxious when I first had a pelvic examination.
d. Ill let you touch each instrument that Ill use during the examination as I tell you how it will be used.

ANS: D

The client who is visually impaired needs to be oriented to the examination room and needs a full explanation of what the examination entails before the nurse proceeds. Telling the client that the examination will be over quickly diminishes the clients concerns. The nurse should openly and directly communicate with sensitivity. Women who have physical disabilities should be

respected and involved in the assessment and physical examination to the full extent of their abilities. Telling the client that she will not be hurt does not reflect respect or sensitivity. Although anxiety may be common, the nurse should not discuss her own issues nor compare them to the clients concerns.

DIF: Cognitive Level: Apply REF: IMS: 80 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

11. Which female reproductive organ(s) is(are) responsible for cyclic menstruation?

a. Uterus
b. Ovaries
c. Vaginal vestibule
d. Urethra

ANS: A

The uterus is responsible for cyclic menstruation and also houses and nourishes the fertilized ovum and the fetus. The ovaries are responsible for ovulation and the production of estrogen. The vaginal vestibule is an external organ that has openings to the urethra and vagina. The urethra is not a reproductive organ, although it is found in the area.

DIF: Cognitive Level: Remember REF: IMS: 60

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. Which body part both protects the pelvic structures and accommodates the growing fetus during pregnancy?

a. Perineum
b. Bony pelvis
c. Vaginal vestibule
d. Fourchette

ANS: B

The bony pelvis protects and accommodates the growing fetus. The perineum covers the pelvic structures. The vaginal vestibule contains openings to the urethra and vagina. The fourchette is formed by the labia minor.

DIF: Cognitive Level: Knowledge REF: IMS: 62

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. Which phase of the endometrial cycle best describes a heavy, velvety soft, fully matured endometrium?

a. Menstrual
b. Proliferative
c. Secretory
d. Ischemic

ANS: C

The secretory phase extends from the day of ovulation to approximately 3 days before the next menstrual cycle. During this secretory phase, the endometrium becomes fully mature again. During the menstrual phase, the endometrium is shed. The proliferative phase is a period of rapid growth. During the ischemic phase, the blood supply is blocked and necrosis develops.

DIF: Cognitive Level: Understand REF: IMS: 67

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. Which part of the menstrual cycle includes the stimulated release of gonadotropin-releasing hormone (GnRH) and follicle-stimulating hormone (FSH)?

a. Menstrual phase
b. Endometrial cycle
c. Ovarian cycle

d. Hypothalamic-pituitary cycle

ANS: D

The cyclic release of hormones is the function of the hypothalamus and pituitary glands. The menstrual cycle is a complex interplay of events that simultaneously occur in the endometrium, hypothalamus, pituitary glands, and ovaries. The endometrial cycle consists of four phases: menstrual phase, proliferative phase, secretory phase, and ischemic phase. The ovarian cycle remains under the influence of FSH and estrogen.

DIF: Cognitive Level: Remember REF: pp. 65-66

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

15. What fatty acids (classified as hormones) are found in many body tissues with complex roles in many reproductive functions?

a. GnRH
b. Prostaglandins (PGs)
c. FSH
d. Luteinizing hormone (LH)

ANS: B

PGs affect smooth muscle contraction and changes in the cervix. GnRH is part of the hypothalamic-pituitary cycle, which responds to the rise and fall of estrogen and progesterone. FSH is part of the hypothalamic-pituitary cycle, which responds to the rise and fall of estrogen and progesterone. LH is part of the hypothalamic-pituitary cycle, which responds to the rise and fall of estrogen and progesterone.

DIF: Cognitive Level: Remember REF: IMS: 67

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. Which information regarding substance abuse is important for the nurse to understand?

a. Although cigarette smoking causes a number of health problems, it has little direct effect on maternity-related health.
b. Women, ages 21 to 34 years, have the highest rates of specific alcohol-related problems.
c. Coffee is a stimulant that can interrupt body functions and has been related to birth defects.
d. Prescription psychotherapeutic drugs taken by the mother do not affect the fetus; otherwise, they would not have been prescribed.

ANS: B

Although a very small percentage of childbearing women have alcohol-related problems, alcohol abuse during pregnancy has been associated with a number of negative outcomes. Cigarette smoking impairs fertility and is a cause of low-birth-weight infants. Caffeine consumption has not been related to birth defects. Psychotherapeutic drugs have some effect on the fetus, and that risk must be weighed against their benefit to the mother.

DIF: Cognitive Level: Understand REF: IMS: 74

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. As part of their participation in the gynecologic portion of the physical examination, which approach should the nurse take?

a. Take a firm approach that encourages the client to facilitate the examination by following the physicians instructions exactly.
b. Explain the procedure as it unfolds, and continue to question the client to get information in a timely manner.
c. Take the opportunity to explain that the trendy vulvar self-examination is only for women at risk for developing cancer.
d. Help the woman relax through the proper placement of her hands and proper breathing during the examination.

ANS: D

Breathing techniques are important relaxation techniques that can help the client during the examination. The nurse should encourage the client to participate in an active partnership with the health care provider. Explanations during the procedure are fine, but many women are uncomfortable answering questions in the exposed and awkward position of the examination. Vulvar self-examination on a regular basis should be encouraged and taught during the examination.

DIF: Cognitive Level: Apply REF: IMS: 83

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

18. Which statement best describes Kegel exercises?

a. Kegel exercises were developed to control or reduce incontinent urine loss.
b. Kegel exercises are the best exercises for a pregnant woman because they are so pleasurable.
c. Kegel exercises help manage stress.
d. Kegel exercises are ineffective without sufficient calcium in the diet.

ANS: A

Kegel exercises help control the urge to urinate. Although these exercises may be fun for some, the most important factor is the control they provide over incontinence. Kegel exercises help manage urination, not stress. Calcium in the diet is important but not related to Kegel exercises.

DIF: Cognitive Level: Remember REF: IMS: 92 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. The microscopic examination of scrapings from the cervix, endocervix, or other mucous membranes to detect premalignant or malignant cells is called what?

a. Bimanual palpation
b. Rectovaginal palpation

c. Papanicolaou (Pap) test
d. Four As procedure

ANS: C

The Pap test is a microscopic examination for cancer that should be regularly performed, depending on the clients age. Bimanual palpation is a physical examination of the vagina. Rectovaginal palpation is a physical examination performed through the rectum. The four As procedure is an intervention to help a client stop smoking.

DIF: Cognitive Level: Remember REF: IMS: 86

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

20. Which questionnaire would be best for the nurse to use when screening an adolescent client for an eating disorder?

a. Four Cs
b. Dietary Guidelines for Americans
c. SCOFF screening tool
d. Dual-energy x-ray absorptiometry (DEXA) scan

ANS: C

A screening tool specifically developed to identify eating disorders uses the acronym SCOFF. Each question scores 1 point. A score of 2 or more indicates that the client may have anorexia nervosa or bulimia. The letters represent the following questions:

Do you make yourself **S**ick because you feel too full?

Do you worry about loss of **C**ontrol over the amount that you eat?

Have you recently lost more than **O**ne stone (14 pounds) in a 3-month period?

Do you think that you are too **F**at, even if others think you are thin?

Does **F**ood dominate your life?

The 4 Cs are used to determine cultural competence. Dietary Guidelines for Americans provide nutritional guidance for all, not only for those with eating disorders. The DEXA scan is used to determine bone density.

DIF: Cognitive Level: Apply REF: IMS: 75 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

21. The unique muscle fibers that constitute the uterine myometrium make it ideally suited for what?

a. Menstruation
b. Birth process
c. Ovulation
d. Fertilization

ANS: B

The myometrium is made up of layers of smooth muscle that extend in three directions. These muscles assist in the birth process by expelling the fetus, ligating blood vessels after birth, and controlling the opening of the cervical os.

DIF: Cognitive Level: Apply REF: pp. 60-61

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

22. Which hormone is responsible for the maturation of mammary gland tissue?

a. Estrogen
b. Testosterone
c. Prolactin
d. Progesterone

ANS: D

Progesterone causes maturation of the mammary gland tissue, specifically acinar structures of the lobules. Estrogen increases the vascularity of the breast tissue. Testosterone has no bearing on breast development. Prolactin is produced after birth and released from the pituitary gland; it is produced in response to infant suckling and an emptying of the breasts.

DIF: Cognitive Level: Remember REF: IMS: 62

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

23. What is the goal of a long-term treatment plan for an adolescent with an eating disorder?

a. Managing the effects of malnutrition
b. Establishing sufficient caloric intake
c. Improving family dynamics
d. Restructuring client perception of body image

ANS: D

The treatment of eating disorders is initially focused on reestablishing physiologic homeostasis. Once body systems are stabilized, the next goal of treatment for eating disorders is maintaining adequate caloric intake. Although family therapy is indicated when dysfunctional family relationships exist, the primary focus of therapy for eating disorders is to help the adolescent cope with complex issues. The focus of treatment in individual therapy for an eating disorder involves restructuring cognitive perceptions about the individuals body image.

DIF: Cognitive Level: Apply REF: IMS: 75

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. A 62-year-old woman has not been to the clinic for an annual examination for 5 years. The recent death of her husband reminded her that she should come for a visit. Her family physician has retired, and she is going to see the womens health nurse practitioner for her visit. What should the nurse do to facilitate a positive health care experience for this client?

a. Remind the woman that she is long overdue for her examination and that she should come in annually.
b. Carefully listen, and allow extra time for this womans health history interview.
c. Reassure the woman that a nurse practitioner is just as good as her old physician.
d. Encourage the woman to talk about the death of her husband and her fears about her own death.

ANS: B

The nurse has an opportunity to use reflection and empathy while listening, as well as ensure an open and caring communication. Scheduling a longer appointment time may be necessary because older women may have longer histories or may need to talk. A respectful and reassuring approach to caring for women older than age 50 years can help ensure that they continue to seek health care. Reminding the woman about her overdue examination, reassuring the woman that she has a good practitioner, and encouraging conversation about the death of her husband and her own death are not the best approaches.

DIF: Cognitive Level: Apply REF: pp. 78-79 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

25. During a health history interview, a woman states that she thinks that she has bumps on her labia. She also states that she is not sure how to check herself. The correct response by the nurse would be what?

a. Reassure the woman that the examination will reveal any problems.
b. Explain the process of vulvar self-examination, and reassure the woman that she should become familiar with normal and abnormal findings during the examination.
c. Reassure the woman that bumps can be treated.
d. Reassure her that most women have bumps on their labia.

ANS: B

During the assessment and evaluation, the responsibility for self-care, health promotion, and enhancement of wellness is emphasized. The pelvic examination provides a good opportunity for the practitioner to emphasize the need for regular vulvar self-examination. Providing reassurance to the woman concerning the bumps would not be an accurate response.

DIF: Cognitive Level: Apply REF: IMS: 86

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

26. Which statement regarding female sexual response is *inaccurate*?

a. Women and men are more alike than different in their physiologic response to sexual arousal and orgasm.
b. Vasocongestion is the congestion of blood vessels.
c. Orgasmic phase is the final state of the sexual response cycle.
d. Facial grimaces and spasms of the hands and feet are often part of arousal.

ANS: C

The final state of the sexual response cycle is the resolution phase after orgasm. Men and women are surprisingly alike. Vasocongestion causes vaginal lubrication and engorgement of the genitals. Arousal is characterized by increased muscular tension (myotonia).

DIF: Cognitive Level: Remember REF: IMS: 68

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

27. A client at 24 weeks of gestation says she has a glass of wine with dinner every evening. Why should the nurse counsel her to eliminate all alcohol intake?

a. Daily consumption of alcohol indicates a risk for alcoholism.
b. She is at risk for abusing other substances as well.
c. Alcohol places the fetus at risk for altered brain growth.
d. Alcohol places the fetus at risk for multiple organ anomalies.

ANS: C

No period during pregnancy is safe to consume alcohol. The documented effects of alcohol consumption during pregnancy include fetal mental retardation, learning disabilities, high activity level, and short attention span. The fetal brain grows most rapidly in the third trimester and is vulnerable to alcohol exposure during this time. Abuse of other substances has not been linked to alcohol use.

DIF: Cognitive Level: Understand REF: IMS: 74

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

28. Which statement by the client indicates that she understands BSE?

a. I will examine both breasts in two different positions.
b. I will examine my breasts 1 week after my menstrual period starts.
c. I will examine only the outer upper area of the breast.
d. I will use the palm of the hand to perform the examination.

ANS: B

The woman should examine her breasts when hormonal influences are at their lowest level. The client should be instructed to use four positions: standing with arms at her sides, standing with arms raised above her head, standing with hands pressed against hips, and lying down. The entire breast needs to be examined, including the outer upper area. The client should use the sensitive pads of the middle three fingers.

DIF: Cognitive Level: Analyze REF: IMS: 63 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

29. What is the primary reason why a woman who is older than 35 years may have difficulty achieving pregnancy?

a. Personal risk behaviors influence fertility.

b. Mature women have often used contraceptives for an extended time.
c. Her ovaries may be affected by the aging process.
d. Prepregnancy medical attention is lacking.

ANS: C

Once the mature woman decides to conceive, a delay in becoming pregnant may occur because of the normal aging of the ovaries. Older adults participate in fewer risk behaviors than younger adults. The past use of contraceptives is not the problem. Prepregnancy medical care is both available and encouraged.

DIF: Cognitive Level: Knowledge REF: IMS: 73

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

30. What is the most dangerous effect on the fetus of a mother who smokes cigarettes while pregnant?

a. Genetic changes and anomalies
b. Extensive central nervous system damage
c. Fetal addiction to the substance inhaled
d. Intrauterine growth restriction

ANS: D

The major consequences of smoking tobacco during pregnancy are low-birth-weight infants, prematurity, and increased perinatal loss. Cigarettes will not normally cause genetic changes or extensive central nervous system damage. Addiction to tobacco is not usually a concern related to the neonate.

DIF: Cognitive Level: Comprehend REF: IMS: 74

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. What are the two primary functions of the ovary? *(Select all that apply.)*

a. Normal female development
b. Ovulation
c. Sexual response
d. Hormone production
e. Sex hormone release

ANS: B, D

The two functions of the ovaries are ovulation and hormone production. The presence of ovaries does not guarantee normal female development. The ovaries produce estrogen, progesterone, and androgen. Ovulation is the release of a mature ovum from the ovary. Sexual response is a feedback mechanism involving the hypothalamus, anterior pituitary gland, and ovaries.

DIF: Cognitive Level: Apply REF: IMS: 62

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. Which statements regarding menstruation (periodic uterine bleeding) are *accurate*? *(Select all that apply.)*

a. Menstruation occurs every 28 days.
b. During menstruation, the entire uterine lining is shed.
c. Menstruation begins 7 to 10 days after ovulation.
d. Menstruation leads to fertilization.
e. Average blood loss during menstruation is 50 ml.

ANS: A, B, E

Menstruation is the periodic uterine bleeding that is controlled by a feedback system involving three cycles: the endometrial cycle, the hypothalamic-pituitary cycle, and the ovarian cycle. The average length of a menstrual cycle is 28 days; however, variations are normal. During the endometrial cycle, the functional two thirds of the endometrium is shed. The average blood loss

is 50 ml with a normal range of 20 to 80 ml. Menstruation occurs 14 days after ovulation. The lack of fertilization leads to menstruation.

DIF: Cognitive Level: Apply REF: IMS: 65

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Women of all ages will receive substantial and immediate benefits from smoking cessation. The process is not easy, and most people have attempted to quit numerous times before achieving success. Which organizations provide self-help and smoking cessation materials? *(Select all that apply.)*

a. Leukemia and Lymphoma Society
b. March of Dimes
c. American Cancer Society
d. American Lung Association
e. Easter Seals

ANS: B, C, D

The March of Dimes, the American Lung Association, and the American Cancer Society have self-help materials available. The Leukemia and Lymphoma Society support research for these two types of cancer. Easter Seals is best known for its work with disabled children.

DIF: Cognitive Level: Apply REF: IMS: 93 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

4. Many pregnant teenagers wait until the second or third trimester to seek prenatal care. What should the nurse recognize as reasons for this delay? *(Select all that apply.)*

a. Lack of realization that they are pregnant
b. Uncertainty as to where to go for care
c. Continuing to deny the pregnancy
d. Desire to gain control over their situation

e. Wanting to hide the pregnancy as long as possible

ANS: A, B, C, E

These reasons are all valid explanations why teens delay seeking prenatal care. An adolescent often has little to no understanding of the increased physiologic needs that a pregnancy places on her body. Once care is sought, it is often sporadic, and many appointments are usually missed. The nurse should formulate a diagnosis that assists the pregnant teen to receive adequate prenatal care. Planning for her pregnancy and impending birth actually provides some sense of control for the teen and increases her feelings of competency. Receiving praise from the nurse when she attends her prenatal appointments will reinforce the teens positive self-image.

Chapter 5: Violence Against Women

MULTIPLE CHOICE

1. Historically, what was the justification for the victimization of women?

a. Women were regarded as possessions.
b. Women were the weaker sex.
c. Control of women was necessary to protect them.
d. Women were created subordinate to men.

ANS: A

Misogyny, patriarchy, devaluation of women, power imbalance, a view of women as property, gender-role stereotyping, and acceptance of aggressive male behaviors as appropriate contributed and continue to contribute to the subordinate status of women in many of the worlds societies. Viewing women as the weaker sex is a cultural and modern stereotype that contributes to the victimization of women. Control of women to protect them is another cultural and modern stereotype that contributes to the victimization of women. Yet another cultural stereotype that contributes to the victimization of women is the idea that women were created as subordinate to men.

DIF: Cognitive Level: Remember REF: pp. 98-99

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. What is the primary theme of the *feminist perspective* regarding violence against women?

a. Role of testosterone as the underlying cause of mens violent behavior
b. Basic human instinctual drive toward aggression
c. Male dominance and coercive control over women
d. Cultural norm of violence in Western society

ANS: C

The contemporary social view of violence is derived from the feminist theory. With the primary theme of male dominance and coercive control, this view enhances an understanding of all forms of violence against women, including wife battering, stranger and acquaintance rape, incest, and sexual harassment in the workplace. The role of testosterone as an underlying cause of mens violent behavior, the basic human instinctual drive toward aggression, and the cultural norm of violence in Western society are not associated with the feminist perspective regarding violence against women.

DIF: Cognitive Level: Remember REF: IMS: 100

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

3. Which trait is least likely to be displayed by a woman experiencing intimate partner violence (IPV)?

a. Socially isolated
b. Assertive personality
c. Struggling with depression
d. Dependent partner in a relationship

ANS: B

Every segment of society is represented among women who are suffering abuse. However, traits of assertiveness, independence, and willingness to take a stand have been documented as more characteristic of women who are in nonviolent relationships. Women who are financially more dependent have fewer resources and support systems, exhibit symptoms of depression, and are more often seen as victims.

DIF: Cognitive Level: Analyze REF: pp. 101-102

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

4. A woman who is 6 months pregnant has sought medical attention, saying she fell down the stairs. What scenario would cause an emergency department nurse to suspect that the woman has been a victim of IPV?

a. The woman and her partner are having an argument that is loud and hostile.
b. The woman has injuries on various parts of her body that are in different stages of healing.
c. Examination reveals a fractured arm and fresh bruises.
d. She avoids making eye contact and is hesitant to answer questions.

ANS: B

The client may have multiple injuries in various stages of healing that indicates a pattern of violence. An argument is not always an indication of battering. A fractured arm and fresh bruises could be caused by the reported fall and do not necessarily indicate IPV. It may be normal for the woman to be reticent and have a dull affect.

DIF: Cognitive Level: Analyze REF: IMS: 107

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. Which statement is most accurate regarding the reporting of IPV in the United States?

a. Asian women report more IPV than do other minority groups.
b. Caucasian women report less IPV than do non-Caucasians.

c. Native-American women report IPV at a rate similar to other groups.
d. African-American women are less likely to report IPV than Caucasian women.

ANS: B

Caucasian women report less IPV than other ethnic groups. Asian women report significantly less IPV than do other racial groups. Native-American and Alaska Native women report significantly more IPV than do women of any other racial background. African-American women tend to report violence at a slightly higher rate than Caucasian women.

DIF: Cognitive Level: Understand REF: IMS: 103

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. Intervention for the sexual abuse survivor is often not attempted by maternity and womens health nurses because of the concern about increasing the distress of the woman and the lack of expertise in counseling. What initial intervention is appropriate and most important in facilitating the womans care?

a. Initiating a referral to an expert counselor
b. Setting limits on what the client discloses
c. Listening and encouraging therapeutic communication skills
d. Acknowledging the nurses discomfort to the client as an expression of empathy

ANS: C

The survivor needs support on many different levels, and a womens health nurse may be the first person to whom she relates her story. Therapeutic communication skills and listening are initial interventions. Referring this client to a counselor is an appropriate measure but not the most important initial intervention. A client should be allowed to disclose any information she feels the need to discuss. A nurse should provide a safe environment in which she can do so. Either verbal or nonverbal shock and horror reactions from the nurse are particularly devastating. Professional demeanor and professional empathy are essential.

DIF: Cognitive Level: Analyze REF: IMS: 107

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

7. A young woman arrives at the emergency department and states that she thinks she has been raped. She is sobbing and expresses disbelief that this could happen because the perpetrator was a very close friend. Which statement is most appropriate at this time?

a. Rape is not limited to strangers and frequently occurs by someone who is known to the victim.
b. I would be very upset if my best friend did that to me; that is very unusual.
c. You must feel very betrayed. In what way do you think you might have led him on?
d. This does not sound like rape. Didnt you just change your mind about having sex after the fact?

ANS: A

Acquaintance rape involves individuals who know one another. Sexual assault occurs when the trust of a relationship is violated. Victims may be less prone to recognize what is happening to them because the dynamics are different from those of stranger rape. It is not at all unusual for the victim to know and trust the perpetrator. Stating that the woman might have led the man to attack her indicates that the sexual assault was somehow the victims fault. This type of mentality is not constructive. Nurses must first reflect on their own feelings and learn to be unbiased when dealing with victims. A statement of this type can be very psychologically damaging to the victim. Nurses must display compassion by first believing what the victim states. The nurse is not responsible for deciphering the facts involving the victims claim.

DIF: Cognitive Level: Apply REF: IMS: 107

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. Nurses are often the first health care professional with whom a woman comes into contact after being sexually assaulted. Which statement best describes the initial care of a rape victim?

a. All legal evidence is preserved during the physical examination.
b. The victim appreciates the legal information; however, decides not to pursue legal proceedings.

c. The victim states that she is going to advocate against sexual violence.
d. The victim leaves the health care facility without feeling re-victimized.

ANS: D

Nurses can assist clients through an examination that is as nontraumatic as possible with kindness, skill, and empathy. The initial care of the victim affects her recovery and decision to receive follow-up care. Preservation of all legal evidence is very important; however, this may not be the best measure in terms of evaluating the care of a rape victim. Offering legal information is not the best measure of evaluating the care that this victim received. The victim may well decide not to pursue legal proceedings. Advocating against sexual violence may be extremely therapeutic for the client after her initial recovery but not a measure of evaluating her care.

DIF: Cognitive Level: Understand REF: pp. 112-113 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

9. When the nurse is alone with a battered client, the client seems extremely anxious and says, It was all my fault. The house was so messy when he got home, and I know he hates that. What is the most suitable response by the nurse?

a. No one deserves to be hurt. Its not your fault. How can I help you?
b. What else do you do that makes him angry enough to hurt you?
c. He will never find out what we talk about. Dont worry. Were here to help you.
d. You have to remember that he is frustrated and angry so he takes it out on you.

ANS: A

The nurse should stress that the client is not at fault. Asking what the client did to make her husband angry is placing the blame on the woman and would be an inappropriate statement. The nurse should not provide false reassurance. To assist the woman, the nurse should be honest. Often the batterer will find out about the conversation.

DIF: Cognitive Level: Apply REF: IMS: 107

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. Nurses who provide care to victims of IPV should be keenly aware of what?

a. Relationship violence usually consists of a single episode that the couple can put behind them.
b. Violence often declines or ends with pregnancy.
c. Financial coercion is considered part of IPV.
d. Battered women are generally poorly educated and come from a deprived social background.

ANS: C

Economic coercion may accompany physical assault and psychologic attacks. IPV almost always follows an escalating pattern. It rarely ends with a single episode of violence. IPV often begins with and escalates during pregnancy. It may include both psychologic attacks and economic coercion. Race, religion, social background, age, and education level are not significant factors in differentiating women at risk.

DIF: Cognitive Level: Understand REF: IMS: 98

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. In 1979, Lenore Walker pioneered the cause of women as victims of violence when she published her book *The Battered Woman.* While Walker conducted her research, she found a similar pattern of abuse among many of the women. This concept is now referred to as the cycle of violence. Which phase does not belong in this three-cycle pattern of violence?

a. Tension-building state
b. Frustration, followed by violence
c. Acute battering incident
d. Kindness and contrite, loving behavior

ANS: B

Frustration, followed by violence, is not part of the cycle of violence. The tension-building state is also known as phase I of the cycle. The batterer expresses dissatisfaction and hostility with violent outbursts. The woman senses anger and anxiously tries to placate him. An acute battering incident is phase II of the cycle. It results in the mans uncontrollable discharge of tension toward the woman. Outbursts can last from several hours to several days and may involve kicking, punching, slapping, choking, burns, broken bones, and the use of weapons. Phase III of the cycle is sometimes referred to as the *honeymoon*, *kindness and contrite*, and *loving behavior* phase, during which the batterer feels remorseful and profusely apologizes. He tries to help the woman and often showers her with gifts.

DIF: Cognitive Level: Analyze REF: IMS: 99 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

12. Nurses must remember that pregnancy is a time of risk for all women. Which condition is likely the biggest risk for the pregnant client?

a. Preeclampsia
b. IPV
c. Diabetes
d. Abnormal Pap test

ANS: B

The prevalence of IPV during pregnancy is estimated at 6% of all pregnant women. The risk for IPV and even IPV-related homicide is more common than all of the other pregnancy-related conditions. Although preeclampsia poses a risk to the health of the pregnant client, it is less common than IPV. Gestational diabetes continues to be a complication of pregnancy; however, it is less common than IPV during pregnancy. Some women are at risk for an abnormal Pap screening during pregnancy, but this finding is not as common as IPV.

DIF: Cognitive Level: Understand REF: IMS: 105 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

13. In the 1970s, the rape-trauma syndrome (RTS) was identified as a cluster of symptoms and related behaviors observed in the weeks and months after an episode of rape. Researchers identified three phases related to this condition. Which phase is not displayed in a client with RTS?

a. Acute Phase: Disorganization
b. Outward Adjustment Phase
c. Shock/Disbelief: Disorientation Phase
d. Long-Term Process: Reorganization Phase

ANS: C

Shock, disbelief, or disorientation is a component of the *Acute Phase*. The rape survivor feels embarrassed, degraded, fearful, and angry. She may feel unclean and want to bathe and douche repeatedly, even though doing so may destroy evidence. The victim relives the scene over and over in her mind, thinking of things she should have done. During the *Outward Adjustment Phase*, the victim may appear to have resolved her crisis and return to activities of daily living and work. Other women may move, leave their job, and buy a weapon to protect themselves. *Disorientation* is a reaction during which the victim may feel disoriented, have difficulty concentrating, or have poor recall. The *Long-Term Process* is the reorganization phase. This recovery phase may take years and may be difficult and painful.

DIF: Cognitive Level: Understand REF: pp. 111-112

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. Documentation of abuse can be useful to women later in court, should they elect to press charges. It is of key importance for the nurse to document accurately at the time that the client is seen. Which entry into the medical record would be the least helpful to the court?

a. Photographs of injuries
b. Clear and legible written documentation
c. Summary of information (e.g., The client is a battered woman.)
d. Accurate description of the clients demeanor

ANS: C

A statement such as, The client is a battered woman lacks the supporting factual information and will render the report inadmissible. More appropriate documentation would include exact statements from the woman in quotations (e.g., My husband kicked me in the stomach). The time and date of the examination should also be included.

DIF: Cognitive Level: Apply REF: IMS: 107

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

15. Which statement regarding human trafficking is *correct*?

a. Human trafficking is a multibillion-dollar business that primarily exists in the United States.
b. Victims often experience the Stockholm syndrome.
c. Vast majority of the victims are young boys and girls.
d. Human trafficking primarily refers to commercial sex work.

ANS: B

Although victims of sex trafficking can be young boys and girls, the vast majority are women and girls. They are often lured by false promises, such as a job or marriage, sold by their parents, or kidnapped by traffickers. These individuals are forced into sex work, hard labor, and organ donation. This $32 billion business exists in the United States and internationally. The *Stockholm syndrome* occurs when the slaves become attached to their enslavers. Health care professionals may interact with victims who are in captivity should they require emergent health care. The nurse is challenged to find an opportunity to speak with the client alone and assess for victimization.

DIF: Cognitive Level: Understand REF: IMS: 115

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

16. Which statement is the most comprehensive description of sexual violence?

a. Sexual violence is limited to rape.
b. Sexual violence is an act of force during which an unwanted and uncomfortable sexual act occurs.
c. Sexual violence encompasses a number of sexual acts.
d. Sexual violence includes degrading sexual comments and behaviors.

ANS: C

Sexual violence is a broad term that includes a range of sexual victimization including sexual assault, sexual harassment, and rape. It may include but is not limited to rape. *Sexual assault* includes unwanted or uncomfortable touches, kisses, hugs, petting, intercourse, or other sexual acts. It is a component of sexual violence. Unwelcome or degrading e-mail messages, comments, contact, or behavior, such as exhibitionism, that makes any environment feel unsafe is known as *sexual harassment.*

DIF: Cognitive Level: Understand REF: IMS: 110

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

17. Women with severe and persistent mental illness are likely to be more vulnerable to being involved in controlling and/or violent relationships; however, many women develop mental health problems as a result of long-term abuse. Which condition is unlikely to be a psychologic consequence of continued abuse?

a. Substance abuse
b. Posttraumatic stress disorder (PTSD)
c. Eating disorders
d. Bipolar disorder

ANS: D

Bipolar disorder is a specific illness (also known as *manic depressive disorder*) not related to abuse. Substance abuse is a common method of coping with long-term abuse. The abuser is also more likely to use alcohol and other chemical substances. PTSD is the most prevalent mental

health sequela of long-term abuse. The traumatic event is persistently re-experienced through distress recollection and dreams. Eating disorders, depression, psychologic-physiologic illness, and anxiety reactions are all mental health problems associated with repeated abuse.

DIF: Cognitive Level: Analyze REF: pp. 99-100 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. The nurse who is evaluating the client for potential abuse should be aware that IPV includes a number of different forms of abuse, including which of the following? *(Select all that apply.)*

a. Physical
b. Sexual
c. Emotional
d. Psychologic
e. Financial

ANS: A, B, D, E

Physical, sexual, financial, and psychologic abuse can all be components in a relationship with IPV. Emotional abuse is a form of psychologic abuse.

DIF: Cognitive Level: Understand REF: IMS: 98

TOP: Nursing Process: Assessment

MSC: Client Needs: Psychosocial and Physiologic Integrity

2. What are some common characteristics of a potential male batterer? *(Select all that apply.)*

a. High level of self-esteem
b. High frustration tolerance
c. Substance abuse problems

d. Excellent verbal skills
e. Personality disorders

ANS: C, E

Substance abuse and personality disorders are often observed in batterers. Typically, the batterer has low self-esteem. Batterers usually have a low frustration level (i.e., they easily lose their temper). Batterers characteristically have poor verbal skills and can especially have difficulty expressing their feelings.

DIF: Cognitive Level: Understand REF: IMS: 100 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

3. Which nursing diagnoses would be most applicable for battered women? *(Select all that apply.)*

a. Loss of trust
b. Ineffective family coping
c. Situational low self-esteem
d. Risk for self-directed violence
e. Enhanced communication

ANS: A, B, C, D

Loss of trust, ineffective family coping, situational low self-esteem, and risk for self-directed violence are potential nursing diagnoses associated with battered women. A more appropriate nursing diagnosis for a battered woman would be impaired communication.

DIF: Cognitive Level: Analyze REF: IMS: 108 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

4. A thorough abuse assessment screen should be completed on all female clients. This screen should include which components? *(Select all that apply.)*

a. Asking the client if she has ever been slapped, kicked, punched, or physically hurt by her partner
b. Asking the client if she is afraid of her partner
c. Asking the client if she has been forced to perform sexual acts
d. Diagramming the clients current injuries on a body map
e. Asking the client what she did wrong to elicit the abuse

ANS: A, B, C, D

Asking the client if she has been slapped, kicked, punched, or physically hurt by her partner, if she is afraid of her partner, or if she has been forced to perform sexual acts are questions that should be posed to all clients. If any physical injuries are present, then they should be marked on a form that indicates their locations on the body. Implying that a client did something wrong can be very emotionally damaging. Many victims of violence are not aware that they are in an abusive relationship. They may not respond to questions about abuse. Using general descriptive words such as slap, kick, or punch to elicit information is best.

DIF: Cognitive Level: Analyze REF: IMS: 106

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe and Effective Care Environment

5. What are the responsibilities of the nurse who suspects or confirms any type of violence against a woman? *(Select all that apply.)*

a. Report the incident to legal authorities.
b. Provide resources for domestic violence shelters.
c. Call a client advocate who can assist in the clients decision about what actions to take.
d. Accurately and concisely document the incident (or findings) in the clients record.
e. Reassure and support the client.

ANS: B, C, D, E

Domestic violence is considered a crime in all states; however, mandatory reporting remains controversial. Nurses must become knowledgeable on the laws that apply in the state in which they practice. Caring for a client who may be a victim of domestic abuse is an ideal opportunity to provide the woman with information for safe houses or support groups for herself and her children. The nurse may assist in reaching out to a client advocate, which often occurs when potential legal action is taken or if the woman is seeking shelter. Documentation must be accurate and timely to be useful to the client later in court if she chooses to press charges. The primary functions for the nurse are to reassure the client and to provide her with emotional support.

Chapter 6: Reproductive System Concerns

MULTIPLE CHOICE

1. Which condition is the least likely cause of amenorrhea in a 17yearold client?

a. Anatomic abnormalities
b. Type 1 diabetes mellitus
c. Obesity
d. Pregnancy

ANS: C

A moderately obese adolescent (20% to 30% above ideal weight) may have early onset menstruation. Girls who regularly exercise before menarche can have delayed onset of menstruation to age 18 years. Anatomic abnormalities are a possible cause of amenorrhea. Type 1 diabetes mellitus is a possible cause of amenorrhea. Pregnancy is the most common cause of amenorrhea.

DIF: Cognitive Level: Remember REF: IMS: 121

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. When a nurse is counseling a woman for primary dysmenorrhea, which nonpharmacologic intervention might be recommended?

a. Increasing the intake of red meat to replace blood loss
b. Reducing the intake of diuretic foods, such as peaches and asparagus
c. Temporarily substituting physical activity for a sedentary lifestyle
d. Using a heating pad on the abdomen to relieve cramping

ANS: D

Heat minimizes cramping by increasing vasodilation and muscle relaxation and minimizing uterine ischemia. Dietary changes such as a lowfat vegetarian diet may be recommended for women experiencing dysmenorrhea. Increasing the intake of diuretics, including natural diuretics such as asparagus, cranberry juice, peaches, parsley, and watermelon, may help ease the symptoms associated with dysmenorrhea. Exercise has been found to help relieve menstrual discomfort through increased vasodilation and subsequent decreased ischemia.

DIF: Cognitive Level: Analyze REF: pp. 122-123 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

3. Nafarelin (Synarel) is used to treat mildtosevere endometriosis. What instruction or information should the nurse provide to a client regarding nafarelin administration?

a. Nafarelin stimulates the secretion of gonadotropin-releasing hormone (GnRH), thereby stimulating ovarian activity.
b. It should be administered by intramuscular (IM) injection.
c. Nafarelin should be administered by a subcutaneous implant.
d. It can cause the client to experience some hot flashes and vaginal dryness.

ANS: D

Nafarelin is a GnRH agonist, and its side effects are similar to those of menopause. The hypoestrogenism effect results in hot flashes and vaginal dryness. Nafarelin is a GnRH agonist that suppresses the secretion of GnRH. Nafarelin is administered twice daily by nasal spray and

can be intranasally administered. Leuprolide is given once per month by IM injection. Goserelin is administered by subcutaneous implant.

DIF: Cognitive Level: Apply REF: IMS: 127 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

4. While interviewing a 31-year-old woman before her routine gynecologic examination, the nurse collects data about the clients recent menstrual cycles. Which statement by the client should prompt the nurse to collect further information?

a. My menstrual flow lasts 5 to 6 days.
b. My flow is very heavy.
c. I have had a small amount of spotting midway between my periods for the past 2 months.
d. The length of my menstrual cycles varies from 26 to 29 days.

ANS: B

Menorrhagia is defined as excessive menstrual bleeding, either in duration or in amount. Heavy bleeding can have many causes. The amount of bleeding and its effect on daily activities should be evaluated. A menstrual flow that lasts 5 to 6 days is a normal finding. Mittlestaining, a small amount of bleeding or spotting that occurs at the time of ovulation (14 days before the onset of the next menses), is considered normal. During her reproductive years, a woman may have physiologic variations in her menstrual cycle. Variations in the length of a menstrual cycle are considered normal.

DIF: Cognitive Level: Understand REF: IMS: 131

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. A 21yearold client complains of severe pain immediately after the commencement of her menses. Which gynecologic condition is the most likely cause of this clients presenting complaint?

a. Primary dysmenorrhea
b. Secondary dysmenorrhea
c. Dyspareunia
d. Endometriosis

ANS: A

Primary dysmenorrhea, or pain during or shortly before menstruation, has a biochemical basis and arises from the release of prostaglandins with menses. Secondary dysmenorrhea develops after the age of 25 years and is usually associated with a pelvic pathologic condition. Dyspareunia, or painful intercourse, is commonly associated with endometriosis. Endometriosis is characterized by endometrial glands and stoma outside of the uterus.

DIF: Cognitive Level: Remember REF: IMS: 122

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Which symptom described by a client is characteristic of premenstrual syndrome (PMS)?

a. I feel irritable and moody a week before my period is supposed to start.
b. I have lower abdominal pain beginning on the third day of my menstrual period.
c. I have nausea and headaches after my period starts, and they last 2 to 3 days.
d. I have abdominal bloating and breast pain after a couple days of my period.

ANS: A

PMS is a cluster of physical, psychologic, and behavioral symptoms that begin in the luteal phase of the menstrual cycle and resolve within a couple of days of the onset of menses. Complaints of lower abdominal pain, nausea and headaches, and abdominal bloating all are associated with PMS; however, the timing reflected is inaccurate.

DIF: Cognitive Level: Apply REF: IMS: 125

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. A client complains of severe abdominal and pelvic pain around the time of menstruation. This pain has become progressively worse over the last 5 years. She also complains of pain during intercourse and has tried unsuccessfully to become pregnant for the past 18 months. To which condition are these symptoms most likely related?

a. Endometriosis
b. PMS
c. Primary dysmenorrhea
d. Secondary dysmenorrhea

ANS: A

Symptoms of endometriosis can change over time and may not reflect the extent of the disease. Major symptoms include dysmenorrhea and deep pelvic dyspareunia (painful intercourse). Impaired fertility may result from adhesions caused by endometriosis. Although endometriosis may be associated with secondary dysmenorrhea, it is not a cause of primary dysmenorrhea or PMS. In addition, this woman is complaining of dyspareunia and infertility, which are associated with endometriosis, not with PMS or primary or secondary dysmenorrhea.

DIF: Cognitive Level: Understand REF: pp. 126-127

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

8. Which menopausal discomfort would the nurse anticipate when evaluating a woman for signs and symptoms of the climacteric?

a. Headaches
b. Hot flashes
c. Mood swings
d. Vaginal dryness with dyspareunia

ANS: B

Vasomotor instability, in the form of hot flashes or flushing, is a result of fluctuating estrogen levels and is the most common disturbance of the perimenopausal woman. Headaches may be associated with a decline in hormonal levels; however, headaches are not the most frequently reported discomfort for menopausal women. Mood swings may also be associated with a decline in hormonal levels; however, mood swings are not the most frequently reported discomfort for menopausal women. Vaginal dryness and dyspareunia may be associated with a decline in hormonal levels; however, both are not the most frequently reported discomforts for menopausal women.

DIF: Cognitive Level: Understand REF: IMS: 133

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. Which risk factor would the nurse recognize as being frequently associated with osteoporosis?

a. African-American race
b. Lowprotein intake
c. Obesity
d. Cigarette smoking

ANS: D

Smoking is associated with earlier and greater bone loss and decreased estrogen production. Women at risk for osteoporosis are likely to be Caucasian or Asian. Inadequate calcium intake is a risk factor for osteoporosis. Women at risk for osteoporosis are likely to be small boned and thin. Obese women have higher estrogen levels as a result of the conversion of androgens in the adipose tissue. Mechanical stress from extra weight also helps preserve bone mass.

DIF: Cognitive Level: Remember REF: IMS: 135

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. A perimenopausal client has arrived for her annual gynecologic examination. Which preexisting condition would be extremely important for the nurse to identify during a discussion regarding the risks and benefits of hormone therapy?

a. Breast cancer
b. Vaginal and urinary tract atrophy
c. Osteoporosis
d. Arteriosclerosis

ANS: A

Women with a high risk for breast cancer should be counseled against using estrogen replacement therapy (ERT). Estrogen prevents the atrophy of vaginal and urinary tract tissue and protects against the development of osteoporosis. Estrogen also has a favorable effect on circulating lipids, reducing low-density lipoprotein (LDL) and total cholesterol levels and increasing high-density lipoprotein (HDL) levels. It also has a direct antiatherosclerotic effect on the arteries.

DIF: Cognitive Level: Apply REF: IMS: 136 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

11. Dysfunctional uterine bleeding (DUB) is defined as excessive uterine bleeding without a demonstrable cause. Which statement regarding this condition is *most* accurate?

a. DUB is most commonly caused by anovulation.
b. DUB most often occurs in middle age.
c. The diagnosis of DUB should be the first consideration for abnormal menstrual bleeding.
d. Steroids are the most effective medical treatment for DUB.

ANS: A

Anovulation may occur because of hypothalamic dysfunction or polycystic ovary syndrome. DUB most often occurs when the menstrual cycle is being established or when it draws to a close at menopause. A diagnosis of DUB is made only after all other causes of abnormal menstrual bleeding have been ruled out. The most effective medical treatment is oral or intravenous estrogen.

DIF: Cognitive Level: Remember REF: IMS: 131 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

12. The female athlete triad includes which common menstrual disorder?

a. Amenorrhea
b. Dysmenorrhea
c. Menorrhagia
d. Metrorrhagia

ANS: A

The interrelatedness of disordered eating, amenorrhea, and altered bone mineral density have been described as the *female athlete triad*. Dysmenorrhea is painful menstruation that begins 2 to 6 months after menarche. Menorrhagia is abnormally profuse or excessive bleeding from the uterus. Metrorrhagia is bleeding between periods and can be caused by progestin injections and implants.

DIF: Cognitive Level: Understand REF: IMS: 121 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

13. Which system responses would the nurse recognize as being unrelated to prostaglandin (PGF_2) release?

a. Systemic responses
b. Gastrointestinal system
c. Central nervous system
d. Genitourinary system

ANS: D

Systemic responses to PGF_2 include backache, weakness, and sweating. Gastrointestinal system changes include nausea, vomiting, anorexia, and diarrhea. Central nervous system changes

manifest themselves as dizziness, syncope, headache, and poor concentration; they usually begin at the onset of menstruation and last 8 to 48 hours.

DIF: Cognitive Level: Understand REF: IMS: 122

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

14. Which statement concerning cyclic perimenstrual pain and discomfort (CPPD) is *accurate*?

a. Premenstrual dysphoric disorder (PMDD) is a milder form of PMS and more common in young women.
b. Secondary dysmenorrhea is more intense and more medically significant than primary dysmenorrhea.
c. PMS is a complex, poorly understood condition that may include any of a hundred symptoms.
d. The causes of PMS have been well established.

ANS: C

PMS may manifest itself with one or more of a hundred physical and psychologic symptoms. PDD is a more severe variant of PMS. Secondary dysmenorrhea is characterized by more muted pain than the pain reported in primary dysmenorrhea; however, the medical treatment is close to the same. The cause of PMS is unknown and may be, in fact, a collection of different problems.

DIF: Cognitive Level: Understand REF: IMS: 125 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

15. To assist a client in managing the symptoms of PMS, what should the nurse recommend based on current evidence?

a. Diet with more body-building and energy foods, such as carbohydrates
b. Herbal therapies, yoga, and massage
c. Antidepressants for symptom control
d. Discouraging the use of diuretics

ANS: B

Herbal therapies, yoga, and massage have been reported to have a beneficial effect on the symptoms of PMS. Limiting red meat, simple carbohydrates, caffeinated beverages, and alcohol improves the diet and may mitigate symptoms. Medication is usually begun only if lifestyle changes fail to provide significant relief. Natural diuretics may help reduce fluid retention.

DIF: Cognitive Level: Apply REF: pp. 125-126 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

16. Which statement related to the condition of endometriosis is *most accurate*?

a. Endometriosis is characterized by the presence and growth of endometrial tissue inside the uterus.
b. It is found more often in African-American women than in Caucasian or Asian women.
c. Endometriosis may worsen with repeated cycles or remain asymptomatic and disappear after menopause.
d. It is unlikely to affect sexual intercourse or fertility.

ANS: C

With endometriosis, the endometrial tissue is outside the uterus. Endometriosis is found equally in Caucasian and African-American women and is slightly more prevalent in Asian women. Symptoms vary among women, ranging from nonexistent to incapacitating. The condition is seven times more prevalent in women who have a firstdegree relative with endometriosis. Women can experience painful intercourse and impaired fertility with endometriosis.

DIF: Cognitive Level: Understand REF: pp. 126-127

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

17. Which alteration in cyclic bleeding best describes bleeding that occurs at any time other than menses?

a. Oligomenorrhea
b. Menorrhagia
c. Leiomyoma
d. Metrorrhagia

ANS: D

Metrorrhagia (intermenstrual bleeding) refers to any episode or degree of bleeding that occurs between periods. It may be caused by contraceptives that contain progesterone or by intrauterine devices (IUDs).Oligomenorrhea is infrequent or scanty menstruation. Menorrhagia is excessive menstruation. Leiomyoma is a common cause of excessive bleeding.

DIF: Cognitive Level: Remember REF: IMS: 129 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

18. Management of primary dysmenorrhea often requires a multifaceted approach. Which pharmacologic therapy provides optimal pain relief for this condition?

a. Acetaminophen
b. Oral contraceptive pills (OCPs)
c. Nonsteroidal antiinflammatory drugs (NSAIDs)
d. Aspirin

ANS: C

NSAIDs have the strongest research results for pain relief. If one NSAID is not effective, then another one may provide relief. Approximately 80% of women find relief from these prostaglandin inhibitors. Preparations containing acetaminophen are less effective for dysmenorrhea because they lack the antiprostaglandin properties of NSAIDs. OCPs are a reasonable choice for women who also want birth control. The benefit of OCPs is the reduction of menstrual flow and irregularities. OCPs may be contraindicated for some women and have a number of potential side effects. NSAIDs are the drug of choice. However, if a woman is taking an NSAID, she should avoid taking aspirin as well.

DIF: Cognitive Level: Apply REF: IMS: 123 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A client has requested information regarding alternatives to hormonal therapy for menopausal symptoms. Which current information should the nurse provide to the client? (*Select all that apply.)*

a. Soy
b. Vitamin C
c. Vitamin K
d. Vitamin E
e. Vitamin A

ANS: A, D

Both soy and vitamin E have been reported to help alleviate menopausal symptoms, and both are readily available in food sources. Vitamin E can be also be taken as a supplement. Vitamins C, K, and A have no apparent effect on menopausal symptoms.

DIF: Cognitive Level: Understand REF: IMS: 139 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

2. Which suggestions are appropriate for a client who complains of hot flashes? (*Select all that apply.)*

a. Avoid caffeine.
b. Drink a glass of wine to relax.
c. Wear layered clothing.
d. Drink ice water.
e. Drink warm beverages for their calming effect.

ANS: A, C

Layered clothing allows the client to remove layers if a hot flash occurs. Ice water may help alleviate the hot flashes. Slow, deep breathing is also beneficial. Avoid triggers such as exercising on hot days, spicy foods, hot beverages, and alcohol.

DIF: Cognitive Level: Understand REF: IMS: 139 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

3. Which medications can be taken by postmenopausal women to treat and/or prevent osteoporosis? (*Select all that apply.)*

a. Calcium
b. NSAIDs
c. Fosamax
d. Actonel
e. Calcitonin

ANS: A, C, D, E

Calcium, Evista, Fosamax, Actonel, and Calcitonin can be used by postmenopausal women to treat or prevent osteoporosis. Parathyroid hormone and estrogen may also be of value. NSAIDs may provide pain relief; however, these medications neither prevent nor treat osteoporosis.

DIF: Cognitive Level: Apply REF: pp. 140-142

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

4. Which statement(s) might the nurse appropriately include when teaching a client about calcium intake for osteoporosis? (*Select all that apply.)*

a. You should try to increase your protein intake when you are taking calcium.
b. It is best to take calcium in one large dose.
c. Tums are the most soluble form of calcium.

d. You should take calcium with vitamin D because the vitamin D helps your body better absorb calcium.
e. Its okay to take calcium if you have had a history of kidney stones.

ANS: C, D

Teaching the client to take calcium with vitamin D is accurate. Excessive protein should be avoided. Calcium is best taken in divided doses to increase absorption. Calcium should be taken with vitamin D to increase absorption. Calcium is contraindicated in women with a history of kidney stones.

Chapter 7: Sexually Transmitted and Other Infections

MULTIPLE CHOICE

1. Syphilis is a complex disease that can lead to serious systemic illness and even death if left untreated. Which manifestation differentiates primary syphilis from secondary syphilis?

a. Fever, headache, and malaise
b. Widespread rash
c. Identified by serologic testing
d. Appearance of a chancre 2 months after infection

ANS: D

Primary syphilis is characterized by a primary lesion (the chancre), which appears 5 to 90 days after infection. The chancre begins as a painless papule at the site of inoculation and erodes to form a nontender, shallow, and clean ulcer several millimeters to centimeters in size. *Secondary* syphilis occurs 6 weeks to 6 months after the appearance of the chancre and is characterized by a widespread maculopapular rash. The individual may also experience fever, headache, and malaise. *Latent* syphilis are those infections that lack clinical manifestations; however, they are detected by serologic testing.

DIF: Cognitive Level: Understand REF: IMS: 151

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. The human papillomavirus (HPV), also known as *genital warts*, affects 79 million Americans, with an estimated number of 14 million new infections each year. The highest rate of infection occurs in young women, ages 20 to 24 years. Prophylactic vaccination to prevent the HPV is now available. Which statement regarding this vaccine is *inaccurate*?

a. Only one vaccine for the HPV is available.
b. The vaccine is given in three doses over a 6-month period.
c. The vaccine is recommended for both boys and girls.
d. Ideally, the vaccine is administered before the first sexual contact.

ANS: A

Two vaccines for HPV are availableCervarix and Gardasiland other vaccines continue to be investigated. These vaccines protect against HPV types 6, 11, 16, and 18. They are most effective if administered before the first sexual contact. Recommendations are that vaccines be administered to 11- and 12-year-old girls and boys. The vaccine can be given to girls as young as 9 years of age and young women ages 13 to 26 years in three doses over a 6-month period.

DIF: Cognitive Level: Remember REF: IMS: 154

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Which sexually transmitted infection (STI) is the most commonly reported in American women?

a. Gonorrhea
b. Syphilis
c. *Chlamydia*
d. Candidiasis

ANS: C

Chlamydia is the most common and fastest spreading STI among American women, with an estimated 3 million new cases each year. Infection rates are two and a half times that of men. Gonorrhea is probably the oldest communicable disease in the United States and second to *Chlamydia* in reported conditions. Syphilis is the earliest described STI. Candidiasis is a relatively common fungal infection.

DIF: Cognitive Level: Remember REF: IMS: 149

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. The Centers for Disease Control and Prevention (CDC) recommends which therapy for the treatment of the HPV?

a. Miconazole ointment
b. Topical podofilox 0.5% solution or gel
c. Two doses of penicillin administered intramuscularly (IM)
d. Metronidazole by mouth

ANS: B

Available treatments are imiquimod, podophyllin, and podofilox. Miconazole ointment is used to treat athletes foot. Penicillin IM is used to treat syphilis. Metronidazole is used to treat bacterial vaginosis.

DIF: Cognitive Level: Remember REF: IMS: 148

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

5. A client exhibits a thick, white, lumpy, cottage cheeselike discharge, along with white patches on her labia and in her vagina. She complains of intense pruritus. Which medication should the nurse practitioner order to treat this condition?

a. Fluconazole
b. Tetracycline
c. Clindamycin

d. Acyclovir

ANS: A

The client is experiencing a candidiasis infection. Fluconazole, metronidazole, and clotrimazole are the drugs of choice to treat this condition. Tetracycline is used to treat syphilis. Clindamycin is used to treat bacterial vaginosis. Acyclovir is used to treat genital herpes.

DIF: Cognitive Level: Apply REF: IMS: 163

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

6. Which laboratory testing is used to detect the human immunodeficiency virus (HIV)?

a. HIV screening
b. HIV antibody testing
c. Cluster of differentiation 4 (CD4) counts
d. Cluster of differentiation 8 (CD8) counts

ANS: B

The screening tool used to detect HIV is the enzyme immunoassay, which tests for the presence of antibodies to the HIV. HIV-1 and HIV-2 antibody tests are used to confirm the diagnosis. To determine whether the HIV is present, the test performed must be able to detect antibodies to the virus, not the virus itself. CD4 counts are associated with the incidence of acquired immunodeficiency syndrome (AIDS) in HIV-infected individuals. CD8 counts are not performed to detect HIV.

DIF: Cognitive Level: Understand REF: IMS: 160 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

7. Which condition is the most life-threatening virus to the fetus and neonate?

a. Hepatitis A virus (HAV)

b. Herpes simplex virus (HSV)
c. Hepatitis B virus (HBV)
d. Cytomegalovirus (CMV)

ANS: C

HBV is the most life-threatening viral condition to the fetus and neonate. HAV is *not* the most threatening to the fetus nor is HSV the most threatening to the neonate. Although serious, CMV is *not* the most life-threatening viral condition to the fetus.

DIF: Cognitive Level: Remember REF: IMS: 158 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Safe and Effective Care Environment

8. Which treatment regime would be most appropriate for a client who has been recently diagnosed with acute pelvic inflammatory disease (PID)?

a. Oral antiviral therapy
b. Bed rest in a semi-Fowler position
c. Antibiotic regimen continued until symptoms subside
d. Frequent pelvic examination to monitor the healing progress

ANS: B

The woman with acute PID should be on bed rest in a semi-Fowler position. Broad-spectrum antibiotics are used; antiviral therapy is ineffective. Antibiotics must be taken as prescribed, even if symptoms subside. Few pelvic examinations should be conducted during the acute phase of the disease.

DIF: Cognitive Level: Apply REF: IMS: 153 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

9. On vaginal examination of a 30-year-old woman, the nurse documents the following findings: profuse, thin, grayish-white vaginal discharge with a fishy odor and complaints of pruritus. Based upon these findings, which condition would the nurse suspect?

a. Bacterial vaginosis
b. Candidiasis
c. Trichomoniasis
d. Gonorrhea

ANS: A

Most women with bacterial vaginosis complain of a characteristic fishy odor. The discharge is usually profuse, thin, and has a white, gray, or milky color. Some women may also experience mild irritation or pruritus. The discharge associated with candidiasis is thick, white, and lumpy and resembles cottage cheese. Trichomoniasis may be asymptomatic, but women commonly have a characteristic yellow-to-green, frothy, mucopurulent, copious, and malodorous discharge. Women with gonorrhea are often asymptomatic. Although they may have a purulent endocervical discharge, the discharge is usually minimal or absent.

DIF: Cognitive Level: Understand REF: IMS: 162

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. Which viral sexually transmitted infection is characterized by a primary infection followed by recurrent episodes?

a. Herpes simplex virus 2 (HSV-2)
b. HPV
c. HIV
d. CMV

ANS: A

The initial HSV genital infection is characterized by multiple painful lesions, fever, chills, malaise, and severe dysuria; it may last 2 to 3 weeks. Recurrent episodes of the HSV infection commonly have only local symptoms that usually are less severe than those of the initial infection. With HPV infection, lesions are a chronic problem. The HIV is a retrovirus. Seroconversion to HIV positivity usually occurs within 6 to 12 weeks after the virus has entered the body. Severe depression of the cellular immune system associated with the HIV infection characterizes AIDS, which has no cure. In most adults, the onset of CMV infection is uncertain and asymptomatic. However, the disease may become a chronic, persistent infection.

DIF: Cognitive Level: Understand REF: IMS: 156

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

11. The nurse should understand the process by which the HIV infection occurs. Once the virus has entered the body, what is the time frame for seroconversion to HIV positivity?

a. 6 to 10 days
b. 2 to 4 weeks
c. 6 to 12 weeks
d. 6 months

ANS: C

Seroconversion to HIV positivity usually occurs within 6 to 12 weeks after the virus has entered the body. Both 6 to 10 days and 2 to 4 weeks are too short for seroconversion to HIV positivity to occur, and 6 months is too long.

DIF: Cognitive Level: Understand REF: IMS: 159

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

12. A 25-year-old single woman comes to the gynecologists office for a follow-up visit related to her abnormal Papanicolaou (Pap) smear. The test revealed that the client has the HPV. The woman asks, What is that? Can you get rid of it? Which is the best response for the nurse to provide?

a. Its just a little lump on your cervix. We can just freeze it off.
b. HPV stands for human papillomavirus. It is a sexually transmitted infection that may lead to cervical cancer.
c. HPV is a type of early human immunodeficiency virus. You will die from this.
d. You probably caught this from your current boyfriend. He should get tested for this.

ANS: B

Informing the client about STIs and the risks involved with the HPV is important. The health care team has a duty to provide proper information to the client, including information related to STIs and the fact that although the HPV and HIV are both viruses that can be sexually transmitted, they are not the same virus. The onset of the HPV can be insidious. Often STIs go unnoticed. Abnormal bleeding is frequently the initial symptom. The client may have had the HPV before her current boyfriend. The nurse should make no deductions from this limited information.

DIF: Cognitive Level: Analyze REF: IMS: 154 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. Which STI does *not* respond well to antibiotic therapy?

a. *Chlamydia*
b. Gonorrhea
c. Genital herpes
d. Syphilis

ANS: C

Genital herpes is a chronic and recurring disease for which no known cure is available; therefore, it does not respond to antibiotics. *Chlamydia* is a bacterial infection that is treated with doxycycline or azithromycin. Gonorrhea is a bacterial infection that is treated with any of several antibiotics. Syphilis is a bacterial infection that is treated with penicillin.

DIF: Cognitive Level: Understand REF: IMS: 156 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

14. Five different viruses (A, B, C, D, and E) account for almost all cases of hepatitis infections. Which statement regarding the various forms of hepatitis is most accurate?

a. Vaccine exists for hepatitis C virus (HCV) but not for HBV.
b. HAV is acquired by eating contaminated food or drinking polluted water.
c. HBV is less contagious than HIV.
d. Incidence of HCV is decreasing.

ANS: B

Contaminated milk and shellfish are common sources of infection for HAV. A vaccine exists for HBV but not for HCV. HBV is more contagious than HIV. The incidence of HCV is on the rise.

DIF: Cognitive Level: Understand REF: IMS: 158

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

15. A 21-year-old client exhibits a greenish, copious, and malodorous discharge with vulvar irritation. A speculum examination and wet smear are performed. Which condition is this client most likely experiencing?

a. Bacterial vaginosis
b. Candidiasis
c. Yeast infection
d. Trichomoniasis

ANS: D

Although uncomfortable, a speculum examination is always performed and a wet smear obtained if the client exhibits symptoms of trichomoniasis. The presence of many white blood cell protozoa is a positive finding for trichomoniasis. A normal saline test is used to test for bacterial

vaginosis. A potassium hydroxide preparation is used to test for candidiasis. *Yeast infection* is the common name for candidiasis, for which the test is a potassium hydroxide preparation.

DIF: Cognitive Level: Understand REF: IMS: 164 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

16. An essential component of counseling women regarding safe sex practices includes a discussion regarding avoiding the exchange of body fluids. The most effective physical barrier promoted for the prevention of STIs and HIV is the condom. To educate the client about the use of condoms, which information related to condom use is the most important?

a. Strategies to enhance condom use
b. Choice of colors and special features
c. Leaving the decision up to the male partner
d. Places to carry condoms safely

ANS: A

When the nurse opens the discussion on safe-sex practices, it gives the woman permission to clear up any concerns or misapprehensions that she may have regarding condom use. The nurse can also suggest ways that the woman can enhance her condom negotiation and communications skills with a sexual partner. These include role-playing, rehearsal, cultural barriers, and situations that place the client at risk. Although women can be taught the differences among condoms, such as size ranges, where to purchase, and price, these features are not as important as negotiating the use of safe sex practices. Although not ideal, women may safely choose to carry condoms in shoes, wallets, or inside their bra. They should be taught to keep the condom away from heat. Although this information is important, it is not relevant if the woman cannot even discuss strategies on how to enhance condom use.

DIF: Cognitive Level: Analyze REF: pp. 147-148 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. Group B *Streptococcus* (GBS) is part of the normal vaginal flora in 20% to 30% of healthy pregnant women. GBS has been associated with poor pregnancy outcomes and is an important factor in neonatal morbidity and mortality. Which finding is *not* a risk factor for neonatal GBS infection?

a. Positive prenatal culture
b. Preterm birth at 37 weeks or less of gestation
c. Maternal temperature of 38 C or higher
d. Premature rupture of membranes (PROM) 24 hours or longer before the birth

ANS: D

PROM 18 hours or longer before the birth increases the risk for neonatal GBS infection. Positive prenatal culture is a risk factor for neonatal GBS infection. Preterm birth at 37 weeks or less of gestation remains a risk factor for neonatal GBS infection. Maternal temperature of 38 C or higher is also a risk factor for neonatal GBS infection.

DIF: Cognitive Level: Understand REF: IMS: 164

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

18. Clients treated for syphilis with penicillin may experience a Jarisch-Herxheimer reaction. Which clinical presentation would be unlikely if a client is experiencing this reaction?

a. Vomiting and diarrhea
b. Headache, myalgias, and arthralgia
c. Preterm labor
d. Jarisch-Herxheimer in the first 24 hours after treatment

ANS: A

The Jarisch-Herxheimer reaction is an acute febrile reaction that occurs within the first 24 hours of treatment and is accompanied by headache, myalgias, and arthralgia. Vomiting and diarrhea are not anticipated. If the client is pregnant, then she is at risk for preterm labor and birth.

DIF: Cognitive Level: Remember REF: IMS: 152

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. The health history and physical examination cannot reliably identify all persons infected with HIV or other blood-borne pathogens. Which infection control practice should the nurse use when providing eye prophylaxis to a term newborn?

a. Wear gloves.
b. Wear mouth, nose, and eye protection.
c. Wear a mask.
d. Wash the hands after medication administration.

ANS: A

Standard Precautions should be consistently used in the care of all persons. Personal protective equipment in the form of gloves should be worn during infant eye prophylaxis, care of the umbilical cord, circumcision site care, diaper changes, handling of colostrum, and parenteral procedures. Masks are worn during respiratory isolation or if the health care practitioner has a cough. Mouth, eye, and nose protection are used to protect the mucous membranes if client-care activities are likely to generate splashes or sprays of body fluids. The hands should be washed both before having contact with the client and after administering medications.

DIF: Cognitive Level: Apply REF: IMS: 168 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

20. The nurse providing care in a womens health care setting must be knowledgeable about STIs. Which STIs can be successfully treated?

a. HSV
b. AIDS
c. Venereal warts
d. *Chlamydia*

ANS: D

The usual treatment for *Chlamydia* bacterial infection is doxycycline or azithromycin. Concurrent treatment of all sexual partners is needed to prevent recurrence. No known cure is available for HSV; therefore, the treatment focuses on pain relief and preventing secondary infections. Because no cure is known for AIDS, prevention and early detection are the primary focus of care management. HPV causes condylomata acuminata (venereal warts); no available treatment eradicates the virus.

DIF: Cognitive Level: Remember REF: IMS: 150

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

21. What is the drug of choice for the treatment of gonorrhea?

a. Penicillin G
b. Tetracycline
c. Ceftriaxone
d. Acyclovir

ANS: C

Ceftriaxone is effective for the treatment of all gonococcal infections. Penicillin is used to treat syphilis. Tetracycline is prescribed for chlamydial infections. Acyclovir is used to treat herpes genitalis.

DIF: Cognitive Level: Remember REF: IMS: 151 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which sexual behaviors are associated with exposure to an STI? *(Select all that apply.)*

a. Fellatio
b. Unprotected anal intercourse

c. Multiple sex partners
d. Dry kissing
e. Abstinence

ANS: A, B, C

Engaging in fellatio, unprotected anal intercourse, or having multiple sex partners increases the exposure risk and the possibility of acquiring an STI. Dry kissing and abstinence are considered safe sexual practices.

DIF: Cognitive Level: Understand REF: IMS: 147

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. Which statements regarding the HPV are accurate? *(Select all that apply.)*

HPV infections:

a. are thought to be less common in pregnant women than in women who are not pregnant.
b. are thought to be more common in pregnant women than in women who are not pregnant.
c. were previously called genital warts.
d. were previously called herpes.
e. may cause cancer.

ANS: B, C, E

HPV infections are thought to be more common in pregnant women than in women who are not pregnant, with an increase in incidence from the first trimester to the third trimester. HPV, formerly called venereal or genital warts, is an STI with more than 30 known serotypes, several of which are associated with cervical cancer.

DIF: Cognitive Level: Understand REF: IMS: 154 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

3. A 23-year-old primiparous client with inconsistent prenatal care is admitted to the hospitals maternity unit in labor. The client states that she has tested positive for the HIV. She has not undergone any treatment during her pregnancy. The nurse understands that the risk of perinatal transmission can be significantly decreased by a number of prophylactic interventions. Which interventions should be included in the plan of care?

a. Intrapartum treatment with antiviral medications
b. Cesarean birth
c. Postpartum treatment with antiviral medications
d. Avoidance of breastfeeding
e. Pneumococcal, HBV, and *Haemophilus influenzae* vaccine

ANS: A, B, D

The prophylactic measures of prenatal antiviral use, elective cesarean birth, and formula feeding reduce the transmission of the HIV to as low as 1% to 2%. The client who refuses a cesarean birth should be given intravenous antiviral therapy during labor. Ideally, medications should be given prenatally. Administration of antiviral drugs in the postpartum period will not reduce transmission to the infant. All women who are HIV positive should be encouraged to receive these immunizations. They will not reduce the risk of perinatal transmission.

DIF: Cognitive Level: Apply REF: IMS: 161 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. A group of infections known collaboratively as TORCH infections are capable of crossing the placenta and causing serious prenatal effects on the fetus. Which infections are included in this group of organisms? *(Select all that apply.)*

a. Toxoplasmosis
b. Other infections
c. Roseola
d. *Clostridium*
e. Herpes simplex

ANS: A, B, E

Toxoplasmosis, other infections, rubella virus, CMV, and HSV are collectively known as TORCH infections. Generally, all TORCH infections produce influenza-like symptoms in the mother; however, fetal effects are generally more serious.

DIF: Cognitive Level: Remember REF: IMS: 165

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

5. The nurse should be familiar with the use of the five Ps as a tool for evaluating risk behaviors for STIs and the HIV. Which components would the nurse include in her use of the five Ps as an assessment tool? *(Select all that apply.)*

a. Number of partners
b. Level of physical activity
c. Prevention of pregnancy
d. Protection from STIs
e. Past history

ANS: A, C, D, E

Level of physical activity is not a component of this assessment. The five Ps include ***p****artners*, ***p****revention of pregnancy*, ***p****rotection from STIs*, understanding of sexual ***p****ractices*, and ***p****ast history.*

DIF: Cognitive Level: Apply REF: IMS: 145

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Counseling and education are critical components of the nursing care of women with herpes infections. Clients should be taught to identify triggers that might result in a herpes attack. Which factors are possible triggers for a recurrence? *(Select all that apply.)*

a. Menstruation

b. Trauma
c. Febrile illness
d. Soap
e. Ultraviolet light

ANS: A, B, C, E

Stress, menstruation, trauma, febrile illness, chronic illnesses, and ultraviolet light have all been found to trigger genital herpes. Women might elect to keep a diary of symptoms to help identify stressors. Lesions should be cleansed with saline or simple soap and water. Lesions can be kept dry by using a blow dryer, wearing cotton underwear, and wearing loose clothing. Tea bags or hydrogen peroxide might also be helpful.

Chapter 8: Contraception and Abortion

MULTIPLE CHOICE

1. A woman has chosen the calendar method of conception control. Which is the most important action the nurse should perform during the assessment process?

a. Obtain a history of the womans menstrual cycle lengths for the past 6 to 12 months.
b. Determine the clients weight gain and loss pattern for the previous year.
c. Examine skin pigmentation and hair texture for hormonal changes.
d. Explore the clients previous experiences with conception control.

ANS: A

The calendar method of conception control is based on the number of days in each cycle, counting from the first day of menses. The fertile period is determined after the lengths of menstrual cycles have been accurately recorded for 6 months. Weight gain or loss may be partly related to hormonal fluctuations, but it has no bearing on the use of the calendar method. Integumentary changes may be related to hormonal changes, but they are not indicators for use

of the calendar method. Exploring previous experiences with conception control may demonstrate client understanding and compliancy, but these experiences are not the most important aspect to assess for the discussion of the calendar method.

DIF: Cognitive Level: Analyze REF: IMS: 174

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. A married couple is discussing alternatives for pregnancy prevention and has asked about fertility awareness methods (FAMs). Which response by the nurse is most appropriate?

a. Theyre not very effective, and it is very likely that youll get pregnant.
b. FAMs can be effective for many couples; however, they require motivation.
c. These methods have a few advantages and several health risks.
d. You would be much safer going on the pill and not having to worry.

ANS: B

FAMs are effective with proper vigilance about ovulatory changes in the body and with adherence to coitus intervals. FAMs are effective if correctly used by a woman with a regular menstrual cycle. The typical failure rate for all FAMs is 24% during the first year of use. FAMs have no associated health risks. The use of birth control has associated health risks. In addition, taking a pill daily requires compliance on the clients part.

DIF: Cognitive Level: Apply REF: pp. 173-174 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A woman who has a seizure disorder and takes barbiturates and phenytoin sodium daily asks the nurse about the pill as a contraceptive choice. What is the nurses *best* response?

a. Oral contraceptives are a highly effective method, but they have some side effects.
b. Your current medications will reduce the effectiveness of the pill.
c. Oral contraceptives will reduce the effectiveness of your seizure medication.

d. The pill is a good choice for a woman of your age and with your personal history.

ANS: B

Because the liver metabolizes oral contraceptives, their effectiveness is reduced when they are simultaneously taken with anticonvulsants. Stating that the pill is an effective birth control method with side effects is a true statement, but this response is not the most appropriate. The anticonvulsant reduces the effectiveness of the pill, not the other way around. Stating that the pill is a good choice for a woman of her age and personal history does not teach the client that the effectiveness of the pill may be reduced because of her anticonvulsant therapy.

DIF: Cognitive Level: Apply REF: IMS: 184 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

4. A woman who has just undergone a first-trimester abortion will be using oral contraceptives. To protect against pregnancy, the client should be advised to do what?

a. Avoid sexual contact for at least 10 days after starting the pill.
b. Use condoms and foam for the first few weeks as a backup.
c. Use another method of contraception for 1 week after starting the pill.
d. Begin sexual relations once vaginal bleeding has ended.

ANS: C

If oral contraceptives are to be started within 3 weeks after an abortion, additional forms of contraception should be used throughout the first week to avoid the risk of pregnancy.

DIF: Cognitive Level: Apply REF: IMS: 193 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

5. Which client would be an ideal candidate for injectable progestins such as Depo-Provera (DMPA) as a contraceptive choice?

a. The ideal candidate for DMPA wants menstrual regularity and predictability.

b. The client has a history of thrombotic problems or breast cancer.
c. The ideal candidate has difficulty remembering to take oral contraceptives daily.
d. The client is homeless or mobile and rarely receives health care.

ANS: C

Advantages of DMPA include its contraceptive effectiveness, compared with the effectiveness of combined oral contraceptives, and the requirement of only four injections a year. The disadvantages of injectable progestins are prolonged amenorrhea and uterine bleeding. The use of injectable progestin carries an increased risk of venous thrombosis and thromboembolism. To be effective, DMPA injections must be administered every 11 to 13 weeks. Access to health care is necessary to prevent pregnancy or potential complications.

DIF: Cognitive Level: Understand REF: IMS: 186

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. A client currently uses a diaphragm and spermicide for contraception. She asks the nurse to explain the major differences between the cervical cap and the diaphragm. What is the *most* appropriate response by the nurse?

a. No spermicide is used with the cervical cap, so its less messy.
b. The diaphragm can be left in place longer after intercourse.
c. Repeated intercourse with the diaphragm is more convenient.
d. The cervical cap can be safely used for repeated acts of intercourse without adding more spermicide later.

ANS: D

The cervical cap can be inserted hours before sexual intercourse without the need for additional spermicide later. Spermicide should be used inside the cap as an additional chemical barrier. The cervical cap should remain in place for 6 hours after the last act of intercourse. Repeated intercourse with the cervical cap is more convenient because no additional spermicide is needed.

DIF: Cognitive Level: Apply REF: IMS: 181 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. Which statement regarding emergency contraception is *correct*?

a. Emergency contraception requires that the first dose be taken within 72 hours of unprotected intercourse.
b. Emergency contraception may be taken right after ovulation.
c. Emergency contraception has an effectiveness rate in preventing pregnancy of approximately 50%.
d. Emergency contraception is commonly associated with the side effect of menorrhagia.

ANS: A

Emergency contraception should be taken as soon as possible or within 72 hours of unprotected intercourse to prevent pregnancy. If taken before ovulation, follicular development is inhibited, which prevents ovulation. The risk of pregnancy is reduced by as much as 75%. The most common side effect of postcoital contraception is nausea.

DIF: Cognitive Level: Understand REF: IMS: 186

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

8. An unmarried young woman describes her sex life as active and involving many partners. She wants a contraceptive method that is reliable and does not interfere with sex. She requests an intrauterine device (IUD). Which information is *most* important for the nurse to share?

a. The IUD does not interfere with sex.
b. The risk of pelvic inflammatory disease will be higher with the IUD.
c. The IUD will protect you from sexually transmitted infections.
d. Pregnancy rates are high with the IUD.

ANS: B

Disadvantages of IUDs include an increased risk of pelvic inflammatory disease (PID) in the first 20 days after insertion, as well as the risks of bacterial vaginosis and uterine perforation. The

IUD offers no protection against sexually transmitted infections (STIs) or the human immunodeficiency virus (HIV), as does a barrier method. Because this woman has multiple sex partners, she is at higher risk of developing an STI. Stating that an IUD does not interfere with sex may be correct; however, it is not the most appropriate response. The typical failure rate of the IUD is approximately 1%.

DIF: Cognitive Level: Apply REF: IMS: 187 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

9. A woman is 16 weeks pregnant and has elected to terminate her pregnancy. Which is the *most* common technique used for the termination of a pregnancy in the second trimester?

a. Dilation and evacuation (D&E)
b. Methotrexate administration
c. Prostaglandin administration
d. Vacuum aspiration

ANS: A

D&E can be performed at any point up to 20 weeks of gestation. It is more commonly performed between 13 and 16 weeks of gestation. Methotrexate is a cytotoxic drug that causes early abortion by preventing fetal cell division. Prostaglandins are also used for early abortion and work by dilating the cervix and initiating uterine wall contractions. Vacuum aspiration is used for abortions in the first trimester.

DIF: Cognitive Level: Understand REF: IMS: 194

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

10. A woman will be taking oral contraceptives using a 28-day pack. What advice should the nurse provide to protect this client from an unintended pregnancy?

a. Limit sexual contact for one cycle after starting the pill.

b. Use condoms and foam instead of the pill for as long as the client takes an antibiotic.

c. Take one pill at the same time every day.

d. Throw away the pack and use a backup method if two pills are missed during week 1 of her cycle.

ANS: C

To maintain adequate hormone levels for contraception and to enhance compliance, clients should take oral contraceptives at the same time each day. If contraceptives are to be started at any time other than during normal menses or within 3 weeks after birth or an abortion, then another method of contraception should be used through the first week to prevent the risk of pregnancy. Taken exactly as directed, oral contraceptives prevent ovulation, and pregnancy cannot occur. No strong pharmacokinetic evidence indicates a link between the use of broad-spectrum antibiotics and altered hormonal levels in oral contraceptive users. If the client misses two pills during week 1, then she should take two pills a day for 2 days and finish the package and use a backup contraceptive method for the next 7 consecutive days.

DIF: Cognitive Level: Apply REF: pp. 181-184 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

11. The lactational amenorrhea method (LAM) of birth control is popular in developing countries and has had limited use in the United States. As breastfeeding rates increase, more women may rely upon this method for birth control. Which information is most important to provide to the client interested in using the LAM for contraception?

a. LAM is effective until the infant is 9 months of age.

b. This popular method of birth control works best if the mother is exclusively breastfeeding.

c. Its typical failure rate is 5%.

d. Feeding intervals should be 6 hours during the day.

ANS: B

The LAM works best if the mother is exclusively or almost exclusively breastfeeding. Disruption of the breastfeeding pattern increases the risk of pregnancy. After the infant is 6 months of age or menstrual flow has resumed, effectiveness decreases. The typical failure rate is 1% to 2%. Feeding intervals should be no greater than 4 hours during the day and 6 hours at night.

DIF: Cognitive Level: Understand REF: IMS: 191

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. Although reported in small numbers, toxic shock syndrome (TSS) can occur with the use of a diaphragm. If a client is interested in this form of conception control, then the nurse must instruct the woman on how best to reduce her risk of TSS. Which comment by the nurse would be *most* helpful in achieving this goal?

a. You should always remove your diaphragm 6 to 8 hours after intercourse. Dont use the diaphragm during menses, and watch for danger signs of TSS, including a sudden onset of fever over 38.4 C, hypotension, and a rash.
b. You should remove your diaphragm right after intercourse to prevent TSS.
c. Its okay to use your diaphragm during your menstrual cycle. Just be sure to wash it thoroughly first to prevent TSS.
d. Make sure you dont leave your diaphragm in for longer than 24 hours, or you may get TSS.

ANS: A

The nurse should instruct the client on the proper use and removal of the diaphragm and include the danger signs of TSS. The diaphragm must remain against the cervix for 6 to 8 hours to prevent pregnancy, but it should not remain in place longer than 8 hours to avoid the risk of TSS. The diaphragm should not be used during menses.

DIF: Cognitive Level: Apply REF: IMS: 180 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. Which term best describes the conscious decision concerning when to conceive or avoid pregnancy as opposed to the intentional prevention of pregnancy during intercourse?

a. Family planning
b. Birth control
c. Contraception
d. Assisted reproductive therapy

ANS: A

Family planning is the process of deciding when and if to have children. *Birth control* is the device and/or practice used to reduce the risk of conceiving or bearing children. *Contraception* is the intentional prevention of pregnancy during sexual intercourse. *Assisted reproductive therapy* is one of several possible treatments for infertility.

DIF: Cognitive Level: Understand REF: IMS: 171

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. In the acronym BRAIDED, which letter is used to identify the key components of informed consent that the nurse must document?

a. *B* stands for birth control.
b. *R* stands for reproduction.
c. *A* stands for alternatives.
d. *I* stands for ineffective.

ANS: C

In the acronym BRAIDED, A stands for alternatives and information about other viable methods. *B* stands for benefits and information about the advantages of a particular birth control method and its success rates. *R*stands for risks and information about the disadvantages of a particular method and its failure rates. *I* stands for inquiries and the opportunity to ask questions.

DIF: Cognitive Level: Remember REF: IMS: 172 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Safe and Effective Care Environment

15. Which benefit regarding FAMs makes it an appealing choice for some women?

a. Adherence to strict recordkeeping
b. Absence of chemicals and hormones
c. Decreased involvement and intimacy of partner
d. Increased spontaneity of coitus

ANS: B

The absence of chemicals or hormones to alter the natural menstrual flow is extremely important to some women. The strict recordkeeping with FAMs may be difficult and creates a potential risk for failure. These methods require increased involvement by the partner; however, they also reduce the spontaneity of coitus.

DIF: Cognitive Level: Understand REF: IMS: 174 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

16. The nurse is providing contraceptive instruction to a young couple who are eager to learn. The nurse should be cognizant of which information regarding the natural family planning method?

a. The natural family planning method is the same as coitus interruptus or pulling out.
b. This contraception method uses the calendar method to align the womans cycle with the natural phases of the moon.
c. This practice is the only contraceptive method acceptable to the Roman Catholic Church.
d. The natural family planning method relies on barrier methods during the fertility phases.

ANS: C

Natural family planning is the only contraceptive practice acceptable to the Roman Catholic Church. Pulling out is not the same as periodic abstinence, another name for natural family planning. The phases of the moon are not part of the calendar method or any method. Natural

family planning is another name for periodic abstinence, which is the accepted way to pass safely through the fertility phases without relying on chemical or physical barriers.

DIF: Cognitive Level: Understand REF: IMS: 173 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. Which nonpharmacologic contraceptive method has a failure rate of less than 25%?

a. Standard days variation
b. Periodic abstinence
c. Postovulation
d. Coitus interruptus

ANS: A

The standard days variation on the calendar method has a failure rate of 12% and is a variation of the calendar rhythm method with a fixed number of days for fertility in each cycle. The periodic abstinence method has a failure rate of 25% or higher. The postovulation method has a failure rate of 25% or higher. The coitus interruptus method has a failure rate of 27% or higher.

DIF: Cognitive Level: Remember REF: IMS: 174

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

18. Which contraceptive method *best* protects against STIs and the HIV?

a. Periodic abstinence
b. Barrier methods
c. Hormonal methods
d. Same protection with all methods

ANS: B

Barrier methods, such as condoms, protect against STIs and the HIV the best of all contraceptive methods. Periodic abstinence and hormonal methods, such as birth control pills, offer no protection against STIs or the HIV.

DIF: Cognitive Level: Apply REF: IMS: 177 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. Nurses should be cognizant of what information with regard to the noncontraceptive medical effects of combination oral contraceptives (COCs)?

a. COCs can cause TSS if the prescription is wrong.
b. Hormonal withdrawal bleeding is usually a little more profuse than in normal menstruation and lasts a week for those who use COCs.
c. COCs increase the risk of endometrial and ovarian cancers.
d. Effectiveness of COCs can be altered by some over-the-counter medications and herbal supplements.

ANS: D

The effectiveness of COCs can be altered by some over-the-counter medications and herbal supplements. TSS can occur in some who use the diaphragm, but it is not a consequence of taking oral contraceptive pills. Hormonal withdrawal bleeding usually is lighter than in normal menstruation and lasts a couple of days. Oral contraceptive pills offer protection against the risk of endometrial and ovarian cancers.

DIF: Cognitive Level: Understand REF: IMS: 184 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. Importantly, the nurse must be aware of which information related to the use of IUDs?

a. Return to fertility can take several weeks after the device is removed.
b. IUDs containing copper can provide an emergency contraception option if inserted within a few days of unprotected intercourse.
c. IUDs offer the same protection against STIs as the diaphragm.

d. Consent forms are not needed for IUD insertion.

ANS: B

The woman has up to 5 days to insert the IUD after unprotected sex. The return to fertility is immediate after the removal of the IUD. IUDs offer no protection against STIs. A consent form is required for insertion, as is a negative pregnancy test.

DIF: Cognitive Level: Remember REF: IMS: 187

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

21. Which statement is the *most* complete and accurate description of medical abortions?

a. Medical abortions are performed only for maternal health.
b. They can be achieved through surgical procedures or with drugs.
c. Medical abortions are mostly performed in the second trimester.
d. They can be either elective or therapeutic.

ANS: D

Medical abortions can be either elective (the womans choice) or therapeutic (for reasons of maternal or fetal health) and are performed through the use of medications rather than surgical procedures. Medical abortions are usually performed in the first trimester.

DIF: Cognitive Level: Understand REF: IMS: 194

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

22. A woman is using the basal body temperature (BBT) method of contraception. She calls the clinic and tells the nurse, My period is due in a few days, and my temperature has not gone up. What is the nurses *most*appropriate response?

a. This probably means that youre pregnant.
b. Dont worry; its probably nothing.

c. Have you been sick this month?

d. You probably didnt ovulate during this cycle.

ANS: D

The absence of a temperature decrease most likely is the result of a lack of ovulation. Pregnancy cannot occur without ovulation, which is being measured using the BBT method. A comment such as, Dont worry; its probably nothing, discredits the clients concerns. Illness is most likely the cause of an increase in BBT.

DIF: Cognitive Level: Apply REF: pp. 175-176

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

23. A male client asks the nurse why it is better to purchase condoms that are not lubricated with nonoxynol-9 (a common spermicide). Which response by the nurse is the *most* accurate?

a. The lubricant prevents vaginal irritation.

b. Nonoxynol-9 does not provide protection against STIs as originally thought; it has also been linked to an increase in the transmission of the HIV and can cause genital lesions.

c. The additional lubrication improves sex.

d. Nonoxynol-9 improves penile sensitivity.

ANS: B

Nonoxynol-9 does not provide protection against STIs as originally thought; it has also been linked to an increase in the transmission of the HIV and can cause genital lesions. Nonoxynol-9 may cause vaginal irritation, has no effect on the quality of sexual activity, and has no effect on penile sensitivity.

DIF: Cognitive Level: Apply REF: IMS: 177 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

24. Which statement regarding the term *contraceptive failure rate* is the *most* accurate?

a. The contraceptive failure rate refers to the percentage of users expected to have an accidental pregnancy over a 5-year span.
b. It refers to the minimum rate that must be achieved to receive a government license.
c. The contraceptive failure rate increases over time as couples become more careless.
d. It varies from couple to couple, depending on the method and the users.

ANS: D

Contraceptive effectiveness varies from couple to couple, depending on how well a contraceptive method is used and how well it suits the couple. The contraceptive failure rate measures the likelihood of accidental pregnancy in the first year only. Failure rates decline over time because users gain experience.

DIF: Cognitive Level: Remember REF: IMS: 172

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

25. Nurses, certified nurse-midwives, and other advanced practice nurses have the knowledge and expertise to assist women in making informed choices regarding contraception. A multidisciplinary approach should ensure that the womans social, cultural, and interpersonal needs are met. Which action should the nurse first take when meeting with a new client to discuss contraception?

a. Obtain data about the frequency of coitus.
b. Determine the womans level of knowledge concerning contraception and her commitment to any particular method.
c. Assess the womans willingness to touch her genitals and cervical mucus.
d. Evaluate the womans contraceptive life plan.

ANS: B

Determining the womans level of knowledge concerning contraception and her commitment to any particular method is the primary step of this nursing assessment and necessary before

completing the process and moving on to a nursing diagnosis. Once the clients level of knowledge is determined, the nurse can interact with the woman to compare options, reliability, cost, comfort level, protection from STIs, and her partners willingness to participate. Although important, obtaining data about the frequency of coitus is not the first action that the nurse should undertake when completing an assessment. Data should include not only the frequency of coitus but also the number of sexual partners, level of contraceptive involvement, and the partners objections. Assessing the womans willingness to touch herself is a key factor for the nurse to discuss should the client express an interest in using one of the fertility awareness methods of contraception. The nurse must be aware of the clients plan regarding whether she is attempting to prevent conception, delay conception, or conceive.

DIF: Cognitive Level: Analyze REF: pp. 171-172

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

26. What is the importance of obtaining informed consent for a number of contraceptive methods?

a. Contraception is an invasive procedure that requires hospitalization.
b. The method may require a surgical procedure to insert a device.
c. The contraception method chosen may be unreliable.
d. The method chosen has potentially dangerous side effects.

ANS: D

Being aware of the potential side effects is important for couples who are making an informed decision about the use of contraceptives. The only contraceptive method that is a surgical procedure and requires hospitalization is sterilization. Some methods have greater efficacy than others, and this efficacy should be included in the teaching.

DIF: Cognitive Level: Understand REF: IMS: 172

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe and Effective Care Environment

27. If consistently and correctly used, which of the barrier methods of contraception has the lowest failure rate?

a. Spermicides
b. Female condoms
c. Male condoms
d. Diaphragms

ANS: C

For typical users, the failure rate for male condoms may approach 18%. Spermicide failure rates are approximately 28%. The failure rate for female condoms is approximately 21%. The failure rate for diaphragms with spermicides is 12%.

DIF: Cognitive Level: Remember REF: IMS: 179 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The nurse is reviewing the educational packet provided to a client about tubal ligation. Which information regarding this procedure is important for the nurse to share? *(Select all that apply.)*

a. It is highly unlikely that you will become pregnant after the procedure.
b. Tubal ligation is an effective form of 100% permanent sterilization. You wont be able to get pregnant.
c. Sterilization offers some form of protection against STIs.
d. Sterilization offers no protection against STIs.
e. Your menstrual cycle will greatly increase after your sterilization.

ANS: A, D

A woman is unlikely to become pregnant after tubal ligation. However, sterilization offers no protection against STIs and is *not* 100% effective. Typically, the menstrual cycle remains the same after a tubal ligation.

DIF: Cognitive Level: Apply REF: IMS: 190

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. Postabortion instructions may differ among providers regarding tampon use and the resumption of intercourse. However, education should be provided regarding serious complications. When should the woman who has undergone an induced abortion be instructed to return to the emergency department? *(Select all that apply.)*

a. Fever higher than 39 C
b. Chills
c. Foul-smelling vaginal discharge
d. Bleeding greater than four pads in 2 hours
e. Severe abdominal pain

ANS: B, C, E

The client should report to a health care facility for any of the following symptoms: fever higher than 38 C, chills, bleeding more than two saturated pads in 2 hours or heavy bleeding lasting for days, foul-smelling discharge, abdominal tenderness or pain, and cramping or backache.

DIF: Cognitive Level: Apply REF: IMS: 193

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is responsible for providing health teaching regarding the side effects of COCs. These side effects are attributed to estrogen, progesterone, or both. Which side effects are related to the use of COCs? *(Select all that apply.)*

a. Gallbladder disease
b. Myocardial infarction and stroke
c. Hypotension
d. Breast tenderness and fluid retention
e. Dry skin and scalp

ANS: A, B, D

Serious side effects include stroke, myocardial infarction, hypertension, gallbladder disease, and liver tumors. More common side effects include nausea, breast tenderness, fluid retention, increased appetite, oily skin and scalp, and chloasma.

DIF: Cognitive Level: Understand REF: IMS: 184

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. The client and her partner are considering male sterilization as a form of permanent birth control. While educating the client regarding the risks and benefits of the procedure, which information should the nurse include? *(Select all that apply.)*

a. Sterilization should be performed under general anesthesia.
b. Pain, bleeding, and infection are possible complications.
c. Pregnancy may still be possible.
d. Vasectomy may affect potency.
e. Secondary sex characteristics are unaffected.

ANS: B, C, E

Vasectomy is the most commonly used procedure for male sterilization and is performed on an outpatient basis under local anesthesia. Pain, bleeding, swelling, and infection are considered complications. Reversal is generally unsuccessful; however, it may take several weeks to months for all sperm to be cleared from the sperm ducts. Another form of contraception is necessary until the sperm counts are zero. Vasectomy has no effect on potency, and secondary sex characteristics are not affected.

DIF: Cognitive Level: Understand REF: IMS: 190

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

COMPLETION

1. The practice of the calendar rhythm method is based on the number of days in each menstrual cycle. The fertile period is determined after monitoring each cycle for 6 months. The beginning of the fertile period is estimated by subtracting 18 days from the longest cycle and 11 days from the shortest. If the womans cycles vary in length from 24 to 30 days, then her fertile period would be day _____ through day _____.

ANS:

6; 19

To avoid pregnancy, the couple must abstain from intercourse on days 6 through 19. Ovulation occurs on day 12 (plus or minus 2 days either way).

Chapter 9: Infertility

MULTIPLE CHOICE

1. Which test is performed around the time of ovulation to diagnose the basis of infertility?

a. Hysterosalpingogram
b. Ultrasonography
c. Laparoscopy
d. Follicle-stimulating hormone (FSH) level

ANS: B

Ultrasonography is performed around the time of ovulation to assess pelvic structures for abnormalities, to verify follicular development, and to assess the thickness of the endometrium. A hysterosalpingogram is scheduled 2 to 5 days after menstruation to avoid flushing a potentially fertilized ovum out through a uterine tube into the peritoneal cavity. Laparoscopy is usually scheduled early in the menstrual cycle. Hormone analysis is performed to assess endocrine function of the hypothalamic-pituitary-ovarian axis when menstrual cycles are absent or irregular.

DIF: Cognitive Level: Understand REF: IMS: 201 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

2. An infertility specialist prescribes clomiphene citrate (Clomid, Serophene) for a woman experiencing infertility. She is very concerned about the risk of multiple pregnancies. What is the nurses most appropriate response?

a. This is a legitimate concern. Would you like to discuss further the chances of multiple pregnancies before your treatment begins?
b. No one has ever had more than triplets with Clomid.
c. Ovulation will be monitored with ultrasound to ensure that multiple pregnancies will not happen.
d. Ten percent is a very low risk, so you dont need to worry too much.

ANS: A

The incidence of multiple pregnancies with the use of these medications is higher than 25%. The clients concern is legitimate and should be discussed so that she can make an informed decision. Stating that no one has ever had more than triplets with Clomid is inaccurate and negates the clients concerns. Ultrasound cannot ensure that a multiple pregnancy will not occur, and 10% is inaccurate. Furthermore, the clients concern is discredited with a statement such as, dont worry.

DIF: Cognitive Level: Apply REF: IMS: 208 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A man smokes two packs of cigarettes a day. He wants to know if smoking is contributing to the difficulty he and his wife are having getting pregnant. Which guidance should the nurse provide?

a. Your sperm count seems to be okay in the first semen analysis.
b. Only marijuana cigarettes affect sperm count.
c. Although smoking has no effect on sperm count, it can give you lung cancer.
d. Smoking can reduce the quality of your sperm.

ANS: D

Cigarette smoking has detrimental effects on sperm and has been associated with abnormal sperm, a decreased number of sperm, and chromosomal damage. The nurse may suggest a smoking cessation program to increase the fertility of the male partner. Sperm counts vary from day to day and are dependent on emotional and physical status and sexual activity. Therefore, a single analysis may be inconclusive. A minimum of two analyses must be performed several weeks apart to assess male fertility. Marijuana use may depress the number and motility of sperm. Smoking is indeed a causative agent for lung cancer.

DIF: Cognitive Level: Apply REF: IMS: 199 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

4. A couple comes in for an infertility workup, having attempted to achieve pregnancy for 2 years. The woman, 37 years of age, has always had irregular menstrual cycles but is otherwise healthy. The man has fathered two children from a previous marriage and had a vasectomy reversal 2 years ago. The man has had two normal semen analyses, but the sperm seem to be clumped together. What additional testing is needed?

a. Testicular biopsy
b. Antisperm antibodies
c. FSH level
d. Examination for testicular infection

ANS: C

This scenario does not indicate that the woman has had any testing related to her irregular menstrual cycles. Hormone analysis is performed to assess endocrine function of the hypothalamic-pituitary-ovarian axis when menstrual cycles are absent or irregular. Determining the blood levels of prolactin, FSH, luteinizing hormone (LH), estradiol, progesterone, and thyroid hormones may be necessary to diagnose the cause of the womans irregular menstrual cycles. A testicular biopsy is indicated only in cases of azoospermia (no sperm cells) or severe oligospermia (low number of sperm cells). Although unlikely to be the case because the husband has already produced children, antisperm antibodies may be produced by the man against his

own sperm. Examination for testicular infection would be performed before semen analysis. Furthermore, infection would affect spermatogenesis.

DIF: Cognitive Level: Analyze REF: IMS: 201 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

5. A couple is attempting to cope with an infertility problem. They want to know what they can do to preserve their emotional equilibrium. What is the nurses most appropriate response?

a. Tell your friends and family so that they can help you.
b. Talk only to other friends who are infertile, because only they can help.
c. Get involved with a support group. Ill give you some names.
d. Start adoption proceedings immediately, because adopting an infant can be very difficult.

ANS: C

Venting negative feelings may unburden the couple. A support group may provide a safe haven for the couple to share their experiences and gain insight from others experiences. Although talking about their feelings may unburden them of negative feelings, infertility can be a major stressor that affects the couples relationships with family and friends. Limiting their interactions to other infertile couples may be a beginning point for addressing psychosocial needs. However, depending on where the other couple is in their own recovery process, limiting their interactions may not be of assistance to them. Telling the couple to start adoption proceedings immediately is not supportive of the psychosocial needs of this couple and may be detrimental to their well-being.

DIF: Cognitive Level: Apply REF: IMS: 204

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. The nurse working with clients who have infertility concerns should be aware of the use of leuprolide acetate (Lupron) as a gonadotropin-releasing hormone (GnRH) agonist. For which condition would this medication be prescribed?

a. Anovulatory cycles
b. Uterine fibroids
c. Polycystic ovary disease (PCOD)
d. Luteal phase inadequacy

ANS: B

Leuprolide acetate is used to treat endometriosis and uterine fibroids. Anovulatory cycles are treated with Clomid, Serophene, Pergonal, or Profasi, all of which stimulate ovulation induction. Metrodin is used to treat PCOD. Progesterone is used to treat luteal phase inadequacy.

DIF: Cognitive Level: Remember REF: IMS: 206

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

7. Which condition would be inappropriate to treat with exogenous progesterone (human chorionic gonadotropin)?

a. Thyroid dysfunction
b. Recent miscarriage
c. PCOD
d. Oocyte retrieval

ANS: A

Synthroid is administered for anovulation associated with hypothyroidism. For women with polycystic ovulation syndrome or a history of miscarriage, oocyte retrieval may have insufficient progesterone and require exogenous progesterone until placental production is sufficient.

DIF: Cognitive Level: Remember REF: IMS: 205 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

8. In vitro fertilizationembryo transfer (IVF-ET) is a common approach for women with blocked fallopian tubes or with unexplained infertility and for men with very low sperm counts. A

husband and wife have arrived for their preprocedural interview. Which explanation regarding the procedure is *most* accurate?

a. The procedure begins with collecting eggs from your wifes ovaries.
b. A donor embryo will be transferred into your wifes uterus.
c. Donor sperm will be used to inseminate your wife.
d. Dont worry about the technical stuff; thats what we are here for.

ANS: A

A womans eggs are collected from her ovaries, fertilized in the laboratory with the partners sperm, and transferred to her uterus after normal embryonic development has occurred. Transferring a donor embryo to the womans uterus describes the procedure for a donor embryo. Inseminating the woman with donor sperm describes therapeutic donor insemination. Telling the client not to worry discredits the clients need for teaching and is not the most appropriate response.

DIF: Cognitive Level: Apply REF: IMS: 207 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

9. With regard to the assessment of female, male, or couple infertility, the nurse should be aware of which important information?

a. The couples religious, cultural, and ethnic backgrounds provide emotional clutter that does not affect the clinical scientific diagnosis.
b. The investigation will take several months and can be very costly.
c. The woman is assessed first; if she is not the problem, then the male partner is analyzed.
d. Semen analysis is for men; the postcoital test is for women.

ANS: B

Fertility assessment and diagnosis take time, money, and commitment from the couple. Religious, cultural, and ethnic-bred attitudes about fertility and related issues always have an

effect on diagnosis and assessment. Both partners are systematically and simultaneously assessed, first as individuals and then as a couple. Semen analysis is for men; however, the postcoital test is for the couple.

DIF: Cognitive Level: Apply REF: IMS: 199

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. The nurse is having her first meeting with a couple experiencing infertility. The nurse has formulated the nursing diagnosis, Deficient knowledge, related to lack of understanding of the reproductive process with regard to conception. Which nursing intervention does *not* apply to this diagnosis?

a. Assess the current level of factors promoting conception.
b. Provide information regarding conception in a supportive manner.
c. Evaluate the couples support system.
d. Identify and describe the basic infertility tests.

ANS: C

Evaluating the couples support system would be a nursing action more suitable to the diagnosis, Ineffective individual coping, related to the ability to conceive.

DIF: Cognitive Level: Analyze REF: IMS: 203 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

11. Male fertility declines slowly after age 40 years; however, no cessation of sperm production analogous to menopause in women occurs in men. What condition is *not* associated with advanced paternal age?

a. Autosomal dominant disorder
b. Schizophrenia
c. Autism spectrum disorder
d. Down syndrome

ANS: D

Paternal age older than 40 years is associated with an increased risk for autosomal dominant disorder, schizophrenia, and autism spectrum disorder in their offspring. Although Down syndrome can occur in any pregnancy, it is often associated with advanced maternal age.

DIF: Cognitive Level: Understand REF: IMS: 199

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

12. A woman inquires about herbal alternative methods for improving fertility. Which statement by the nurse is *most* appropriate when informing the client on which herbal preparations may improve ovulation induction therapy?

a. You should avoid nettle leaf, dong quai, and vitamin E while you are trying to get pregnant.
b. You may want to try black cohosh or phytoestrogens.
c. You should take vitamins E and C, selenium, and zinc.
d. Herbs have no bearing on fertility.

ANS: B

Ovulation therapy may have better outcomes when supplemented by black cohosh, progesterone, or plant estrogens. Antioxidant vitamins E and C, selenium, zinc, coenzyme 10, and ginseng have been shown to improve male fertility. Although most herbal remedies have not been clinically proven, many women find them helpful. They should be prescribed by a health care provider who has knowledge of herbalism.

DIF: Cognitive Level: Apply REF: IMS: 205 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. To provide adequate care, the nurse should be cognitive of which important information regarding infertility?

a. Is perceived differently by women and men.

b. Has a relatively stable prevalence among the overall population and throughout a womans potential reproductive years.
c. Is more likely the result of a physical flaw in the woman than in her male partner.
d. Is the same thing as sterility.

ANS: A

Women tend to be more stressed about infertility tests and to place more importance on having children. The prevalence of infertility is stable among the overall population, but it increases with a womans age, especially after age 40 years. Of cases with an identifiable cause, approximately 40% are related to female factors, 40% to male factors, and 20% to both partners. *Sterility* is the inability to conceive. *Infertility* or *subfertility* is a state of requiring a prolonged time to conceive.

DIF: Cognitive Level: Understand REF: IMS: 204

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. Although remarkable developments have occurred in reproductive medicine, assisted reproductive therapies are associated with numerous legal and ethical issues. Nurses can provide accurate information about the risks and benefits of treatment alternatives to enable couples to make informed decisions about their choice of treatment. Which concern is unnecessary for the nurse to address before treatment?

a. Risks of multiple gestation
b. Whether or how to disclose the facts of conception to offspring
c. Freezing embryos for later use
d. Financial ability to cover the cost of treatment

ANS: D

Although the method of payment is important, obtaining this information is not the responsibility of the nurse. Many states have mandated some form of insurance to assist couples with coverage for infertility. Multiple gestation is a risk of treatment of which the couple needs to be aware. To minimize the chance of multiple gestation, generally only three or fewer embryos are transferred.

The couple should be informed that multifetal reduction may be needed. Nurses can provide anticipatory guidance on this matter. Depending on the therapy chosen, donor oocytes, sperm, embryos, or a surrogate mother may be needed. Couples who have excess embryos frozen for later transfer must be fully informed before consenting to the procedure. A decision must be made regarding the disposal of embryos in the event of death or divorce or if the couple no longer wants the embryos at a future time.

DIF: Cognitive Level: Apply REF: IMS: 208

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

15. Which statement regarding gamete intrafallopian transfer (GIFT) is *most* accurate?

a. Semen is collected after laparoscopy.
b. Women must have two normal fallopian tubes.
c. Ovulation spontaneously occurs.
d. Ova and sperm are transferred to one tube.

ANS: D

Similar to in vitro fertilization (IVF), GIFT requires the woman to have at least one normal tube. Ovulation is induced, and the oocytes are aspirated during laparoscopy. Semen is collected before laparoscopy. The ova and sperm are then transferred to one uterine tube, permitting natural fertilization and cleavage.

DIF: Cognitive Level: Remember REF: IMS: 207

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. Significant advances have been made with most reproductive technologies. Which improvement has resulted in increased success related to preimplantation genetic diagnosis?

a. Embryos are transferred at the cleavage stage.

b. Embryos are transferred at the blastocyst stage.
c. More than two embryos can be transferred at a time.
d. Two cells are removed from each embryo.

ANS: B

Preimplantation genetic diagnosis can be performed on a single cell removed from each embryo after 3 to 4 days. With the availability of extended culture mediums, embryos are transferred at the blastocyst stage (day 5), which increases the chance of a live birth, compared with the older practice of transferring embryos at the cleavage stage (day 3). No more than two embryos should be transferred at a time.

DIF: Cognitive Level: Understand REF: IMS: 207

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

17. An infertile woman is about to begin pharmacologic treatment. As part of the regimen, she will take purified FSH (Metrodin). The nurse instructs her that this medication is administered in the form of what?

a. Intranasal spray
b. Vaginal suppository
c. Intramuscular (IM) injection
d. Tablet

ANS: C

Metrodin is only administered by IM injection, and the dose may vary. An intranasal spray or a vaginal suppository are not appropriate routes for Metrodin, nor can Metrodin be given by mouth in tablet form.

DIF: Cognitive Level: Comprehend REF: IMS: 206

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

18. A couple arrives for their first appointment at an infertility center. Which of the following is a noninvasive test performed during the initial diagnostic phase of testing?

a. Hysterosalpingogram
b. Endometrial biopsy
c. Sperm analysis
d. Laparoscopy

ANS: C

Sperm analysis is the basic noninvasive test performed during initial diagnostic phase of testing for male infertility. Radiographic film examination allows visualization of the uterine cavity after the instillation of a radiopaque contrast medium through the cervix. The endometrial biopsy is an invasive procedure, during which a small cannula is introduced into the uterus and a portion of the endometrium is removed for histologic examination. Laparoscopy is useful to view the pelvic structures intraperitoneally and is an invasive procedure.

DIF: Cognitive Level: Comprehend REF: pp. 202-203 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Many factors, male and female, contribute to normal fertility. Approximately 40% of cases of infertility are related to the female partner. Which factors are possible causes for female infertility? *(Select all that apply.)*

a. Congenital or developmental
b. Hormonal or ovulatory
c. Tubal or peritoneal
d. Uterine
e. Emotional or psychologic

ANS: A, B, C, D

Female infertility can be attributed to alterations in any one of these systems along with possible vaginal-cervical factors. Although the diagnosis and treatment of infertility require considerable emotional investment and may cause psychologic stress, these are not considered factors associated with infertility. Feelings connected with infertility are many and complex. Resolve is an organization that provides support, advocacy, and education for both clients and health care providers.

DIF: Cognitive Level: Remember REF: pp. 197-199

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. A probable cause for increasing infertility is the societal delay in pregnancy until later in life. What are the natural reasons for the decrease in female fertility? *(Select all that apply.)*

a. Ovulation dysfunction
b. Endocrine dysfunction
c. Organ damage from toxins
d. Endometriosis
e. Tubal infections

ANS: A, C, D, E

All of these factors may result in a cumulative effect, decreasing fertility in women. Male infertility is more often caused by unfavorable sperm production attributable to endocrine dysfunction or cumulative metabolic disease.

DIF: Cognitive Level: Comprehend REF: IMS: 197

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Women who have undergone an oophorectomy, have ovarian failure, or a genetic defect may be eligible to receive donor oocytes (eggs). Which statements regarding oocyte donation are accurate? *(Select all that apply.)*

a. Donor is inseminated with semen from the parent.

b. Donor eggs are fertilized with the male partners sperm.
c. Donors are under 35 years of age.
d. Recipient undergoes hormonal stimulation.
e. Ovum is placed into a surrogate.

ANS: B, C, D

Oocyte donation is usually provided by healthy women under the age of 35 years, who are recruited and paid to undergo ovarian stimulation and oocyte retrieval. The donor eggs are fertilized in a laboratory with the male partners sperm. The woman undergoes hormonal stimulation to allow the development of the uterine lining. Embryos are then transferred. A donor that is inseminated with the male partners semen or receives the fertilized ovum and then carries it to gestation is known as a *surrogate mother*.

DIF: Cognitive Level: Understand REF: IMS: 207

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. Which procedure falls into the category of micromanipulation techniques of the follicle? *(Select all that apply.)*

a. Intrauterine insemination
b. Preimplantation genetic diagnosis
c. Intracytoplasmic sperm injection (ISCI)
d. Assisted hatching
e. IVF-ET

ANS: C, D

ISCI makes it possible to achieve fertilization even with a few or poor quality sperm by introducing sperm beneath the zone pellucid into the egg. Another micromanipulation technique is assisted hatching.

Chapter 10: Problems of the Breast

MULTIPLE CHOICE

1. A nurse is providing breast care education to a client after mammography. Which information regarding fibrocystic changes in the breast is important for the nurse to share?

a. Fibrocystic breast disease is a disease of the milk ducts and glands in the breasts.
b. It is a premalignant disorder characterized by lumps found in the breast tissue.
c. Healthy women with fibrocystic breast disease find lumpiness with pain and tenderness in varying degrees in the breast tissue during menstrual cycles.
d. Lumpiness is accompanied by tenderness after menses.

ANS: C

Fibrocystic changes are palpable thickenings in the breast usually associated with pain and tenderness. The pain and tenderness fluctuate with the menstrual cycle. Fibrocystic changes are not premalignant changes; this information is inaccurate. Tenderness most often occurs before menses.

DIF: Cognitive Level: Apply REF: IMS: 212

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. A nurse is providing education to a support group of women newly diagnosed with breast cancer. It is important for the nurse to discuss which factor related to breast cancer with the group?

a. Genetic mutations account for 50% of women who will develop breast cancer.
b. Breast cancer is the leading cause of cancer death in women.
c. In the United States, 1 in 10 women will develop breast cancer in her lifetime.
d. The exact cause of breast cancer remains unknown.

ANS: D

The exact cause of breast cancer is unknown. Between 15% and 20% of these cancers are related to genetic mutations. Breast cancer is the second leading cause of cancer death in woman ages 45 to 55 years. One in eight women in the United States will develop breast cancer in her lifetime.

DIF: Cognitive Level: Apply REF: IMS: 215

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Which diagnostic test is used to confirm a suspected diagnosis of breast cancer?

a. Mammogram
b. Ultrasound
c. Needle-localization biopsy
d. Magnetic resonance imaging (MRI)

ANS: C

When a suspicious mammogram is noted or a lump is detected, diagnosis is confirmed by either a core-needle biopsy or a needle-localization biopsy. Mammography is a clinical screening tool that may aid in the early detection of breast cancers. Transillumination, thermography, and ultrasound breast imaging are being explored as methods for detecting early breast carcinoma. An MRI is useful in women with masses that are difficult to find (occult breast cancer).

DIF: Cognitive Level: Understand REF: IMS: 218 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

4. A healthy 60-year-old African-American woman regularly receives health care at her neighborhood clinic. She is due for a mammogram. At her first visit, her health care provider is concerned about the 3-week wait at the neighborhood clinic and made an appointment for her to have a mammogram at a teaching hospital across town. She did not keep her appointment and returned to the clinic today to have the nurse check her blood pressure. What is the *most* appropriate statement for the nurse to make to this client?

a. Do you have transportation to the teaching hospital so that you can get your mammogram?
b. Im concerned that you missed your appointment; let me make another one for you.
c. Its very dangerous to skip your mammograms; your breasts need to be checked.
d. Would you like me to make an appointment for you to have your mammogram here?

ANS: D

Offering to make an appointment for the client at the neighborhood location is nonjudgmental and gives her options as to where she may have her mammogram. Furthermore, it is an innocuous way to investigate the reasons the client missed her previous appointment. Mortality rates from breast cancer remain high for African-American women. Rather than reminding this woman that she has missed her appointment, discussing the evidence behind the recommendations for a mammogram might be preferable for the nurse. The nurse can offer to reschedule should the client agree to return for the test. Telling the client that it is dangerous to skip mammograms can be perceived as judgmental and derogatory and may alienate and embarrass the client.

DIF: Cognitive Level: Apply REF: IMS: 217 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. A clients oncologist has just finished explaining the diagnostic workup results to her, and she still has questions. The woman states, The physician says I have a slow-growing cancer. Very few cells are dividing. How does she know this? What is the name of the test that gave the health care provider this information?

a. Tumor ploidy
b. S-phase index
c. Nuclear grade
d. Estrogen-receptor assay

ANS: B

The S-phase index measures the number of cells in the synthesis phase of cell development. If the number of cells noted is high, then the cancer is growing at a fast rate. In this clients case, her S-phase index is assumed to be low. Tumor ploidy is the amount of deoxyribonucleic acid (DNA) in a tumor cell, compared with that in a normal cell. Nuclear grade describes the degree of abnormalities present in the cancer cell tubules, the nuclei morphologic features, and mitotic rates. Estrogen and progesterone receptors are proteins found in the cell cytoplasm and surface of some breast cancer cells.

DIF: Cognitive Level: Understand REF: IMS: 219

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. Breast pain occurs in many women during their perimenopausal years. Which information is a priority for the nurse to share with the client?

a. Breast pain is an early indication of cancer.
b. Pain is almost always an indication of a solid mass.
c. Distinguishing between cyclical and noncyclical pain is important.
d. Breast pain is most often treated with narcotics.

ANS: C

Breast pain is unusual in breast cancer. Solid masses are generally benign and described as smooth, round, mobile, and painless. Distinguishing between cyclical and noncyclical pain is important to determine whether the cause is hormonal. Idiopathic pain is most often treated with nonsteroidal antiinflammatory medications.

DIF: Cognitive Level: Understand REF: IMS: 212

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

7. After a mastectomy, which activity should the client be instructed to avoid?

a. Emptying surgical drains twice a day and as needed

b. Lifting more than 4.5 kg (10 lb) or reaching above her head until given permission by her surgeon
c. Wearing clothing with snug sleeves to support the tissue of the arm on the operative side
d. Immediately reporting inflammation that develops at the incision site or in the affected arm

ANS: C

The woman should not be advised to wear snug clothing. She should be advised to avoid tight clothing, tight jewelry, and other apparel that might cause decreased circulation in the affected arm. As part of the teaching plan, the woman should be instructed to empty the surgical drains twice a day, to avoid lifting more than 4.5 kg (10 lb) or reaching above her head until given permission by her surgeon, and to report immediately any inflammation that develops at the incision site or in the affected arm.

DIF: Cognitive Level: Apply REF: IMS: 231 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

8. A health care provider performs a clinical breast examination on a woman diagnosed with fibroadenoma. How would the nurse explain the defining characteristics of a fibroadenoma?

a. Inflammation of the milk ducts and glands behind the nipples
b. Thick, sticky discharge from the nipple of the affected breast
c. Lumpiness in both breasts that develops 1 week before menstruation
d. Single lump in one breast that can be expected to shrink as the woman ages

ANS: D

Fibroadenomas are characterized by discrete, usually solitary lumps smaller than 3 cm in diameter. Fibroadenomas increase in size during pregnancy and shrink as the woman ages. Inflammation of the milk ducts and glands behind the nipples is associated with mammary duct ectasia, not fibroadenoma. Thick, sticky discharge from the nipple of the affected breast is

associated with galactorrhea, not fibroadenoma. Lumpiness in both breasts that develops 1 week before menstruation is associated with fibrocystic changes of the breast, not fibroadenoma.

DIF: Cognitive Level: Apply REF: IMS: 213

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

9. What important, immediate postoperative care practice should the nurse remember when caring for a woman who has had a mastectomy?

a. The blood pressure (BP) cuff should not be applied to the affected arm.
b. Venipuncture for blood work should be performed on the affected arm.
c. The affected arm should be used for intravenous (IV) therapy.
d. The affected arm should be held down close to the womans side.

ANS: A

The affected arm should not be used for BP readings, IV therapy, or venipuncture. The affected arm should be elevated with pillows above the level of the right atrium.

DIF: Cognitive Level: Apply REF: pp. 228, 229

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

10. A woman has a breast mass that is not well delineated and is nonpalpable, immobile, and nontender. Which condition is this client experiencing?

a. Fibroadenoma
b. Lipoma
c. Intraductal papilloma
d. Mammary duct ectasia

ANS: C

Intraductal papilloma is the only benign breast mass that is nonpalpable. Fibroadenoma is well delineated, palpable, and movable. Lipoma is palpable and movable. Mammary duct ectasia is not well delineated and is immobile, but it is palpable and painful.

DIF: Cognitive Level: Understand REF: IMS: 213 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

11. A client is concerned because she has been experiencing some milky, sticky breast discharge. Which nonmalignant condition is exhibited with this finding?

a. Relative inflammatory lesion
b. Galactorrhea
c. Mammary duct ectasia
d. Breast infection

ANS: B

Galactorrhea bilaterally exhibits a spontaneous, milky, and sticky discharge and is a normal finding during pregnancy; however, it may also occur as the result of elevated prolactin levels. Prolactin can become elevated as a result of a thyroid disorder, pituitary tumor, stress, coitus, trauma, or chest wall surgery.

DIF: Cognitive Level: Understand REF: IMS: 213 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

12. A client has been prescribed adjuvant tamoxifen therapy. What common side effect might she experience?

a. Weight gain, hot flashes, and blood clots
b. Vomiting, weight loss, and hair loss
c. Nausea, vomiting, and diarrhea
d. Hot flashes, weight gain, and headaches

ANS: A

Common side effects of tamoxifen therapy include hot flashes, weight gain, and blood clots. Weight loss, hair loss, diarrhea, and headaches are not common side effects of tamoxifen.

DIF: Cognitive Level: Apply REF: IMS: 215 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

13. Fibrocystic changes in the breast most often appear in women in their 20s and 30s. Although the cause is unknown, an imbalance of estrogen and progesterone may be the cause. The nurse who cares for this client should be aware that treatment modalities are conservative. Which proven modality may offer relief for this condition?

a. Diuretic administration
b. Daily inclusion of caffeine in the diet
c. Increased vitamin C supplementation
d. Application of cold packs to the breast as necessary

ANS: A

Diuretic administration plus a decrease in sodium and fluid intake are recommended. Although not supported by research, some advocate eliminating dimethylxanthines (caffeine) from the diet. Smoking should also be avoided, and alcohol consumption should be reduced. Vitamin E supplements are recommended; however, the client should avoid megadoses because vitamin E is a fat-soluble vitamin. Pain relief measures include applying heat to the breast, wearing a supportive bra, and taking nonsteroidal antiinflammatory drugs.

DIF: Cognitive Level: Apply REF: IMS: 212 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

14. What is the correct name describing a benign breast condition that includes dilation and inflammation of the collecting ducts?

a. Mammary duct ectasia
b. Intraductal papilloma
c. Chronic cystic disease
d. Fibroadenoma

ANS: A

Generally occurring in women approaching menopause, mammary duct ectasia results in a firm irregular mass in the breast, enlarged axillary nodes, and nipple discharge. Intraductal papillomas develop in the epithelium of the ducts of the breasts; as the mass grows, it causes trauma or erosion within the ducts. Chronic cystic disease causes pain and tenderness. The cysts that form are multiple, smooth, and well delineated. Fibroadenoma is evidenced by fibrous and glandular tissues. They are felt as firm, rubbery, and freely mobile nodules.

DIF: Cognitive Level: Understand REF: IMS: 213

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

15. Which client is most at risk for fibroadenoma of the breast?

a. 38-year-old woman
b. 50-year-old woman
c. 16-year-old girl
d. 27-year-old woman

ANS: C

Although it may occur at any age, fibroadenoma is most common in the teenage years. Ductal ectasia and intraductal papilloma become more common as a woman approaches menopause. Fibrocystic breast changes are more common during the reproductive years.

DIF: Cognitive Level: Understand REF: IMS: 213

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

16. Which client should the nurse refer for further testing?

a. Left breast slightly smaller than right breast
b. Eversion (elevation) of both nipples
c. Faintly visible bilateral symmetry of venous network
d. Small dimple located in the upper outer quadrant of the right breast

ANS: D

A small dimple is an abnormal finding and should be further evaluated. Nipple retraction and a dimpling or pitting of the skin is suggestive of a locally advanced, aggressive form of breast cancer. In many women, one breast is smaller than the other, and eversion of both nipples is a normal finding. Faintly visible venous network is also a normal finding.

DIF: Cognitive Level: Apply REF: IMS: 216 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

17. The most conservative approach for early breast cancer treatment involves lumpectomy followed by which procedure?

a. Radiation
b. Adjuvant systemic therapy
c. Hormonal therapy
d. Chemotherapy

ANS: A

Radiation therapy, in the form of either *brachytherapy* or *accelerated breast radiation,* is the standard therapy after lumpectomy for the treatment of early-stage breast cancer. Chemotherapy administered soon after surgical removal of the tumor is referred to as adjuvant chemotherapy. Not all women are candidates for hormonal therapy. After the entire tumor or portion is removed by excision, a receptor assay must be performed. Chemotherapy with multiple-drug

combinations is used in the treatment of recurrent and advanced breast cancer with positive results.

DIF: Cognitive Level: Apply REF: IMS: 221 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. Macromastia, or breast hyperplasia, is a condition in which women have very large and pendulous breasts. Breast hyperplasia can be corrected with a reduction mammoplasty. Which statement regarding this procedure is the*most* accurate?

a. Breast reduction surgery is covered by insurance.
b. Breastfeeding might be difficult.
c. No sequelae after the procedure is known.
d. Pain in the back and shoulders may not be relieved.

ANS: B

If breast reduction surgery is performed, then establishing breastfeeding at a later date may be difficult. Macromastia may not be covered by all insurance companies. A consequence of surgery may be decreased sensation and pain, secondary to scar tissue. Reduction mammoplasty will relieve chronic neck and back pain.

DIF: Cognitive Level: Apply REF: IMS: 211

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

19. Having a genetic mutation may create an 85% chance of developing breast cancer in a womans lifetime. Which condition does not increase a clients risk for breast cancer?

a. BRCA1 or BRCA2 gene mutation
b. Li-Fraumeni syndrome
c. Paget disease
d. Cowden syndrome

ANS: C

Paget disease originates in the nipple and causes nipple carcinoma and exhibits bleeding, oozing, and crusting of the nipple. BRCA1 or BRCA2, Li-Fraumeni syndrome, and Cowden syndrome are all genetic mutations that have different family pedigrees and increase the risk of breast cancer.

DIF: Cognitive Level: Remember REF: IMS: 215

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. A client is scheduled for surgery after a recent breast cancer diagnosis. The nurse is discussing the procedure with the client. To allay her fears, which explanation best describes a skin-sparing mastectomy?

a. Removal of the breast, nipple, and areola, leaving only the skin
b. Removal of the breast, nipple, areola, and axillary node dissection
c. Incision on the outside of the breast, leaving the nipple intact
d. Removal of both breasts in their entirety

ANS: A

A skin-sparing mastectomy is a special procedure that keeps the outer breast of the skin intact. The breast, nipple, and areola are removed. A tissue expander may be placed for later reconstruction. A modified radical mastectomy also removes the axillary lymph nodes. The nipple-sparing mastectomy is reserved for a small number of women during which the areola is removed leaving the nipple intact. Women who test positive for the BRCA1 or BRCA2 gene mutation may have both breasts removed to reduce the risk of cancer and is most commonly known as a prophylactic or preventative mastectomy.

DIF: Cognitive Level: Analyze REF: IMS: 219

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Researchers have found a number of common risk factors that increase a womans chance of developing a breast malignancy. It is essential for the nurse who provides care to women of any age to be aware of which risk factors? *(Select all that apply.)*

a. Family history
b. Late menarche
c. Early menopause
d. Race
e. Nulliparity or first pregnancy after age 40 years

ANS: A, D, E

Family history, race, and nulliparity or the first pregnancy after age 40 years are known risk factors for the development of breast cancer. Others risk factors include age, personal history of cancer, high socioeconomic status, sedentary lifestyle, hormone replacement therapy, recent use of oral contraceptives, never having breastfed a child, and drinking more than one alcoholic beverage per day. Early menarche and late menopause are not risk factors for breast malignancy.

DIF: Cognitive Level: Understand REF: IMS: 215

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. Cellulitis with or without abscess formation is a fairly common condition. The nurse is providing education for a client whose presentation to the emergency department includes an infection of the breast. Which information should the nurse share with this client? *(Select all that apply.)*

a. Nipple piercing may be the cause of a recent infection.
b. Treatment for cellulitis will include antibiotics.
c. *Streptococcus aureus* is the most common pathogen.
d. Obesity, smoking, and diabetes are risk factors.
e. Breast is pale in color and cool to the touch.

ANS: A, B, D

The at-risk population for breast infection shares characteristics such as large breasts, obesity, previous surgeries, sebaceous cysts, smoking, diabetes, and recent nipple piercing. The most common pathogen is*Staphylococcus aureus*. Presentation of cellulitis of the breast includes pain, reddening, and warmth to the touch; treatment includes antibiotics and/or aspiration.

DIF: Cognitive Level: Apply REF: IMS: 214

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

3. Guidelines for breast cancer screening continue to evolve as new evidence is generated. Which examination or procedure and frequency would be recommended for a 31-year-old asymptomatic client? *(Select all that apply.)*

a. Annual mammography
b. Clinical breast examination every 3 years
c. Annual MRI
d. Breast self-examination
e. Mammography every 3 years

ANS: B, D

A 31-year-old client with no risk factors and who is asymptomatic should perform breast self-examination on a regular basis and have a clinical breast examination every 3 years. Women who are 40 years of age and older require both mammography and clinical breast examination annually. High-risk women 30 years and older should have an annual MRI and mammogram.

DIF: Cognitive Level: Apply REF: IMS: 217

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. Chemotherapy with multiple drug agents is used in the treatment of recurrent and advanced breast cancer with positive results. Which side effects would the nurse anticipate for the client once treatment has begun? *(Select all that apply.)*

a. Hair loss

b. Severe constipation
c. Anemia
d. Leukopenia
e. Thrombocytopenia

ANS: A, C, D, E

Because chemotherapeutic agents rapidly kill reproducing cells, treatment also affects normal cells that frequently reproduce. The side effects that the nurse would anticipate and on which the nurse will provide education include partial or full hair loss, gastrointestinal effects (e.g., nausea, vomiting, anorexia, mucositis), leukopenia, neutropenia, thrombocytopenia, and anemia.

Chapter 11: Structural Disorders and Neoplasms of the Reproductive System

MULTIPLE CHOICE

1. The nurse should be aware that a pessary is most effective in the treatment of which disorder?

a. Cystocele
b. Uterine prolapse
c. Rectocele
d. Stress urinary incontinence

ANS: B

A fitted pessary may be inserted into the vagina to support the uterus and hold it in the correct position. Usually a pessary is used for only a short time and is not used for the client with a cystocele. A rectocele cannot be corrected by the use of a pessary. A pessary is not likely the most effective treatment for stress incontinence.

DIF: Cognitive Level: Remember REF: IMS: 235 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

2. A postmenopausal woman has been diagnosed with two leiomyomas (fibroids). Which clinical finding is most commonly associated with the presence of leiomyomas?

a. Abnormal uterine bleeding
b. Diarrhea
c. Weight loss
d. Acute abdominal pain

ANS: A

Most women are asymptomatic. Abnormal uterine bleeding is the most common symptom of leiomyomas. Diarrhea is not commonly associated with leiomyomas. Weight loss does not usually occur in the woman with leiomyomas, and the client with leiomyomas is unlikely to experience abdominal pain.

DIF: Cognitive Level: Understand REF: IMS: 240

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. Which woman is at the greatest risk for psychologic complications after hysterectomy?

a. 55-year-old woman who has been having abnormal bleeding and pain for 3 years
b. 46-year-old woman who has had three children and has just been promoted at work
c. 62-year-old widow who has three friends who have had uncomplicated hysterectomies
d. 19-year-old woman who had a ruptured uterus after giving birth to her first child

ANS: D

The 19-year-old woman is still in her childbearing years. Often the uterus is related to self-concept in women in this age group, and they may feel that sexual functioning is related to having a uterus. The 55-year-old woman is past her childbearing years and has had bleeding and pain for 3 years. The hysterectomy may be well received as a method of pain relief. The 46-year-old woman has a family and positive events occurring in her life (job promotion). The 62-year-

old woman is past her reproductive years and has relationships with others who have had positive outcomes.

DIF: Cognitive Level: Understand REF: IMS: 243 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

4. A 48-year-old woman has just had a hysterectomy for endometrial cancer. Which statement alerts the nurse that further teaching is needed?

a. I cant wait to go on the cruise that I have planned for this summer.
b. I know that the surgery saved my life, but I will miss having sexual intercourse with my husband.
c. I have asked my daughter to come and stay with me next week after I am discharged from the hospital.
d. Well, I dont have to worry about getting pregnant anymore.

ANS: B

Stating that she will miss having sexual intercourse with her husband indicates that further teaching is needed for this client regarding sexual activities after a hysterectomy. Although intercourse may be initially uncomfortable, the use of water-soluble lubricants, relaxation exercises, and changes in position may be helpful. Expressing plans for a vacation is a positive psychologic state with plans for the future. Stating that her daughter will stay with her indicates the client understands that she may need assistance during her acute recovery period. Stating that she no longer needs to worry about getting pregnant indicates knowledge related to the reproductive cycle and a positive outlook.

DIF: Cognitive Level: Apply REF: IMS: 244 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

5. The nurse provides education to a client about to undergo external radiation therapy. Which statement by the client reassures the nurse that the teaching has been effective?

a. I am using ointment to keep my skin from drying out.

b. I wash the irradiated area with deodorant soap.
c. My diet is high in protein, and I drink at least 2000 ml of fluid a day.
d. I wash off the markings for the radiation site after each treatment.

ANS: C

To maintain good nutrition, the woman should eat high-protein meals or use protein supplements and should have a high daily fluid intake of 2 to 3 L. The woman is counseled about good skin care and taught to avoid soaps, ointments, cosmetics, and deodorants because these may contain metals that would alter the radiation dose she receives. Markings may be made to indicate the exact location needed for irradiation and should remain until the treatment is complete.

DIF: Cognitive Level: Understand REF: IMS: 253 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

6. With regard to the treatment plan for a pregnant woman with gynecologic cancer, which statement about timing or type of treatment is *correct*?

a. The fetus is most at risk during the first trimester.
b. The fetus is most at risk during the second trimester.
c. The fetus is most at risk during the third trimester.
d. Surgery is more risky than chemotherapy in the first trimester.

ANS: A

The first trimester is the most vulnerable period for the growing fetus. Women may be faced with making a decision about terminating the pregnancy, depending on the stage and extent of the disease. For advanced disease in the second trimester, alkylating agents, 5-fluorouracil (5-FU), and vincristine are relatively safe for the fetus. For advanced disease in the third trimester, alkylating agents, 5-FU, and vincristine are relatively safe for the fetus. Surgery is less risky than chemotherapy in the first trimester.

DIF: Cognitive Level: Apply REF: IMS: 262 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. Which precaution should the nurse take while caring for a client who is undergoing internal radiation therapy for cervical cancer?

a. Wear gloves when assessing the cervical intracavity implant.
b. Instruct the client to urinate in the lead-lined bedpan or hat every 2 hours.
c. Prepare the client for an enema before inserting the implant.
d. Limit staff or visitor exposure to 30 minutes or less in an 8-hour period.

ANS: D

Staff and visitor exposure should be limited to 30 minutes or less in an 8-hour period to reduce the risk of overexposure to radiation. Nurses need to protect themselves from overexposure to radiation. Wearing a shield is one method of protection. An indwelling catheter is inserted to prevent urinary distention that could dislodge the applicator. No bowel preparation is necessary.

DIF: Cognitive Level: Apply REF: IMS: 255

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

8. What is the most common reproductive tract cancer associated with pregnancy?

a. Cervical
b. Uterine
c. Ovarian
d. Fallopian tube

ANS: A

The incidence of cervical cancer concurrent with pregnancy is reported to be 1 in 2000 pregnancies making it the most common reproductive tract cancer associated with pregnancy. Uterine cancer is rarely diagnosed during pregnancy. Ovarian cancer is the second most frequent

cancer diagnosis in pregnancy. At an incidence rate of approximately 1%, fallopian tube cancer remains a rare occurrence. The peak incidence of tubal cancer is between the ages of 50 and 55 years; for this cancer to be concurrent with pregnancy is only a remote possibility.

DIF: Cognitive Level: Remember REF: IMS: 260

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. When caring for clients with neoplasms of the reproductive system, the nurse must begin by assessing the womans knowledge of the disorder, its management, and prognosis. This assessment should be followed by a nursing diagnosis. Which diagnosis fails to address the psychologic effect of these disorders?

a. Anxiety, related to surgical procedures
b. Disturbed body image, as a result of changes in anatomy
c. Risk for injury, related to lack of skill for self-care
d. Interrupted family processes

ANS: C

Although risk for injury, related to lack of skill for self-care, is appropriate to this clients condition, this diagnosis is more suited to the clients learning needs than the psychologic effect. Anxiety, related to surgical procedures, is appropriate for addressing psychosocial concerns; the client may also develop anxiety related to the diagnosis and prognosis and whether or not surgery is required. Disturbed body image is an applicable diagnosis; changes in her anatomy and function may also result in low self-esteem and ineffective coping skills. Interrupted family processes is a possible and acceptable diagnosis; functional and anatomic changes may result in the clients inability to fulfill her familial role. Depending on the severity of her condition, interrupted family processes could also lead to social isolation.

DIF: Cognitive Level: Analyze REF: IMS: 247 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

10. The prevalence of urinary incontinence (UI) increases as women age, with more than one third of the women in the United States suffering from some form of this disorder. The symptoms of mild-to-moderate UI can be successfully decreased by a number of strategies. Which of these should the nurse instruct the client to use first?

a. Pelvic floor support devices
b. Bladder training and pelvic muscle exercises
c. Surgery
d. Medications

ANS: B

Pelvic muscle exercises, known as Kegel exercises, along with bladder training can significantly decrease or entirely relieve stress incontinence in many women. Pelvic floor support devices, also known as pessaries, come in a variety of shapes and sizes. Pessaries may not be effective for all women and require scrupulous cleaning to prevent infection. Anterior and posterior repairs and even a hysterectomy may be performed. If surgical repair is performed, then the nurse must focus her care on preventing infection and helping the woman avoid putting stress on the surgical site. Pharmacologic therapy includes selective serotonin-norepinephrine reuptake inhibitors or vaginal estrogen therapy. However, pharmacologic therapy is not the first action a nurse should recommend.

DIF: Cognitive Level: Apply REF: IMS: 238

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

11. A woman exhibits symptoms that may lead to a possible diagnosis of polycystic ovary syndrome (PCOS). While completing the initial assessment of the client, which clinical finding would the nurse *not* anticipate?

a. Anorexia
b. Hirsutism
c. Irregular menses
d. Infertility

ANS: A

These clients often are obese rather than anorexic with weight loss. Approximately 40% of these women also display glucose intolerance and hyperinsulinemia. Excessive hair growth is often present in women with PCOS. This client is likely to have irregular menses or even amenorrhea. Infertility as a result of decreased levels of follicle-stimulating hormone is common with this syndrome.

DIF: Cognitive Level: Understand REF: IMS: 239

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

12. What information is important for the nurse to include in planning for the care of a woman who has had a vaginal hysterectomy?

a. Expect to be fully recovered in 4 to 6 weeks.
b. Expect no changes in her hormone levels.
c. Expect surgical menopause.
d. Take tub baths to aid in healing.

ANS: B

Unless the ovaries were also removed, hormonal levels should not change. Menses will cease, but the hypothalamus-pituitary-ovarian axis remains intact. The woman should expect to have vaginal discharge for 4 to 6 weeks. Full recovery varies from woman to woman, depending on risk factors and individual healing. Surgical menopause occurs only if the ovaries are also removed. The client should avoid tub baths, intercourse, and douching until after the follow-up examination.

DIF: Cognitive Level: Understand REF: IMS: 243 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

13. A woman has preinvasive cancer of the cervix. Which modality would the nurse discuss as an available option for a client with this condition?

a. Cryosurgery
b. Colposcopy
c. Hysterectomy
d. Internal radiation

ANS: A

Cryosurgery, laser surgery, and loop electrosurgical excision procedure (LEEP) are several techniques used to treat preinvasive lesions. Colposcopy is the examination of the cervix with a stereoscopic binocular microscope that magnifies the view of the cervix. This examination would have already been performed as part of the diagnosis of preinvasive cancer of the cervix. A hysterectomy is performed if the cancer has extended beyond the cervix. Women with positive pelvic nodes (indicating invasive cancer) usually receive whole pelvis irradiation.

DIF: Cognitive Level: Apply REF: IMS: 253 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

14. Which condition is the *most* common malignancy of the reproductive system?

a. Endometrial cancer
b. Cervical cancer
c. Ovarian cancer
d. Vulvar and vaginal cancer

ANS: A

Endometrial cancer occurs most frequently in Caucasian women and after menopause. Certain viral infections and sexually transmitted diseases (STIs) create risks for cervical cancer. Ovarian cancer is the most malignant reproductive system cancer and accounts for the most deaths. Cancers of the vulva and vagina are relatively rare.

DIF: Cognitive Level: Remember REF: IMS: 245

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

15. A client in late middle age who is certain she is not pregnant tells the nurse during an office visit that she has urinary problems, as well as sensations of bearing down and of something in her vagina. What condition would the nurse suspect based upon this report?

a. Pelvic relaxation
b. Cystoceles and/or rectoceles
c. Uterine prolapse
d. Genital fistulas

ANS: B

Uterine displacement can be caused by congenital or acquired weakness of the pelvic support structures and is known as *pelvic relaxation*. Cystoceles are protrusions of the bladder downward into the vagina; rectoceles are herniations of the anterior rectal wall through a relaxed or ruptured vaginal fascia. Both can produce a bearing-down sensation with urinary dysfunction. They occur more often in older women who have borne children. Uterine prolapse is a more serious type of displacement. In women with a complete prolapse, the cervix and body of the uterus protrude through the vagina. Genital fistulas are perforations between genital tract organs. Most occur between the bladder and the genital tract.

DIF: Cognitive Level: Analyze REF: pp. 235-236 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

16. Which woman has the highest risk for endometrial cancer?

a. Postmenopausal woman with hypertension
b. Woman who has an intrauterine device (IUD)
c. Client who has been on birth control for 15 years
d. Perimenopausal woman who has a cystocele

ANS: A

Endometrial cancer is most often seen in postmenopausal women between the ages of 50 and 65 years. Hypertension is a risk factor associated with the development of this malignancy. The use of an IUD does not increase a womans risk for endometrial cancer. A client who has been on birth control for 15 years is not at increased risk for endometrial cancer; the birth control contraceptives might actually offer some protection. The development of a cystocele will not increase a womans risk for endometrial cancer.

DIF: Cognitive Level: Understand REF: IMS: 245

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

17. A client has just returned from a uterine artery embolization (UAE) procedure. Before her discharge, a discussion concerning the symptoms that require a call to the provider postprocedure is very important. Which symptom would reassure the client that the procedure went well with no reason to call the provider?

a. Temperature of 39 C
b. Swelling or hematoma at the puncture site
c. Abnormal vaginal discharge
d. Urinary frequency

ANS: D

The physician should be notified if the client is experiencing urinary retention. Urinary frequency is not a complication of UAE. A body temperature of 39 C or higher may indicate the presence of an infectious process, and the physician should be notified. A slight fever or pain may be experienced as a result of acute fibroid degradations. Swelling or hematoma at the puncture site may be an indication of bleeding into the groin. The client should not experience any abnormal vaginal discharge (e.g., foul odor, brown color, brown tissue).

DIF: Cognitive Level: Apply REF: IMS: 241

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

18. A woman has arrived for her preoperative testing appointment. She is scheduled for a myomectomy the following day. What condition would require the client to undergo this procedure for symptom relief?

a. Numerous small fibroid tumors
b. Bartholin cysts
c. Fibroid tumors near the outer wall of the uterus with a uterine size no larger than at 12 weeks of gestation
d. Leiomyomas (also known as fibroid tumors) in a uterus larger than 14 weeks of gestation

ANS: C

If a fibroid tumor lies near the outer wall of the uterus and the uterine size is no larger than at 12 to 14 weeks of gestation and the symptoms are significant, a myomectomy (i.e., removal of the tumor) may be performed. This procedure leaves the uterine walls relatively intact, thereby preserving the uterus for future pregnancies. Laser surgery or electrocauterization can be safely used to destroy numerous small fibroid tumors. Bartholin cysts are benign lesions of the vulva. If the cyst is symptomatic or infected, surgical incision and drainage may provide relief. A hysterectomy (i.e., removal of the entire uterus) is the treatment of choice if bleeding is severe or if the fibroid tumor is obstructing the normal function of other organs.

DIF: Cognitive Level: Understand REF: IMS: 242

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

19. Which ovarian neoplasm is described as a growth that contains hair, teeth, and sebaceous secretions?

a. Ovarian fibroma
b. Dermoid cyst
c. Uterine polyp
d. Follicular cyst

ANS: B

Dermoid cysts are germ cell tumors, usually occurring in childhood, that may contain teeth, hair, bones, and sebaceous secretions and may unilaterally or bilaterally develop. Treatment is most often surgical removal. An ovarian fibroma is a solid ovarian neoplasm that develops from connective tissue, usually after menopause. A uterine polyp is a tumor that grows on the uterine wall on a stalk or pedicle. A follicular cyst develops within the ovaries of young women in response to follicle rupture and should resolve within one or two menstrual cycles.

DIF: Cognitive Level: Remember REF: IMS: 239 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. The client is undergoing treatment for ovarian cancer. Which common nutritional problems are related to gynecologic cancers and the treatment thereof? *(Select all that apply.)*

a. Stomatitis
b. Constipation
c. Increased appetite
d. Diarrhea
e. Nausea and vomiting

ANS: A, B, D, E

Altered taste, stomatitis, constipation, anorexia, diarrhea, and nausea and vomiting are all possible nutritional complications related to gynecologic cancers and their treatment. The nurse must assess accordingly and adapt the clients plan of care. To ensure recovery, these women should consume a diet high in iron and protein, drink plenty of fluids, and eat foods high in vitamins C, B, and K.

DIF: Cognitive Level: Apply REF: IMS: 248

TOP: Nursing Process: Assessment | Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. Leiomyomas (also known as fibroid tumors) are benign tumors arising from the muscle tissue of the uterus. Which information related to these tumors is accurate? *(Select all that apply.)*

a. Are rapid growing
b. Are more common in African-American women
c. Are more common in women who have never been pregnant
d. Obesity is a risk factor with leiomyomas
e. Become malignant if left untreated

ANS: B, C, D

The exact cause of leiomyomas remains unknown, although genetic factors may be involved in their development. Most are found in the body of uterus and are classified according to their location on the uterine wall. They are benign, slow growing, and often spontaneously shrink after menopause.

DIF: Cognitive Level: Understand REF: IMS: 240

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. The client has undergone hysteroscopic uterine ablation to destroy a number of smaller fibroids. The nurse is preparing to provide discharge instructions. Which information is a priority for the patient and should be included in the teaching plan? *(Select all that apply.)*

a. Analgesics and nonsteroidal antiinflammatory drugs can be used for pain control.
b. Vaginal discharge is to be expected for 5 to 7 days.
c. Sexual activity can be resumed after 48 hours.
d. Next menstrual period will be irregular.
e. Provider should be notified if heavy bleeding occurs.

ANS: A, D, E

Before discharging the client, the following information should be given: analgesics can be used for pain relief as needed, normal activities can be resumed within several days, vaginal discharge

is to be expected for 4 to 6 weeks, and the use of tampons and sexual activity should be avoided for 2 weeks. The next menstrual period will be irregular, and the provider should be notified for heavy bleeding or signs of infection.

Chapter 12: Conception and Fetal Development

MULTIPLE CHOICE

1. A newly married couple plans to use the natural family planning method of contraception. Understanding how long an ovum can live after ovulation is important to them. The nurse knows that his or her teaching was effective when the couple responds that an ovum is considered fertile for which period of time?

a. 6 to 8 hours
b. 24 hours
c. 2 to 3 days
d. 1 week

ANS: B

Most ova remain fertile for approximately 24 hours after ovulation, much longer than 6 to 8 hours. However, ova do not remain fertile for 2 to 3 days or are viable for 1 week. If unfertilized by a sperm after 24 hours, the ovum degenerates and is reabsorbed.

DIF: Cognitive Level: Understand REF: IMS: 266 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. What kind of fetal anomalies are most often associated with oligohydramnios?

a. Renal
b. Cardiac
c. Gastrointestinal
d. Neurologic

ANS: A

An amniotic fluid volume of less than 300 ml (oligohydramnios) is often associated with fetal renal anomalies. The amniotic fluid volume has no bearing on the fetal cardiovascular system. Gastrointestinal anomalies are associated with hydramnios or an amniotic fluid volume greater than 2 L. The amniotic fluid volume has no bearing on the fetal neurologic system.

DIF: Cognitive Level: Remember REF: IMS: 276

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. A pregnant woman at 25 weeks of gestation tells the nurse that she dropped a pan last week and her baby jumped at the noise. Which response by the nurse is *most* accurate?

a. That must have been a coincidence; babies cant respond like that.
b. The fetus is demonstrating the aural reflex.
c. Babies respond to sound starting at approximately 24 weeks of gestation.
d. Let me know if it happens again; we need to report that to your midwife.

ANS: C

Babies respond to external sound starting at approximately 24 weeks of gestation. Acoustic stimulations can evoke a fetal heart rate response. There is no such thing as an aural reflex. The last statement is inappropriate and may cause undue psychologic alarm to the client.

DIF: Cognitive Level: Apply REF: IMS: 276 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

4. At a routine prenatal visit, the nurse explains the development of the fetus to her client. At approximately ____ weeks of gestation, lecithin is forming on the alveolar surfaces, the eyelids open, and the fetus measures approximately 27 cm crown to rump and weighs approximately 1110 g. The client is how many weeks of gestation at todays visit?

a. 20

b. 24

c. 28

d. 30

ANS: C

These milestones in human development occur at 28 weeks of gestation. These milestones have not occurred by 20 or 24 weeks of gestation but have been reached before 30 weeks of gestation.

DIF: Cognitive Level: Understand REF: IMS: 280

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. Which statement regarding the structure and function of the placenta is *correct*?

a. Produces nutrients for fetal nutrition

b. Secretes both estrogen and progesterone

c. Forms a protective, impenetrable barrier to microorganisms such as bacteria and viruses

d. Excretes prolactin and insulin

ANS: B

As one of its early functions, the placenta acts as an endocrine gland, producing four hormones necessary to maintain the pregnancy and to support the embryo or fetus: human chorionic gonadotropin (hCG), human placental lactogen (hPL), estrogen, and progesterone. The placenta does not produce nutrients. It functions as a means of metabolic exchange between the maternal and fetal blood supplies. Many bacteria and viruses can cross the placental membrane.

DIF: Cognitive Level: Understand REF: IMS: 271

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. A woman in labor passes some thick meconium as her amniotic fluid ruptures. The client asks the nurse where the baby makes the meconium. What is the *correct* response by the nurse?

a. Fetal intestines
b. Fetal kidneys
c. Amniotic fluid
d. Placenta

ANS: A

As the fetus nears term, fetal waste products accumulate in the intestines as dark green-to-black, tarry meconium. Meconium is not produced by the fetal kidneys nor should it be present in the amniotic fluid, which may be an indication of fetal compromise. The placenta does not produce meconium.

DIF: Cognitive Level: Apply REF: IMS: 275

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

7. A woman asks the nurse, What protects my babys umbilical cord from being squashed while the babys inside of me? What is the nurses *best* response?

a. Your babys umbilical cord is surrounded by connective tissue called Whartons jelly, which prevents compression of the blood vessels.
b. Your babys umbilical cord floats around in blood and amniotic fluid.
c. You dont need to be worrying about things like that.
d. The umbilical cord is a group of blood vessels that are very well protected by the placenta.

ANS: A

Explaining the structure and function of the umbilical cord is the most appropriate response. Connective tissue called *Whartons jelly* surrounds the umbilical cord, prevents compression of the blood vessels, and ensures continued nourishment of the embryo or fetus. The umbilical cord does not float around in blood or fluid. Telling the client not to worry negates her need for information and discounts her feelings. The placenta does not protect the umbilical cord.

DIF: Cognitive Level: Apply REF: IMS: 270 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. Which structure is responsible for oxygen and carbon dioxide transport to and from the maternal bloodstream?

a. Decidua basalis
b. Blastocyst
c. Germ layer
d. Chorionic villi

ANS: D

Chorionic villi are fingerlike projections that develop out of the trophoblast and extend into the blood-filled spaces of the endometrium. The villi obtain oxygen and nutrients from the maternal bloodstream and dispose carbon dioxide and waste products into the maternal blood. The decidua basalis is the portion of the decidua (endometrium) under the blastocyst where the villi attach. The blastocyst is the embryonic development stage after the morula; implantation occurs at this stage. The germ layer is a layer of the blastocyst.

DIF: Cognitive Level: Understand REF: IMS: 270

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. A woman who is 8 months pregnant asks the nurse, Does my baby have any antibodies to fight infection? What is the *most* appropriate response by the nurse?

a. Your baby has all the immunoglobulins necessary: immunoglobulin G (IgG), immunoglobulin M (IgM), and immunoglobulin A (IgA).
b. Your baby wont receive any antibodies until he is born and you breastfeed him.
c. Your baby does not have any antibodies to fight infection.
d. Your baby has IgG and IgM.

ANS: D

During the third trimester, IgG is the only immunoglobulin that crosses the placenta; it provides passive acquired immunity to specific bacterial toxins. However, the fetus produces IgM by the end of the first trimester. IgA immunoglobulins are not produced by the baby. Therefore, by the third trimester, the fetus has both IgG and IgM. Breastfeeding supplies the newborn infant with IgA.

DIF: Cognitive Level: Apply REF: IMS: 277 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

10. The measurement of lecithin in relation to sphingomyelin (lecithin/sphingomyelin [L/S] ratio) is used to determine fetal lung maturity. Which ratio reflects fetal maturity of the lungs?

a. 1.4:1
b. 1.8:1
c. 2:1
d. 1:1

ANS: C

The L/S ratio indicates a 2:1 ratio of lecithin to sphingomyelin, which is an indicator of fetal lung maturity and occurs at approximately the middle of the third trimester. L/S ratios of 1.4:1, 1.8:1, and 1:1 each indicate immaturity of the fetal lungs.

DIF: Cognitive Level: Remember REF: IMS: 275 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

11. A client arrives for her initial prenatal examination. This is her first child. She asks the nurse, How does my baby get air inside my uterus? What is the *correct* response by the nurse?

a. The babys lungs work in utero to exchange oxygen and carbon dioxide.
b. The baby absorbs oxygen from your blood system.
c. The placenta provides oxygen to the baby and excretes carbon dioxide into your bloodstream.

d. The placenta delivers oxygen-rich blood through the umbilical artery to the babys abdomen.

ANS: C

The placenta delivers oxygen-rich blood through the umbilical vein, not the artery, to the fetus and excretes carbon dioxide into the maternal bloodstream. The fetal lungs do not function as respiratory gas exchange in utero. The baby does not simply absorb oxygen from a womans blood system; rather, blood and gas transport occur through the placenta.

DIF: Cognitive Level: Apply REF: IMS: 271 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. What is the *most* basic information that a nurse should be able to share with a client who asks about the process of conception?

a. Ova are considered fertile 48 to 72 hours after ovulation.
b. Sperm remain viable in the womans reproductive system for an average of 12 to 24 hours.
c. Conception is achieved when a sperm successfully penetrates the membrane surrounding the ovum.
d. Implantation in the endometrium occurs 6 to 10 days after conception.

ANS: D

After implantation, the endometrium is called the *decidua*. Ova are considered fertile for approximately 24 hours after ovulation. Sperm remain viable in the womans reproductive system for an average of 2 to 3 days. Penetration of the ovum by the sperm is called *fertilization*. Conception occurs when the zygote, the first cell of the new individual, is formed.

DIF: Cognitive Level: Remember REF: IMS: 267

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. The maternity nurse is cognizant of what important structure and function of the placenta?

a. As the placenta widens, it gradually thins to allow easier passage of air and nutrients.
b. As one of its early functions, the placenta acts as an endocrine gland.
c. The placenta is able to keep out most potentially toxic substances, such as cigarette smoke, to which the mother is exposed.
d. Optimal blood circulation is achieved through the placenta when the woman is lying on her back or standing.

ANS: B

The placenta produces four hormones necessary to maintain the pregnancy: hCG, hPL, estrogen, and progesterone. The placenta widens until 20 weeks of gestation and continues to grow thicker. Toxic substances such as nicotine and carbon monoxide readily cross the placenta into the fetus. Optimal circulation occurs when the woman is lying on her side.

DIF: Cognitive Level: Understand REF: IMS: 271

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. Which statement regarding the development of the respiratory system is a high priority for the nurse to understand?

a. The respiratory system does not begin developing until after the embryonic stage.
b. The infants lungs are considered mature when the L/S ratio is 1:1, at approximately 32 weeks of gestation.
c. Maternal hypertension can reduce maternal-placental blood flow, accelerating lung maturity.
d. Fetal respiratory movements are not visible on ultrasound scans until at least 16 weeks of gestation.

ANS: C

A reduction in placental blood flow stresses the fetus, increases blood levels of corticosteroids, and thus accelerates lung maturity. The development of the respiratory system begins during the embryonic phase and continues into childhood. The infants lungs are considered mature when

the L/S ratio is 2:1, at approximately 35 weeks of gestation. Lung movements have been visualized on ultrasound scans at 11 weeks of gestation.

DIF: Cognitive Level: Understand REF: IMS: 275 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

15. The various systems and organs of the fetus develop at different stages. Which statement is *most* accurate?

a. Cardiovascular system is the first organ system to function in the developing human.
b. Hematopoiesis originating in the yolk sac begins in the liver at 10 weeks of gestation.
c. Body changes from straight to C-shape occurs at 8 weeks of gestation.
d. Gastrointestinal system is mature at 32 weeks of gestation.

ANS: A

The heart is developmentally complete by the end of the embryonic stage. Hematopoiesis begins in the liver during the sixth week. The body becomes C-shaped at 21 weeks of gestation. The gastrointestinal system is complete at 36 weeks of gestation.

DIF: Cognitive Level: Remember REF: IMS: 273

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. Which statement concerning neurologic and sensory development in the fetus is *correct*?

a. Brain waves have been recorded on an electroencephalogram as early as the end of the first trimester (12 weeks of gestation).
b. Fetuses respond to sound by 24 weeks of gestation and can be soothed by the sound of the mothers voice.
c. Eyes are first receptive to light at 34 to 36 weeks of gestation.
d. At term, the fetal brain is at least one third the size of an adult brain.

ANS: B

Hearing develops early and is fully developed at birth. Brain waves have been recorded at week 8. Eyes are receptive to light at 28 weeks of gestation. The fetal brain is approximately one fourth the size of an adult brain.

DIF: Cognitive Level: Remember REF: IMS: 276 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. A womans cousin gave birth to an infant with a congenital heart anomaly. The woman asks the nurse when such anomalies occur during development. Which response by the nurse is *most* accurate?

a. We dont really know when such defects occur.
b. It depends on what caused the defect.
c. Defects occur between the third and fifth weeks of development.
d. They usually occur in the first 2 weeks of development.

ANS: C

The cardiovascular system is the first organ system to function in the developing human. Blood vessel and blood formation begins in the third week, and the heart is developmentally complete in the fifth week. We dont really know when such defects occur is an inaccurate statement. Regardless of the cause, the heart is vulnerable during its period of developmentin the third to fifth weeks; therefore, the statement, They usually occur in the first 2 weeks of development is inaccurate.

DIF: Cognitive Level: Apply REF: IMS: 273 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

18. Which information regarding amniotic fluid is important for the nurse to understand?

a. Amniotic fluid serves as a source of oral fluid and a repository for waste from the fetus.

b. Volume of the amniotic fluid remains approximately the same throughout the term of a healthy pregnancy.

c. The study of fetal cells in amniotic fluid yields little information.

d. A volume of more than 2 L of amniotic fluid is associated with fetal renal abnormalities.

ANS: A

Amniotic fluid serves as a source of oral fluid, serves as a repository for waste from the fetus, cushions the fetus, and helps maintain a constant body temperature. The volume of amniotic fluid constantly changes. The study of amniotic fluid yields information regarding the sex of the fetus and the number of chromosomes. Too much amniotic fluid (hydramnios) is associated with gastrointestinal and other abnormalities.

DIF: Cognitive Level: Understand REF: IMS: 270

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. An expectant couple attending childbirth classes have questions regarding multiple births since twins run in the family. What information regarding multiple births is important for the nurse to share?

a. Twinning and other multiple births are increasing because of the use of fertility drugs and delayed childbearing.

b. Dizygotic twins (two fertilized ova) have the potential to be conjoined twins.

c. Identical twins are more common in Caucasian families.

d. Fraternal twins are the same gender, usually male.

ANS: A

If the parents-to-be are older and have taken fertility drugs, then they would be very interested to know about twinning and other multiple births. Conjoined twins are monozygotic; that is, they are from a single fertilized ovum in which division occurred very late. Identical twins show no racial or ethnic preference, and fraternal twins are more common among African-American

women. Fraternal twins can be different genders or the same gender, and identical twins are the same gender.

DIF: Cognitive Level: Understand REF: IMS: 277 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. The nurse caring for a pregnant client is evaluating his or her health teaching regarding fetal circulation. Which statement from the client reassures the nurse that his or her teaching has been effective?

a. Optimal fetal circulation is achieved when I am in the side-lying position.
b. Optimal fetal circulation is achieved when I am on my back with a pillow under my knees.
c. Optimal fetal circulation is achieved when the head of the bed is elevated.
d. Optimal fetal circulation is achieved when I am on my abdomen.

ANS: A

Optimal circulation is achieved when the woman is lying at rest on her side. Decreased uterine circulation may lead to intrauterine growth restriction. Previously, it was believed that the left lateral position promoted maternal cardiac output, enhancing blood flow to the fetus. However, it is now known that the side-lying position enhances uteroplacental blood flow. If a woman lies on her back with the pressure of the uterus compressing the vena cava, then blood return to the right atrium is diminished. Although having the head of the bed elevated is recommended and ideal for later in pregnancy, the woman still must maintain a lateral tilt to the pelvis to avoid compressing the vena cava. Many women find lying on their abdomen uncomfortable as pregnancy advances. Side-lying is the ideal position to promote blood flow to the fetus.

DIF: Cognitive Level: Analyze REF: IMS: 273 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

21. Some of the embryos intestines remain within the umbilical cord during the embryonic period. What is the rationale for this development of the gastrointestinal system?

a. Umbilical cord is much larger at this time than it will be at the end of pregnancy.
b. Intestines begin their development within the umbilical cord.
c. Nutrient content of the blood is higher in this location.
d. Abdomen is too small to contain all the organs while they are developing.

ANS: D

The abdominal contents grow more rapidly than the abdominal cavity; therefore, part of their development takes place in the umbilical cord. By 10 weeks of gestation, the abdomen is large enough to contain them. Intestines begin their development within the umbilical cord but only because the liver and kidneys occupy most of the abdominal cavity. Blood supply is adequate in all areas.

DIF: Cognitive Level: Understand REF: IMS: 275

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

22. A woman is 15 weeks pregnant with her first baby. She asks how long it will be before she feels the baby move. What is the nurses *best* answer?

a. You should have felt the baby move by now.
b. Within the next month, you should start to feel fluttering sensations.
c. The baby is moving; however, you cant feel it yet.
d. Some babies are quiet, and you dont feel them move.

ANS: B

Maternal perception of fetal movement usually begins 16 to 20 weeks after conception. Because this is her first pregnancy, movement is felt toward the later part of the 16- to 20-week time period. Stating, you should have felt the baby move by now is incorrect and may be an alarming statement to the client. Fetal movement should be felt by 16 to 20 weeks. If movement is not felt by the end of that time, then further assessment is necessary.

DIF: Cognitive Level: Comprehend REF: IMS: 277

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

23. A new mother asks the nurse about the white substance covering her infant. How should the nurse explain the purpose of vernix caseosa?

a. Vernix caseosa protects the fetal skin from the amniotic fluid.
b. Vernix caseosa promotes the normal development of the peripheral nervous system.
c. Vernix caseosa allows the transport of oxygen and nutrients across the amnion.
d. Vernix caseosa regulates fetal temperature.

ANS: A

Prolonged exposure to the amniotic fluid during the fetal period could result in the breakdown of the skin without the protection of the vernix caseosa. Normal development of the peripheral nervous system was dependent on nutritional intake of the mother. The amnion was the inner membrane that surrounded the fetus and was not involved in the oxygen and nutrient exchange. The amniotic fluid helped maintain fetal temperature.

DIF: Cognitive Level: Remember REF: IMS: 277

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

24. A woman who is 16 weeks pregnant asks the nurse, Is it possible to tell by ultrasound if the baby is a boy or girl yet? What is the *best* answer?

a. A babys sex is determined as soon as conception occurs.
b. The baby has developed enough to enable us to determine the sex by examining the genitals through an ultrasound scan.
c. Boys and girls look alike until approximately 20 weeks after conception, and then they begin to look different.
d. It might be possible to determine your babys sex, but the external organs look very similar right now.

ANS: B

Although gender is determined at conception, the external genitalia of males and females look similar through the ninth week. By the twelfth week, the external genitalia are distinguishable as male or female.

DIF: Cognitive Level: Understand REF: pp. 276, 278

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

25. Which development related to the integumentary system is *correct*?

a. Very fine hairs called *lanugo* appear at 12 weeks of gestation.
b. Eyelashes, eyebrows, and scalp hair appear at 28 weeks of gestation.
c. Fingernails and toenails develop at 28 weeks of gestation.
d. By 32 weeks, scalp hair becomes apparent.

ANS: A

Very fine hairs, called *lanugo* appear first at 12 weeks of gestational age on the fetus eyebrows and upper lip. By 20 weeks of gestation, lanugo covers the entire body. By 20 weeks of gestation the eyelashes, eyebrows, and scalp hair also begin to grow. By 28 weeks of gestation, the scalp hair is longer than these fine hairs, which is thin and may disappear by term. Fingernails and toenails develop from thickened epidermis, beginning during the 10th week. Fingernails reach the fingertips at 32 weeks of gestation, and the toenails reach the toe tips at 36 weeks of gestation.

DIF: Cognitive Level: Remember REF: IMS: 277

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

26. The pancreas forms in the foregut during the 5th to 8th week of gestation. A client with poorly controlled gestational diabetes asks the nurse what the effects of her condition will be on the fetus. What is the *best* response by the nurse? Poorly controlled maternal gestational diabetes will:

a. produce fetal hypoglycemia.

b. result in a macrocosmic fetus.
c. result in a microcosmic fetus.
d. enhance lung maturation.

ANS: B

Insulin is produced by week 20 of gestation. In the fetus of a mother with uncontrolled diabetes, maternal hypoglycemia produces fetal hypoglycemia and macrocosmia results. Hyperinsulinemia blocks lung maturation, placing the neonate at risk for respiratory distress.

DIF: Cognitive Level: Understand REF: IMS: 276

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Congenital disorders refer to those conditions that are present at birth. These disorders may be inherited and caused by environmental factors or maternal malnutrition. Toxic exposures have the greatest effect on development between 15 and 60 days of gestation. For the nurse to be able to conduct a complete assessment of the newly pregnant client, he or she should be knowledgeable regarding known human teratogens. Which substances might be considered a teratogen? *(Select all that apply.)*

a. Cytomegalovirus (CMV)
b. Ionizing radiation
c. Hypothermia
d. Carbamazepine
e. Lead

ANS: A, B, D, E

Exposure to radiation and a number of infections may result in profound congenital deformities. These include but are not limited to varicella, rubella, syphilis, parvovirus, CMV, and toxoplasmosis. Certain maternal conditions such as diabetes and phenylketonuria (PKU) may

also affect organs and other parts of the embryo during this developmental period. Drugs such as antiseizure medications (e.g., carbamazepine) and some antibiotics, as well as chemicals including lead, mercury, tobacco, and alcohol, may also result in structural and functional abnormalities.

DIF: Cognitive Level: Remember REF: IMS: 273

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. Relating to the fetal circulatory system, which special characteristics allow the fetus to obtain sufficient oxygen from the maternal blood? *(Select all that apply.)*

a. Fetal hemoglobin (Hb) carries 20% to 30% more oxygen than maternal Hb.
b. Fetal Hb carries 40% to 50% more oxygen than maternal Hb.
c. Hb concentration is 50% higher than that of the mother.
d. Fetal heart rate is 110 to 160 beats per minute.
e. Fetal heart rate is 160 to 200 beats per minute.

ANS: A, C, D

The following three special characteristics enable the fetus to obtain sufficient oxygen from maternal blood: (1) the fetal Hb carries 20% to 30% more oxygen; (2) the concentration is 50% higher than that of the mother; and (3) the fetal heart rate is 110 to 160 beats per minute, a cardiac output that is higher than that of an adult.

Chapter 13: Anatomy and Physiology of Pregnancy

MULTIPLE CHOICE

1. A womans obstetric history indicates that she is pregnant for the fourth time, and all of her children from previous pregnancies are living. One was born at 39 weeks of gestation, twins were born at 34 weeks of gestation, and another child was born at 35 weeks of gestation. What is her gravidity and parity using the GTPAL system?

a. 3-1-1-1-3
b. 4-1-2-0-4
c. 3-0-3-0-3
d. 4-2-1-0-3

ANS: B

Using the GTPAL system, 4-1-2-0-4 is the correct calculation of this womans gravidity and parity. The numbers reflect the womans gravidity and parity information. Her information is calculated as: *G* reflects the total number of times the woman has been pregnant; she is pregnant for the fourth time. *T* indicates the number of pregnancies carried to term, not the number of deliveries at term; only one of her pregnancies resulted in a fetus at term. *P* is the number of pregnancies that resulted in a preterm birth; the woman has had two pregnancies in which she delivered preterm. *A* signifies whether the woman has had any abortions or miscarriages before the period of viability; she has not. *L* signifies the number of children born who are currently living; the woman has four children. 3-1-1-1-3 is an incorrect calculation of this womans gravidity and parity; 3-0-3-0-3 is an incorrect calculation of this womans gravidity and parity; and 4-2-1-0-3 is an incorrect calculation of this womans gravidity and parity.

DIF: Cognitive Level: Understand REF: IMS: 284 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

2. Which presumptive sign or symptom of pregnancy would a client experience who is approximately 10 weeks of gestation?

a. Amenorrhea
b. Positive pregnancy test
c. Chadwick sign
d. Hegar sign

ANS: A

Amenorrhea is a presumptive sign of pregnancy. Presumptive signs of pregnancy are those felt by the woman. A positive pregnancy test and the presence of the Chadwick and Hegar signs are all probable signs of pregnancy.

DIF: Cognitive Level: Understand REF: IMS: 285

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. A client is seen at the clinic at 14 weeks of gestation for a follow-up appointment. At which level does the nurse expect to palpate the fundus?

a. Nonpalpable above the symphysis at 14 weeks of gestation
b. Slightly above the symphysis pubis
c. At the level of the umbilicus
d. Slightly above the umbilicus

ANS: B

In normal pregnancies, the uterus grows at a predictable rate. It may be palpated above the symphysis pubis sometime between the 12th and 14th weeks of pregnancy. As the uterus grows, it may be palpated above the symphysis pubis sometime between the 12th and 14th weeks of pregnancy. At 14 weeks, the uterus is not yet at the level of the umbilicus. The fundus is not palpable above the umbilicus until 22 to 24 weeks of gestation.

DIF: Cognitive Level: Apply REF: IMS: 286

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. The musculoskeletal system adapts to the changes that occur throughout the pregnancy. Which musculoskeletal alteration should the client expect?

a. Her center of gravity will shift backward.
b. She will have increased lordosis.
c. She will have increased abdominal muscle tone.
d. She will notice decreased mobility of her pelvic joints.

ANS: B

An increase in the normal lumbosacral curve (lordosis) develops, and a compensatory curvature in the cervicodorsal region develops to help her maintain balance. The center of gravity shifts forward. She will have decreased abdominal muscle tone and will notice increased mobility of her pelvic joints.

DIF: Cognitive Level: Understand REF: IMS: 296 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. A 31-year-old woman believes that she may be pregnant. She took an over-the-counter (OTC) pregnancy test 1 week ago after missing her period; the test was positive. During her assessment interview, the nurse inquires about the womans last menstrual period and asks whether she is taking any medications. The client states that she takes medicine for epilepsy. She has been under considerable stress lately at work and has not been sleeping well. Her physical examination does not indicate that she is pregnant. She has an ultrasound scan, which confirms that she is not pregnant. What is the *most* likely cause of the false-positive pregnancy test result?

a. The pregnancy test was taken too early.
b. Anticonvulsant medications may cause the false-positive test result.
c. The woman has a fibroid tumor.
d. She has been under considerable stress and has a hormone imbalance.

ANS: B

Anticonvulsants may cause false-positive pregnancy test results. OTC pregnancy tests use enzyme-linked immunosorbent assay (ELISA) technology, which can yield positive results as soon as 4 days after implantation. Implantation occurs 6 to 10 days after conception. If the woman were pregnant, then she would be into her third week at this point (having missed her period 1 week ago). Fibroid tumors do not produce hormones and have no bearing on human chorionic gonadotropin (hCG) pregnancy tests. Although stress may interrupt normal hormone cycles (menstrual cycles), it does not affect hCG levels or produce positive pregnancy test results.

DIF: Cognitive Level: Apply REF: IMS: 285

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. A woman is in her seventh month of pregnancy. She has been complaining of nasal congestion and occasional epistaxis. Which statement *best* describes why this may be happening to this client?

a. This respiratory change is normal in pregnancy and caused by an elevated level of estrogen.
b. This cardiovascular change is abnormal, and the nosebleeds are an ominous sign.
c. The woman is a victim of domestic violence and is being hit in the face by her partner.
d. The woman has been intranasally using cocaine.

ANS: A

Elevated levels of estrogen cause capillaries to become engorged in the respiratory tract, which may result in edema in the nose, larynx, trachea, and bronchi. This congestion may cause nasal stuffiness and epistaxis. Cardiovascular changes in pregnancy may cause edema in the lower extremities. Domestic violence cannot be determined on the basis on the sparse facts provided. If the woman had been hit in the face, then she most likely would have additional physical findings. Cocaine use cannot be determined on the basis on the sparse facts provided.

DIF: Cognitive Level: Apply REF: IMS: 294

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

7. The nurse is providing education to a client regarding the normal changes of the breasts during pregnancy. Which statement regarding these changes is *correct*?

a. The visibility of blood vessels that form an intertwining blue network indicates full function of the Montgomery tubercles and possibly an infection of the tubercles.
b. The mammary glands do not develop until 2 weeks before labor.
c. Lactation is inhibited until the estrogen level declines after birth.

d. Colostrum is the yellowish oily substance used to lubricate the nipples for breastfeeding.

ANS: C

Lactation is inhibited until after birth. The visible blue network of blood vessels is a normal outgrowth of a richer blood supply. The mammary glands are functionally complete by midpregnancy. Colostrum is a creamy white-to-yellow premilk fluid that can be expressed from the nipples before birth.

DIF: Cognitive Level: Understand REF: IMS: 290 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. Which hormone is essential for maintaining pregnancy?

a. Estrogen
b. hCG
c. Oxytocin
d. Progesterone

ANS: D

Progesterone is essential for maintaining pregnancy; it does so by relaxing smooth muscles, which reduces uterine activity and prevents miscarriage. Estrogen plays a vital role in pregnancy, but it is not the primary hormone for maintaining pregnancy. hCG levels rise at implantation but decline after 60 to 70 days. Oxytocin stimulates uterine contractions.

DIF: Cognitive Level: Remember REF: IMS: 299

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. Which clinical finding in a primiparous client at 32 weeks of gestation might be an indication of anemia?

a. Ptyalism

b. Pyrosis
c. Pica
d. Decreased peristalsis

ANS: C

Pica (a desire to eat nonfood substances) is an indication of iron deficiency and should be evaluated. Cravings include ice, clay, and laundry starch. Ptyalism (excessive salivation), pyrosis (heartburn), and decreased peristalsis are normal findings.

DIF: Cognitive Level: Analyze REF: IMS: 298

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. Why might it be more difficult to diagnose appendicitis during pregnancy?

a. The appendix is displaced upward and laterally, high and to the right.
b. The appendix is displaced upward and laterally, high and to the left.
c. The appendix is deep at the McBurneys point.
d. The appendix is displaced downward and laterally, low and to the right.

ANS: A

The appendix is displaced high and to the right, not to the left. It is displaced beyond the McBurneys point and is not displaced in a downward direction.

DIF: Cognitive Level: Understand REF: IMS: 298 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

11. The nurse is providing health education to a pregnant client regarding the cardiovascular system. Which information is *correct* and important to share?

a. A pregnant woman experiencing disturbed cardiac rhythm, such as sinus arrhythmia, requires close medical and obstetric observation no matter how healthy she may appear otherwise.

b. Changes in heart size and position and increases in blood volume create auditory changes from 20 weeks of gestation to term.

c. Palpitations are twice as likely to occur in twin gestations.

d. All of the above changes will likely occur.

ANS: B

These auscultatory changes should be discernible after 20 weeks of gestation. A healthy woman with no underlying heart disease does not need any therapy. The maternal heart rate increases in the third trimester, but palpitations may not necessarily occur, let alone double. Auditory changes are discernible at 20 weeks of gestation.

DIF: Cognitive Level: Understand REF: IMS: 290 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

12. Which statement regarding the probable signs of pregnancy is *most* accurate?

a. Determined by ultrasound

b. Observed by the health care provider

c. Reported by the client

d. Confirmed by diagnostic tests

ANS: B

Probable signs are those detected through trained examination. Fetal visualization is a positive sign of pregnancy. Presumptive signs are those reported by the client. The term *diagnostic tests* is open for interpretation. To actually diagnose pregnancy, one would have to see positive signs of pregnancy.

DIF: Cognitive Level: Understand REF: IMS: 285

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. Which time-based description of a stage of development in pregnancy is *correct*?

a. *Viability*22 to 37 weeks of gestation since the last menstrual period (assuming a fetal weight greater than 500 g)
b. *Term*pregnancy from the beginning of 38 weeks of gestation to the end of 42 weeks of gestation
c. *Preterm*pregnancy from 20 to 28 weeks of gestation
d. *Postdate*pregnancy that extends beyond 38 weeks of gestation

ANS: B

Term is 38 to 42 weeks of gestation. *Viability* is the ability of the fetus to live outside the uterus before coming to term, or 22 to 24 weeks since the last menstrual period. *Preterm* is 20 to 37 weeks of gestation. *Postdate*or *postterm* is a pregnancy that extends beyond 42 weeks of gestation or what is considered the limit of full term.

DIF: Cognitive Level: Remember REF: IMS: 283 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

14. hCG is an important biochemical marker for pregnancy and therefore the basis for many tests. Which statement regarding hCG is *true*?

a. hCG can be detected as early as weeks after conception.
b. hCG levels gradually and uniformly increase throughout pregnancy.
c. Significantly lower-than-normal increases in the levels of hCG may indicate a postdate pregnancy.
d. Higher-than-normal levels of hCG may indicate an ectopic pregnancy or Down syndrome.

ANS: D

Higher hCG levels also could be a sign of a multiple gestation. hCG can be detected as early as 7 to 10 days after conception. The hCG levels fluctuate during pregnancy, peaking, declining, stabilizing, and then increasing again. Abnormally slow increases may indicate impending miscarriage.

DIF: Cognitive Level: Understand REF: IMS: 284 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

15. Of which physiologic alteration of the uterus during pregnancy is it important for the nurse to alert the patient?

a. Lightening occurs near the end of the second trimester as the uterus rises into a different position.
b. Womans increased urinary frequency in the first trimester is the result of exaggerated uterine antireflexion caused by softening.
c. Braxton Hicks contractions become more painful in the third trimester, particularly if the woman tries to exercise.
d. Uterine souffle is the movement of the fetus.

ANS: B

The softening of the lower uterine segment is called the *Hegar sign*. In this position, the uterine fundus presses on the bladder, causing urinary frequency that is a normal change of pregnancy. Lightening occurs in the last 2 weeks of pregnancy, when the fetus descends. Braxton Hicks contractions become more defined in the final trimester but are not painful. Walking or exercise usually causes them to stop. The uterine souffle is the sound made by blood in the uterine arteries; it can be heard with a fetal stethoscope.

DIF: Cognitive Level: Understand REF: IMS: 287 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

16. What is the correct term used to describe the mucous plug that forms in the endocervical canal?

a. Operculum
b. Leukorrhea
c. Funic souffle
d. Ballottement

ANS: A

The operculum protects against bacterial invasion. Leukorrhea is the mucus that forms the endocervical plug (the operculum). The funic souffle is the sound of blood flowing through the umbilical vessels. Ballottement is a technique for palpating the fetus.

DIF: Cognitive Level: Remember REF: IMS: 289

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

17. Some pregnant clients may complain of changes in their voice and impaired hearing. What should the nurse explain to the client concerning these findings?

a. Voice changes are caused by decreased estrogen levels.
b. Displacement of the diaphragm results in thoracic breathing.
c. Voice changes and impaired hearing are due to the results of congestion and swelling of the upper respiratory tract.
d. Increased blood volume causes changes in the voice.

ANS: C

Although the diaphragm is displaced and the volume of blood is increased, neither causes changes in the voice nor impairs hearing. The key is that estrogen levels increase, not decrease, which causes the upper respiratory tract to become more vascular, which produces swelling and congestion in the nose and ears and therefore voice changes and impaired hearing.

DIF: Cognitive Level: Understand REF: IMS: 294 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. Which renal system adaptation is an anticipated anatomic change of pregnancy?

a. Increased urinary output makes pregnant women less susceptible to urinary infections.
b. Increased bladder sensitivity and then compression of the bladder by the enlarging uterus result in the urge to urinate even when the bladder is almost empty.

c. Renal (kidney) function is more efficient when the woman assumes a supine position.
d. Using diuretic agents during pregnancy can help keep kidney function regular.

ANS: B

Bladder sensitivity and then compression of the bladder by the uterus result in the urge to urinate more often, even when the bladder is almost empty. A number of anatomic changes in pregnancy make a woman more susceptible to urinary tract infections. Renal function is more efficient when the woman lies in the lateral recumbent position and is less efficient when she is supine. Diuretic use during pregnancy can overstress the system and cause problems.

DIF: Cognitive Level: Understand REF: pp. 294-295 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

19. A pregnant client tells her nurse that she is worried about the blotchy, brownish coloring over her cheeks, nose, and forehead. The nurse can reassure her that this is a normal condition related to hormonal changes. What is the correct term for this integumentary finding?

a. Melasma
b. Linea nigra
c. Striae gravidarum
d. Palmar erythema

ANS: A

Melasma, (also called *chloasma*, the mask of pregnancy), usually fades after birth. This hyperpigmentation of the skin is more common in women with a dark complexion. Melasma appears in 50% to 70% of pregnant women. *Linea nigra* is a pigmented line that runs vertically up the abdomen. *Striae gravidarum* are also known as stretch marks. Palmar erythema is signified by pinkish red blotches on the hands.

DIF: Cognitive Level: Remember REF: IMS: 295 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

20. Which gastrointestinal alteration of pregnancy is a *normal* finding?

a. Insufficient salivation (ptyalism) is caused by increases in estrogen.
b. Acid indigestion (pyrosis) begins early but declines throughout pregnancy.
c. Hyperthyroidism often develops (temporarily) because hormone production increases.
d. Nausea and vomiting rarely have harmful effects on the fetus and may be beneficial.

ANS: D

Normal nausea and vomiting rarely produce harmful effects and may be less likely to result in miscarriage or preterm labor. Ptyalism is excessive salivation that may be caused by a decrease in unconscious swallowing or by stimulation of the salivary glands. Pyrosis begins as early as the first trimester and intensifies through the third trimester. Increased hormone production does not lead to hyperthyroidism in pregnant women.

DIF: Cognitive Level: Apply REF: IMS: 298

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

21. A first-time mother at 18 weeks of gestation is in for her regularly scheduled prenatal visit. The client tells the nurse that she is afraid that she is going into premature labor because she is beginning to have regular contractions. The nurse explains that these are Braxton Hicks contractions. What other information is important for the nurse to share?

a. Braxton Hicks contractions should be painless.
b. They may increase in frequency with walking.
c. These contractions might cause cervical dilation.
d. Braxton Hicks *contractions* will impede oxygen flow to the fetus.

ANS: A

Soon after the fourth month of gestation, uterine contractions can be felt through the abdominal wall. Braxton Hicks contractions are regular and painless and continue throughout the pregnancy. Although they are not painful, some women complain that they are annoying. This type of contraction usually ceases with walking or exercise. Braxton Hicks contractions can be mistaken for true labor; however, they do not increase in intensity, frequency, or cause cervical dilation. These contractions facilitate uterine blood flow through the intervillous spaces of the placenta and thereby promote oxygen delivery to the fetus.

DIF: Cognitive Level: Understand REF: IMS: 287 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

22. Pregnancy hormones prepare the vagina for stretching during labor and birth. Which change related to the pelvic viscera should the nurse share with the client?

a. Because of a number of changes in the cervix, abnormal Papanicolaou (Pap) tests are easier to evaluate.
b. Quickening is a technique of palpating the fetus to engage it in passive movement.
c. The deepening color of the vaginal mucosa and cervix (Chadwick sign) usually appears in the second trimester or later as the vagina prepares to stretch during labor.
d. Increased vascularity of the vagina increases sensitivity and may lead to a high degree of arousal, especially in the second trimester.

ANS: D

Increased sensitivity and an increased interest in sex sometimes go together and frequently occur during the second trimester. These cervical changes make evaluation of abnormal Pap tests more difficult. Quickening is the first recognition of fetal movements by the mother. Ballottement is a technique used to palpate the fetus. The Chadwick sign appears from the 6 to 8 weeks of gestation.

DIF: Cognitive Level: Understand REF: IMS: 289 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

23. Numerous changes in the integumentary system occur during pregnancy. Which change persists after birth?

a. Epulis
b. Chloasma
c. Telangiectasia
d. Striae gravidarum

ANS: D

Striae gravidarum, or stretch marks, reflect a separation within the underlying connective tissue of the skin. They usually fade after birth, although they never completely disappear. An epulis is a red, raised nodule on the gums that easily bleeds; it disappears or shrinks after giving birth. Chloasma, or the mask of pregnancy, is a blotchy, brown hyperpigmentation of the skin over the cheeks, nose, and forehead, especially in dark-complexioned pregnant women. Chloasma usually fades after the birth. Telangiectasia, or vascular spiders, are tiny, star-shaped or branchlike, slightly raised, pulsating end-arterioles usually found on the neck, thorax, face, and arms. They occur as a result of elevated levels of circulating estrogen and usually disappear after birth.

DIF: Cognitive Level: Understand REF: IMS: 290 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

24. What is the correct term for a woman who has completed one pregnancy with a fetus (or fetuses) reaching the stage of fetal viability?

a. Primipara
b. Primigravida
c. Multipara
d. Nulligravida

ANS: A

A *primipara* is a woman who has completed one pregnancy with a viable fetus. To help remember the terms: *gravida* is a pregnant woman; *para* comes from *parity*, meaning a viable fetus; *primi* means first; *multi* means many; and *null* means none. Therefore, a *primigravida* is a woman pregnant for the first time; a *multipara* is a woman who has completed two or more pregnancies with a viable fetus; and a *nulligravida* is a woman who has never been pregnant.

DIF: Cognitive Level: Understand REF: IMS: 283 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

25. To reassure and educate their pregnant clients regarding changes in their blood pressure, nurses should be cognizant of what?

a. A blood pressure cuff that is too small produces a reading that is too low; a cuff that is too large produces a reading that is too high.
b. Shifting the clients position and changing from arm to arm for different measurements produces the most accurate composite blood pressure reading at each visit.
c. Systolic blood pressure slightly increases as the pregnancy advances; diastolic pressure remains constant.
d. Compression of the iliac veins and inferior vena cava by the uterus contributes to hemorrhoids in the later stage of a term pregnancy.

ANS: D

Compression of the iliac veins and inferior vena cava by the uterus contributes to hemorrhoids in the later stage of a term pregnancy. This compression also leads to varicose veins in the legs and vulva. The tightness of a blood pressure cuff that is too small produces a reading that is too high; similarly, the looseness of a cuff that is too large results in a reading that is too low. Because maternal positioning affects readings, blood pressure measurements should be obtained in the same arm and with the woman in the same position. The systolic blood pressure generally remains constant but may decline slightly as the pregnancy advances. The diastolic blood pressure first decreases and then gradually increases.

DIF: Cognitive Level: Understand REF: IMS: 292

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

26. Which finding in the urinalysis of a pregnant woman is considered a variation of normal?

a. Proteinuria
b. Glycosuria
c. Bacteria in the urine
d. Ketones in the urine

ANS: B

Small amounts of glucose may indicate *physiologic spilling*. The presence of protein could indicate kidney disease or preeclampsia. Urinary tract infections are associated with bacteria in the urine. An increase in ketones indicates that the patient is exercising too strenuously or has an inadequate fluid and food intake.

DIF: Cognitive Level: Analyze REF: IMS: 295

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

27. Cardiac output increases from 30% to 50% by the 32nd week of pregnancy. What is the rationale for this change?

a. To compensate for the decreased renal plasma flow
b. To provide adequate perfusion of the placenta
c. To eliminate metabolic wastes of the mother
d. To prevent maternal and fetal dehydration

ANS: B

The primary function of increased vascular volume is to transport oxygen and nutrients to the fetus via the placenta. Renal plasma flow increases during pregnancy. Assisting with pulling

metabolic wastes from the fetus for maternal excretion is one purpose of the increased vascular volume.

DIF: Cognitive Level: Understand REF: IMS: 287

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

28. Which statement *best* describes the rationale for the physiologic anemia that occurs during pregnancy?

a. Physiologic anemia involves an inadequate intake of iron.
b. Dilution of hemoglobin concentration occurs in pregnancy with physiologic anemia.
c. Fetus establishes the iron stores.
d. Decreased production of erythrocytes occur.

ANS: B

When blood volume expansion is more pronounced and occurs earlier than the increase in red blood cells, the woman has physiologic anemia, which is the result of the dilution of hemoglobin concentration rather than inadequate hemoglobin. An inadequate intake of iron may lead to true anemia. The production of erythrocytes increases during pregnancy.

DIF: Cognitive Level: Remember REF: IMS: 292

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

29. A patient in her first trimester complains of nausea and vomiting. She asks, Why does this happen? What is the nurses *best* response?

a. Nausea and vomiting are due to an increase in gastric motility.
b. Nausea and vomiting may be due to changes in hormones.
c. Nausea and vomiting are related to an increase in glucose levels.
d. Nausea and vomiting are caused by a decrease in gastric secretions.

ANS: B

Nausea and vomiting are believed to be caused by increased levels of hormones, decreased gastric motility, and hypoglycemia. Gastric motility decreases during pregnancy. Glucose levels decrease in the first trimester. Although gastric secretions decrease, these secretions are not the primary cause of the nausea and vomiting.

DIF: Cognitive Level: Understand REF: IMS: 297

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The diagnosis of pregnancy is based on which positive signs of pregnancy? *(Select all that apply.)*

a. Identification of fetal heartbeat
b. Palpation of fetal outline
c. Visualization of the fetus
d. Verification of fetal movement
e. Positive hCG test

ANS: A, C, D

Identification of a fetal heartbeat, the visualization of the fetus, and verification of fetal movement are all positive, objective signs of pregnancy. Palpation of fetal outline and positive hCG test are probable signs of pregnancy. A tumor also can be palpated. Medication and tumors may lead to false-positive results on pregnancy tests.

DIF: Cognitive Level: Analyze REF: IMS: 285

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

2. A woman is in for a routine prenatal checkup. The nurse is assessing her urine for glycosuria and proteinuria. Which findings are considered normal? *(Select all that apply.)*

a. Dipstick assessment of trace to +1
b. <300 mg/24 hours
c. Dipstick assessment of +2 glucose
d. >300 mg/24 hours
e. Albumin < 30 mg/24 hours

ANS: A, B, E

Small amounts of protein in the urine are acceptable during pregnancy. The presence of protein in greater amounts may indicate renal problems. A dipstick assessment of +2 and proteinuria >300 mg/24 hours, and albuminuria greater than 30 mg/24 hours are excessive and should be further evaluated.

DIF: Cognitive Level: Apply REF: IMS: 295

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. During pregnancy, many changes occur as a direct result of the presence of the fetus. Which of these adaptations meet this criterion? *(Select all that apply.)*

a. Leukorrhea
b. Development of the operculum
c. Quickening
d. Ballottement
e. Lightening

ANS: C, D, E

Quickening is the first recognition of fetal movements or feeling life. Quickening is often described as a flutter and is felt earlier in the multiparous woman than in the primiparous woman. Passive movement of the unengaged fetus is referred to as *ballottement*. *Lightening*

occurs when the fetus begins to descend into the pelvis and occurs 2 weeks before labor in the nulliparous woman and at the start of labor in the multiparous woman. Leukorrhea is a white or slightly gray vaginal discharge that develops in response to cervical stimulation by estrogen and progesterone. Mucus fills the cervical canal creating a plug otherwise known as the operculum. The operculum acts as a barrier against bacterial invasion during the pregnancy.

DIF: Cognitive Level: Understand REF: IMS: 286 | pp. 287-288

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

4. Pregnancy is a hypercoagulable state in which women are at a fivefold to sixfold increased risk for thromboembolic disease. The tendency for blood to clot is greater, attributable to an increase in various clotting factors. Which of these come into play during pregnancy? *(Select all that apply.)*

a. Factor VII
b. Factor VIII
c. Factor IX
d. Factor XIII
e. Fibrinogen

ANS: A, B, C, E

Factors VII, VIII, IX, X, and fibrinogen increase in pregnancy. Factors that inhibit coagulation decrease. Fibrinolytic activity (dissolving of a clot) is depressed during pregnancy and the early postpartum period to protect the women from postpartum hemorrhage.

DIF: Cognitive Level: Understand REF: IMS: 293

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

COMPLETION

1. To provide optimal prenatal care, a blood pressure reading should be obtained at every prenatal visit. Calculating the mean arterial pressure (MAP) can increase the value of this

diagnostic finding. MAP readings for a pregnant woman at term are 90+ = 5.8 mm Hg. The nurse has just obtained a BP of 106/70 mm Hg on a 37-week primiparous client. The formula for the MAP reading is (systolic + [2 diastolic]) 3. The MAP reading for this client is _____ mm Hg.

ANS:

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Chapter 14: Nursing Care of the Family During Pregnancy

MULTIPLE CHOICE

1. Ideally, when should prenatal care begin?

a. Before the first missed menstrual period
b. After the first missed menstrual period
c. After the second missed menstrual period
d. After the third missed menstrual period

ANS: B

Prenatal care should begin soon after the first missed menstrual period. This offers the greatest opportunities to ensure the health of the expectant mother and her infant. Prenatal care before missing the first menstrual period is too early. It is unlikely the woman is even aware of the pregnancy. Ideally, prenatal visits should begin soon after the first period is missed. Beginning prenatal care after the third missed menstrual period is too late. The woman will have completed the first trimester by that time.

DIF: Cognitive Level: Remember REF: IMS: 301 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. A woman arrives at the clinic for a pregnancy test. Her last menstrual period (LMP) was February 14, 2015. What is the clients expected date of birth (EDB)?

a. September 17, 2015
b. November 7, 2015
c. November 21, 2015
d. December 17, 2015

ANS: C

Using the Ngeles rule, the EDB is calculated by subtracting 3 months from the month of the LMP and adding 7 days + 1 year to the day of the LMP. Therefore, with an LMP of February 14, 2015, her due date is November 21, 2015. September 17, 2015, is too short a period to complete a normal pregnancy. Using the Ngeles rule, an EDB of November 7, 2015, is 2 weeks early. December 17, 2015, is almost a month past the correct EDB.

DIF: Cognitive Level: Apply REF: IMS: 302

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Which women should undergo prenatal testing for the human immunodeficiency virus (HIV)?

a. All women, regardless of risk factors
b. Women who have had more than one sexual partner
c. Women who have had a sexually transmitted infection (STI)
d. Woman who are monogamous with one partner

ANS: A

An HIV test is recommended for all women, regardless of risk factors. The incidence of perinatal transmission from an HIV-positive mother to her fetus ranges from 25% to 35%. Women who test positive for HIV can then be treated.

DIF: Cognitive Level: Understand REF: pp. 312, 313 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

4. Which sign or symptom is considered a first-trimester warning sign and should be immediately reported by the pregnant woman to her health care provider?

a. Nausea with occasional vomiting
b. Fatigue
c. Urinary frequency
d. Vaginal bleeding

ANS: D

Signs and symptoms that must be reported include severe vomiting, fever and chills, burning on urination, diarrhea, abdominal cramping, and vaginal bleeding. These symptoms may be signs of complications of the pregnancy. Nausea with occasional vomiting is a normal first-trimester complaint. Although it may be worrisome or annoying to the mother, it is not usually an indication of a problem with the pregnancy. Fatigue is common during the first trimester. Because of physiologic changes that happen during pregnancy, clients should be taught that urinary frequency is normal.

DIF: Cognitive Level: Understand REF: IMS: 314 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. Which client might be well advised to continue condom use during intercourse throughout her pregnancy?

a. Unmarried pregnant women
b. Women at risk for acquiring or transmitting STIs
c. All pregnant women
d. Women at risk for candidiasis

ANS: B

The objective of *safer sex* is to provide prophylaxis against the acquisition and transmission of STIs. Because these diseases may be transmitted to the woman and then to her fetus, condom use

is recommended throughout the pregnancy if the woman is at risk for acquiring an STI. Pregnant women are encouraged to practice safer sex behaviors. An unmarried pregnant woman may be in a monogamous relationship and not require the use of a condom. The client should be educated as to what may place both herself and her fetus at risk. Any pregnant woman can develop candidiasis, which is an infection not related to condom use.

DIF: Cognitive Level: Apply REF: IMS: 330 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

6. Which condition is likely to be identified by the quadruple marker screen?

a. Down syndrome
b. Diaphragmatic hernia
c. Congenital cardiac abnormality
d. Anencephaly

ANS: A

The maternal serum level marker of alpha-fetoprotein is used to screen for Down syndrome, trisomy 18, neural tube defects, and other chromosomal anomalies. The quadruple-marker screen will not detect diaphragmatic hernia. Additional testing, such as ultrasonography, is required to diagnose diaphragmatic hernia. Congenital cardiac abnormality will most likely be identified during an ultrasound examination. The quadruple-marker screen will not detect anencephaly.

DIF: Cognitive Level: Knowledge REF: IMS: 316

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

7. A pregnant woman at 18 weeks of gestation calls the clinic to report that she has been experiencing occasional backaches of mild-to-moderate intensity. Which intervention should the nurse recommend?

a. Kegel exercises
b. Pelvic rock exercises

c. Softer mattress

d. Bed rest for 24 hours

ANS: B

Pelvic rock exercises may help stretch and strengthen the abdominal and lower back muscles and relieve low back pain. Stretching and other exercises to relieve back pain should be performed several times a day. Kegel exercises increase the tone of the pelvic area, not the back. A softer mattress may not provide the support needed to maintain proper alignment of the spine and may contribute to back pain.

DIF: Cognitive Level: Apply REF: IMS: 320

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

8. A woman is 3 months pregnant. At her prenatal visit she tells the nurse that she does not know what is happening; one minute she is happy that she is pregnant and the next minute she cries for no reason. Which response by the nurse is *most* appropriate?

a. Dont worry about it; youll feel better in a month or so.

b. Have you talked to your husband about how you feel?

c. Perhaps you really dont want to be pregnant.

d. Hormone changes during pregnancy commonly result in mood swings.

ANS: D

Explaining that hormone changes can result in mood swings is an accurate statement and the most appropriate response by the nurse. Telling the woman not to worry dismisses her concerns and is not the most appropriate response. Although the woman should be encouraged to share her feelings, asking if she has spoken to her husband about them is not the most appropriate response and does not provide her with a rationale for the psychosocial dynamics of her pregnancy. Suggesting that the woman does not want to be pregnant is completely inappropriate and deleterious to the psychologic well-being of the woman. Hormonal and metabolic adaptations

often cause mood swings in pregnancy. The womans responses are normal. She should be reassured about her feelings.

DIF: Cognitive Level: Apply REF: IMS: 313 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

9. What is the primary role of the nonpregnant partner during pregnancy?

a. To provide financial support
b. To protect the pregnant woman from old wives tales
c. To support and nurture the pregnant woman
d. To make sure the pregnant woman keeps prenatal appointments

ANS: C

The partners primary role in pregnancy is to nurture the pregnant woman and respond to her feelings of vulnerability. Although financial support is important, it is not the partners primary role in pregnancy. Protecting the pregnant woman from old wives tales is not the partners role. The womans partner can encourage the client to keep all appointments; however, this is not the most important role during the pregnancy.

DIF: Cognitive Level: Understand REF: IMS: 305

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

10. During the first trimester, which of the following changes regarding her sexual drive should a client be taught to expect?

a. Increased sexual drive, because of enlarging breasts
b. Decreased sexual drive, because of nausea and fatigue
c. No change in her sexual drive
d. Increased sexual drive, because of increased levels of female hormones

ANS: B

A pregnant woman usually experiences a decrease, not an increase, in libido during the first trimester. Maternal physiologic changes, such as breast enlargement, nausea, fatigue, abdominal changes, perineal enlargement, leukorrhea, pelvic vasocongestion, and orgasmic responses, may affect sexuality and sexual expression. Libido may be depressed in the first trimester but often increases during the second and third trimesters. During pregnancy, the breasts may become enlarged and tender, which tends to interfere with coitus, thereby decreasing the desire to engage in sexual activity.

DIF: Cognitive Level: Understand REF: IMS: 329 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

11. A 3-year-old girls mother is 6 months pregnant. What concern is this child most likely to verbalize?

a. How the baby will get out?
b. How will the baby eat?
c. Will you die having the baby?
d. What color eyes will the baby have?

ANS: B

By age 3 or 4 years, children like to be told the story of their own beginning and accept it being compared with the present pregnancy. They like to listen to the fetal heartbeat and feel the baby move. Sometimes they worry about how the baby is being fed and what it will wear. School-age children take a more clinical interest in their mothers pregnancy and may want to know How did the baby get in there? and How will it get out? Whether the childs mother will die does not tend to be the focus of her questions about the impending birth of a sibling. The babys eye color does not tend to be the focus of childrens questions about the impending birth of a sibling.

DIF: Cognitive Level: Analyze REF: IMS: 307

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. In her work with pregnant women of different cultures, a nurse practitioner has observed various practices that seemed unfamiliar. The nurse practitioner has learned that cultural rituals and practices during pregnancy seem to have one purpose in common. Which statement *best* describes that purpose?

a. To promote family unity
b. To ward off the evil eye
c. To appease the gods of fertility
d. To protect the mother and fetus during pregnancy

ANS: D

Although many cultures consider pregnancy normal, certain practices are expected of women of all cultures to ensure a good outcome. Cultural prescriptions tell women what to do, and cultural proscriptions establish taboos. The purposes of these practices are to prevent maternal illness resulting from a pregnancy-induced imbalanced state and to protect the vulnerable fetus. Promoting family unity is important, although not usually the premise for cultural rituals and practices. Warding off the evil eye may be specific to one particular culture; however, it is not the primary purpose of these practices. Appeasing the gods of fertility is not the impetus behind cultural rituals.

DIF: Cognitive Level: Understand REF: IMS: 331 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

13. A client has arrived for her first prenatal appointment. She asked the nurse to explain exactly how long the pregnancy will be. What is the nurses *best* response?

a. Normal pregnancy is 10 lunar months.
b. Pregnancy is made up of four trimesters.
c. Pregnancy is considered term at 36 weeks.
d. Estimated date of delivery (EDD) is 40 completed weeks.

ANS: A

Pregnancy spans 9 calendar months; but, health care providers prefer to use the lunar month of 28 days or 4 weeks. Pregnancy consists of three trimesters, each approximately 13 weeks long. A pregnancy is considered term at 37 completed weeks; however, EDD is based upon 40 weeks of gestation.

DIF: Cognitive Level: Apply REF: IMS: 301

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. What should the nurse be cognizant of concerning the clients reordering of personal relationships during pregnancy?

a. Because of the special motherhood bond, a womans relationship with her mother is even more important than with the father of the child.
b. Nurses need not get involved in any sexual issues the couple has during pregnancy, particularly if they have trouble communicating them to each other.
c. Women usually express two major relationship needs during pregnancy: feeling loved and valued and having the child accepted by the father.
d. The womans sexual desire is likely to be highest in the first trimester because of the excitement and because intercourse is physically easier.

ANS: C

Love and support help a woman feel better about her pregnancy. The most important person to the pregnant woman is usually the father of the child. Nurses can facilitate communication between partners about sexual matters if, as is common, they are nervous about expressing their worries and feelings to one another. The second trimester is the time when a womans sense of well-being, along with certain physical changes, increases her desire for sex. Sexual desire is down in the first and third trimesters.

DIF: Cognitive Level: Understand REF: IMS: 304 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. What represents a typical progression through the phases of a womans establishing a relationship with the fetus?

a. Accepts the fetus as distinct from herselfaccepts the biologic fact of pregnancyhas feelings of caring and responsibility.
b. Fantasizes about the childs gender and personalityviews the child as part of herselfbecomes introspective.
c. Views the child as part of herselfhas feelings of well-beingaccepts the biologic fact of the pregnancy.
d. I am pregnantI am going to have a babyI am going to be a mother.

ANS: D

The woman first centers on herself as pregnant, then on the baby as an entity separate from herself, and then on her responsibilities as a mother. The expressions I am pregnant, I am going to have a baby, and I am going to be a mother sum up the progression through the three phases. In phase one, the woman views the child as part of herself and not as a separate being. This is only the first step of the progression through phases of attachment. Accepting the fetus as distinct from herself occurs during the second phase of emotional attachment. Fantasizing about the childs sex and personality based on fetal activity occurs during the third phase of attachment.

DIF: Cognitive Level: Apply REF: IMS: 304 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

16. Who is most likely to experience the phenomenon of someone other than the mother-to-be having pregnancy-like symptoms such as nausea and weight gain?

a. Mother of the pregnant woman
b. Couples teenage daughter
c. Sister of the pregnant woman
d. Expectant father

ANS: D

An expectant fathers experiencing of his partners pregnancy-like symptoms is called the *couvade syndrome*. The mother of the pregnant woman is unlikely to experience this phenomenon. She may be excited about becoming a grandmother or see her daughters pregnancy as a reminder that

she is getting old. A couples teenage daughter is usually preoccupied with her own sexual development and may have difficulty accepting the overwhelming evidence of her parents sexual activity. It is the father of the pregnant woman, not the sister, who experiences these symptoms.

DIF: Cognitive Level: Remember REF: IMS: 305 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

17. During the initial visit with a client who is beginning prenatal care, which action should be the *highest* priority for the nurse?

a. The first interview is a relaxed, get-acquainted affair during which the nurse gathers some general impressions of his or her new client.
b. If the nurse observed handicapping conditions, he or she should be sensitive and not inquire about them because the client will do that in her own time.
c. The nurse should be alert to the appearance of potential parenting problems, such as depression or lack of family support.
d. Because of legal complications, the nurse should not ask about illegal drug use; that is left to the physician.

ANS: C

Besides these potential problems, the nurse needs to be alert to the womans attitude toward keeping regular health care appointments. If the client lacks insurance, then the nurse may be able to direct her to resources that provide assistance for pregnant women (i.e., Women, Infants, and Children [WIC]; Medicaid). The initial interview needs to be planned, purposeful, and focused on specific content. A lot of ground must be covered. The nurse must be sensitive to special problems; he or she should inquire because discovering individual needs is important. A client with a chronic or handicapping condition might forget to mention it because she has adapted to it. Obtaining information on drug use is important and can be confidentially done. Actual testing for drug use requires the clients consent.

DIF: Cognitive Level: Apply REF: IMS: 310

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

18. A pregnant couple has formulated a birth plan and is reviewing it with the nurse at an expectant parents class. Which aspect of their birth plan should be considered potentially unrealistic and require further discussion with the nurse?

a. My husband and I have agreed that my sister will be my coach because he becomes anxious with regard to medical procedures and blood. He will be nearby and check on me every so often to make sure everything is okay.
b. We plan to use the techniques taught in the Lamaze classes to reduce the pain experienced during labor.
c. We want the labor and birth to take place in a birthing room. My husband will come in the minute the baby is born.
d. Regardless of the circumstances, we do not want the fetal monitor used during labor because it will interfere with movement and doing effleurage.

ANS: D

Because monitoring is essential to assess fetal well-being, fetal monitoring is not a factor that can be determined by the couple. The nurse should fully explain its importance. The option for intermittent electronic monitoring could be explored if this is a low-risk pregnancy and as long as labor is normally progressing. The birth plan is a tool with which parents can explore their childbirth options; however, the plan must be viewed as tentative. Having the womans sister as her coach with her husband nearby is an acceptable request for a laboring woman. Using breathing techniques to alleviate pain is a realistic part of a birth plan. Not all fathers are able to be present during the birth; however, this couple has made a realistic plan that works for their specific situation.

DIF: Cognitive Level: Apply REF: IMS: 338

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

19. During the physical examination of a client beginning prenatal care, which initial action is most important for the nurse to perform?

a. Only women who show physical signs or meet the sociologic profile should be assessed for physical abuse.
b. The client should empty her bladder before the pelvic examination.

c. The distribution, amount, and quality of body hair are of no particular importance.

d. The size of the uterus is discounted in the initial examination because it will be increasing in size during the second trimester.

ANS: B

The nurse should instruct the client to empty her bladder. An empty bladder facilitates the examination and also provides an opportunity to obtain a urine sample for a number of tests. All women should be assessed for a history of physical abuse, particularly because the likelihood of abuse increases during pregnancy. Noting body hair is important because body hair reflects nutritional status, endocrine function, and hygiene. Particular attention is paid to the size of the uterus because it is an indication of the duration of gestation.

DIF: Cognitive Level: Apply REF: IMS: 311

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. A woman who is 16 weeks pregnant has come in for a follow-up visit with her significant other. To reassure the client regarding fetal well-being, which is the *highest* priority action for the nurse to perform?

a. Assess the fetal heart tones with a Doppler stethoscope.

b. Measure the girth of the womans abdomen.

c. Complete an ultrasound examination (sonogram).

d. Offer the woman and her family the opportunity to listen to the fetal heart tones.

ANS: D

To provide the parents with the greatest sense of reassurance, the nurse should offer to have the client and her significant other the chance to listen to their babys heartbeat. A fetoscope can detect the fetal heart rate around 20 weeks of gestation. Doppler can detect the fetal heart rate between 10 and 12 weeks and should be performed as part of routine fetal assessment. Abdominal girth is not a valid measure for determining fetal well-being. Fundal height is an important measure that should be determined with precision, with the same technique and

positioning of the client consistently used at every prenatal visit. Routine ultrasound examinations are recommended in early pregnancy; they date the pregnancy and provide useful information about the health of the fetus. However, they are not necessary at each prenatal visit.

DIF: Cognitive Level: Apply REF: IMS: 314

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

21. What is the primary role of the doula during labor?

a. Helps the woman perform Lamaze breathing techniques and to provide support to the woman and her partner
b. Checks the fetal monitor tracing for effects of the labor process on the fetal heart rate
c. Takes the place of the father as a coach and support provider
d. Administers pain medications as needed by the woman

ANS: A

A doula is professionally trained to provide labor support, including physical, emotional, and informational support, to both the woman and her partner during labor and the birth. The doula does not become involved with clinical tasks.

DIF: Cognitive Level: Understand REF: IMS: 338

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

22. A client at 34 weeks of gestation seeks guidance from the nurse regarding personal hygiene. Which information should the nurse provide?

a. Tub bathing is permitted even in late pregnancy unless membranes have ruptured.
b. The perineum should be wiped from back to front.
c. Bubble bath and bath oils are permissible because they add an extra soothing and cleansing action to the bath.

d. Expectant mothers should use specially treated soap to cleanse the nipples.

ANS: A

The primary danger from taking baths is falling in the tub. The perineum should be wiped from front to back. Bubble baths and bath oils should be avoided because they may irritate the urethra. Soap, alcohol, ointments, and tinctures should not be used to cleanse the nipples because they remove protective oils. Warm water is sufficient.

DIF: Cognitive Level: Apply REF: IMS: 317 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

23. The client is instructed to place her thumb and forefinger on the areola and gently press inward. What is the purpose of this exercise?

a. To check the sensitivity of the nipples
b. To determine whether the nipple is everted or inverted
c. To calculate the adipose buildup in the abdomen
d. To see whether the fetus has become inactive

ANS: B

Sometimes known as the pinch test, this exercise is used to determine whether the nipple is everted or inverted. Nipples must be everted to allow breastfeeding. The pinch does not determine the level of sensitivity of the nipples, nor is it not used to determine the level of adipose tissue in the abdomen. Fetal activity is not determined by using the pinch test.

DIF: Cognitive Level: Understand REF: IMS: 318

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

24. Dental care during pregnancy is an important component of good prenatal care. Which instruction regarding dental health should the nurse provide?

a. Regular brushing and flossing may not be necessary during early pregnancy because it may stimulate the woman who is already nauseated to vomit. A cleaning is all that is necessary.

b. Dental surgery, in particular, is contraindicated during pregnancy and should be delayed until after delivery.

c. If dental treatment is necessary, then the woman will be most comfortable with it in the second trimester.

d. If a woman has dental anxiety, then dental care may interfere with the expectant mothers need to practice conscious relaxation and to prepare for labor.

ANS: C

The second trimester is the best time for dental treatment because the woman will be able to sit most comfortably in the dental chair. Dental care, such as brushing with a fluoride toothpaste, is especially important during pregnancy. Periodontal disease has been linked to both preterm labor and low-birth-weight (LBW) infants. Emergency dental surgery is permissible; however, the mother must clearly understand the risks and benefits. Conscious relaxation is useful and may even help the woman get through any dental appointments, but it is not a reason to avoid them.

DIF: Cognitive Level: Understand REF: IMS: 320 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

25. Many pregnant women have questions regarding work and travel during pregnancy. Which education is a priority for the nurse to provide?

a. Women should sit for as long as possible and cross their legs at the knees from time to time for exercise.

b. Women should avoid seat belts and shoulder restraints in the car because they press on the fetus.

c. Metal detectors at airport security checkpoints can harm the fetus if the woman passes through them a number of times.

d. While working or traveling in a car or on an airplane, women should arrange to walk around at least every hour or so.

ANS: D

Periodic walking helps prevent thrombophlebitis. Pregnant women should avoid sitting or standing for long periods and crossing the legs at the knees. Pregnant women must wear lap belts and shoulder restraints. The most common injury to the fetus comes from injury to the mother. Metal detectors at airport security checkpoints do not harm fetuses.

DIF: Cognitive Level: Understand REF: IMS: 323 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

26. Which statement accurately describes the centering model of care?

a. Group sessions begin with the first prenatal visit.
b. Blood pressure (BP), weight, and urine dipsticks are obtained by the nurse at each visit.
c. Approximately 8 to 12 women are placed in each gestational-age cohort group.
d. Outcomes are similar to traditional prenatal care.

ANS: C

Gestational-age cohorts comprise the groups, with approximately 8 to 12 women in each group. The groups remain intact throughout the pregnancy. Individual follow-up visits are scheduled as needed. Group sessions begin at 12 to 16 weeks of gestation and end with an early postpartum visit. Before the group sessions, the client has an individual assessment, physical examination, and history. At the beginning of each group meeting, clients measure their own BP, weight, and urine dips and enter these findings in their record. Fetal heart rate assessment and fundal height are obtained by the nurse. Results evaluating this approach have been very promising. In a recent study of adolescent clients, the number of LBW infants decreased and breastfeeding rates increased.

DIF: Cognitive Level: Apply REF: IMS: 309

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

27. A pregnant woman at 10 weeks of gestation jogs three or four times per week. She is concerned about the effect of the exercise on the fetus. Which guidance should the nurse provide?

a. You dont need to modify your exercising any time during your pregnancy.
b. Stop exercising because it will harm the fetus.
c. You may find that you need to modify your exercise to walking later in your pregnancy, around the seventh month.
d. Jogging is too hard on your joints; switch to walking now.

ANS: C

Typically, running should be replaced with walking around the seventh month of pregnancy. The nurse should inform the woman that she may need to reduce her exercise level as the pregnancy progresses. Physical activity promotes a feeling of well-being in pregnant women. It improves circulation, promotes relaxation and rest, and counteracts boredom. Simple measures should be initiated to prevent injuries, such as warm-up and stretching exercises to prepare the joints for more strenuous exercise.

DIF: Cognitive Level: Apply REF: IMS: 319 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

28. Which sign of a potential complication is the most important for the nurse to share with the client?

a. Constipation
b. Alteration in the pattern of fetal movement
c. Heart palpitations
d. Edema in the ankles and feet at the end of the day

ANS: B

An alteration in the pattern or amount of fetal movement may indicate fetal jeopardy. Constipation, heart palpitations, and ankle and foot edema are normal discomforts of pregnancy that occur in the second and third trimesters.

DIF: Cognitive Level: Apply REF: pp. 327, 329 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

29. A woman who is 14 weeks pregnant tells the nurse that she always had a glass of wine with dinner before she became pregnant. She has abstained during her first trimester and would like to know if it is safe for her to have a drink with dinner now. Which guidance should the nurse provide?

a. Since youre in your second trimester, theres no problem with having one drink with dinner.
b. One drink every night is too much. One drink three times a week should be fine.
c. Since youre in your second trimester, you can drink as much as you like.
d. Because no one knows how much or how little alcohol it takes to cause fetal problems, the best course is to abstain throughout your pregnancy.

ANS: D

The statement Because no one knows how much or how little alcohol it takes to cause fetal problems, the best course is to abstain throughout your pregnancy is accurate. A safe level of alcohol consumption during pregnancy has not yet been established. Although the consumption of occasional alcoholic beverages may not be harmful to the mother or her developing fetus, complete abstinence is strongly advised.

DIF: Cognitive Level: Apply REF: IMS: 326 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

30. Which behavior indicates that a woman is seeking safe passage for herself and her infant?

a. She keeps all prenatal appointments.
b. She eats for two.

c. She slowly drives her car.
d. She wears only low-heeled shoes.

ANS: A

The goal of prenatal care is to foster a safe birth for the infant and mother. Although properly eating, carefully driving, and using proper body mechanics all are healthy measures that a mother can take, obtaining prenatal care is the optimal method for providing safety for both herself and her baby.

DIF: Cognitive Level: Understand REF: IMS: 308 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

31. What type of cultural concern is the most likely deterrent to many women seeking prenatal care?

a. Religion
b. Modesty
c. Ignorance
d. Belief that physicians are evil

ANS: B

A concern for modesty is a deterrent to many women seeking prenatal care. For some women, exposing body parts, especially to a man, is considered a major violation of their modesty. Many cultural variations are found in prenatal care. Even if the prenatal care described is familiar to a woman, some practices may conflict with the beliefs and practices of a subculture group to which she belongs.

DIF: Cognitive Level: Apply REF: IMS: 331 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

32. The nurse working with pregnant clients must seek to gain understanding of the process whereby women accept their pregnancy. Which statement regarding this process is *most* accurate?

a. Nonacceptance of the pregnancy very often equates to a rejection of the child.
b. Mood swings are most likely the result of worries about finances and a changed lifestyle, as well as profound hormonal changes.
c. Ambivalent feelings during pregnancy are usually only expressed in emotionally immature or very young mothers.
d. Conflicts such as not wanting to be pregnant or childrearing and career-related decisions need not be addressed during pregnancy because they will naturally resolve themselves after birth.

ANS: B

Mood swings are natural and are likely to affect every woman to some degree. A woman may dislike being pregnant, refuse to accept it, and still love and accept the child. Ambivalent feelings about pregnancy are normal for the mature or immature woman and for the younger or older woman. Conflicts such as not wanting to be pregnant or childrearing and career-related decisions need to be resolved. The baby ends the pregnancy but not all the issues.

DIF: Cognitive Level: Understand REF: IMS: 303 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

33. What is important for the nurse to recognize regarding the new father and his acceptance of the pregnancy and preparation for childbirth?

a. The father goes through three phases of acceptance of his own.
b. The fathers attachment to the fetus cannot be as strong as that of the mother because it does not start until after the birth.
c. In the last 2 months of pregnancy, most expectant fathers suddenly get very protective of their established lifestyle and resist making changes to the home.
d. Typically, men remain ambivalent about fatherhood right up to the birth of their child.

ANS: A

A father typically goes through three phases of development to reach acceptance of fatherhood: the announcement phase, the moratorium phase, and the focusing phase. The father-child attachment can be as strong as the mother-child relationship and can also begin during pregnancy. During the last 2 months of the pregnancy, many expectant fathers work hard to improve the environment of the home for the child. Typically, the expectant fathers ambivalence ends by the first trimester, and he progresses to adjusting to the reality of the situation and then to focusing on his role.

DIF: Cognitive Level: Comprehend REF: IMS: 305 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

34. Which consideration is essential for the nurse to understand regarding follow-up prenatal care visits?

a. The interview portions become more intensive as the visits become more frequent over the course of the pregnancy.
b. Monthly visits are scheduled for the first trimester, every 2 weeks for the second trimester, and weekly for the third trimester.
c. During the abdominal examination, the nurse should be alert for supine hypotension.
d. For pregnant women, a systolic BP of 130 mm Hg and a diastolic BP of 80 mm Hg is sufficient to be considered hypertensive.

ANS: C

The woman lies on her back during the abdominal examination, possibly compressing the vena cava and aorta, which can cause a decrease in BP and a feeling of faintness. The interview portion of the follow-up examinations is less extensive than in the initial prenatal visits, during which so much new information must be gathered. Monthly visits are routinely scheduled for the first and second trimesters; visits increase to every 2 weeks at week 28 and to once a week at week 36. For pregnant women, hypertension is defined as a systolic BP of 140 mm Hg or higher and a diastolic BP of 90 mm Hg or higher.

DIF: Cognitive Level: Understand REF: IMS: 312

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

35. With regard to medications, herbs, boosters, and other substances normally encountered by pregnant women, what is important for the nurse to be aware of?

a. Both prescription and over-the-counter (OTC) drugs that otherwise are harmless can be made hazardous by metabolic deficiencies of the fetus.
b. The greatest danger of drug-caused developmental deficits in the fetus is observed in the final trimester.
c. Killed-virus vaccines (e.g., tetanus) should not be administered during pregnancy, but live-virus vaccines (e.g., measles) are permissible.
d. No convincing evidence exists that secondhand smoke is potentially dangerous to the fetus.

ANS: A

Both prescription and OTC drugs that otherwise are harmless can be made hazardous by metabolic deficiencies of the fetus. This is especially true for new medications and combinations of drugs. The greatest danger of drug-caused developmental defects exists in the interval from fertilization through the first trimester, during which a woman may not realize that she is pregnant. Live-virus vaccines should be part of postpartum care; killed-virus vaccines may be administered during pregnancy. Secondhand smoke is associated with fetal growth restriction and increases in infant mortality.

DIF: Cognitive Level: Understand REF: IMS: 326

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

36. Which statement regarding multifetal pregnancy is *incorrect*?

a. The expectant mother often develops anemia because the fetuses have a greater demand for iron.
b. Twin pregnancies come to term with the same frequency as single pregnancies.

c. The mother should be counseled to increase her nutritional intake and gain more weight.
d. Backache and varicose veins often are more pronounced with a multifetal pregnancy.

ANS: B

Twin pregnancies often end in prematurity. Serious efforts should be made to bring the pregnancy to term. A woman with a multifetal pregnancy often develops anemia, suffers more or worse backache, and needs to gain more weight. Counseling is needed to help her adjust to these conditions.

DIF: Cognitive Level: Understand REF: IMS: 335

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

37. While assessing the vital signs of a pregnant woman in her third trimester, the client complains of feeling faint, dizzy, and agitated. Which nursing intervention is appropriate?

a. Have the patient stand up, and then retake her BP.
b. Have the patient sit down, and then hold her arm in a dependent position.
c. Have the patient lie supine for 5 minutes, and then recheck her BP on both arms.
d. Have the patient turn to her left side, and then recheck her BP in 5 minutes.

ANS: D

BP is affected by maternal position during pregnancy. The supine position may cause occlusion of the vena cava and descending aorta. Turning the pregnant woman to a lateral recumbent position alleviates pressure on the blood vessels and quickly corrects supine hypotension. Pressures are significantly higher when the client is standing. This option causes an increase in systolic and diastolic pressures. The arm should be supported at the same level of the heart. The supine position may cause occlusion of the vena cava and descending aorta, creating hypotension.

DIF: Cognitive Level: Apply REF: IMS: 312

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which signs and symptoms should a woman immediately report to her health care provider? *(Select all that apply.)*

a. Vaginal bleeding
b. Rupture of membranes
c. Heartburn accompanied by severe headache
d. Decreased libido
e. Urinary frequency

ANS: A, B, C

Vaginal bleeding, rupture of membranes, and severe headaches are signs of potential complications in pregnancy. Clients should be advised to report these signs to their health care provider. Decreased libido and urinary frequency are common discomforts of pregnancy that do not require immediate health care interventions.

DIF: Cognitive Level: Analyze REF: IMS: 329

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

2. A woman has just moved to the United States from Mexico. She is 3 months pregnant and has arrived for her first prenatal visit. During her assessment interview, the nurse learns that the client has not had any immunizations. Which immunizations should she receive at this point in her pregnancy? *(Select all that apply.)*

a. Tetanus
b. Diphtheria
c. Chickenpox
d. Rubella

e. Hepatitis B

ANS: A, B, E

Vaccines consisting of killed viruses may be used. Those that may be administered during pregnancy include tetanus, diphtheria, recombinant hepatitis B, and rabies vaccines. Immunizations with live or attenuated viruses are contraindicated during pregnancy because of their potential teratogenicity. Live-virus vaccines include those for measles (rubeola and rubella), chickenpox, and mumps.

Chapter 15: Maternal and Fetal Nutrition

MULTIPLE CHOICE

1. Which nutrients recommended dietary allowance (RDA) is higher during lactation than during pregnancy?

a. Energy (kcal)
b. Iron
c. Vitamin A
d. Folic acid

ANS: A

Nutrient needs for energyprotein, calcium, iodine, zinc, B vitamins, and vitamin Cremain higher during lactation than during pregnancy. The need for iron is not higher during lactation than during pregnancy. A lactating woman does not have a greater requirement for vitamin A than a nonpregnant woman. Folic acid requirements are the highest during the first trimester of pregnancy.

DIF: Cognitive Level: Remember REF: IMS: 364 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

2. A pregnant womans diet consists almost entirely of whole grain breads and cereals, fruits, and vegetables. Which dietary requirement is the nurse *most* concerned about?

a. Calcium
b. Protein
c. Vitamin B_{12}
d. Folic acid

ANS: C

A pregnant womans diet is consistent with that followed by a strict vegetarian (vegan). Vegans consume only plant products. Because vitamin B_{12} is found in foods of animal origin, this diet is deficient in vitamin B_{12}. Depending on the womans food choices, a pregnant womans diet may be adequate in calcium. Protein needs can be sufficiently met by a vegetarian diet. The nurse should be more concerned with the womans intake of vitamin B_{12} attributable to her dietary restrictions. Folic acid needs can be met by enriched bread products.

DIF: Cognitive Level: Remember REF: IMS: 354

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. Which statement made by a lactating woman leads the nurse to believe that the client might have lactose intolerance?

a. I always have heartburn after I drink milk.
b. If I drink more than a cup of milk, I usually have abdominal cramps and bloating.
c. Drinking milk usually makes me break out in hives.
d. Sometimes I notice that I have bad breath after I drink a cup of milk.

ANS: B

Lactose intolerance, which is an inability to digest milk sugar because of a lack of the enzyme lactose in the small intestine, is a problem that interferes with milk consumption. Milk consumption may cause abdominal cramping, bloating, and diarrhea in such people, although

many lactose-intolerant individuals can tolerate small amounts of milk without symptoms. A woman with lactose intolerance is more likely to experience bloating and cramping, not heartburn. A client who breaks out in hives after consuming milk is more likely to have a milk allergy and should be advised to simply brush her teeth after consuming dairy products.

DIF: Cognitive Level: Apply REF: IMS: 353

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

4. A client states that she does not drink milk. Which foods should the nurse encourage this woman to consume in greater amounts to increase her calcium intake?

a. Fresh apricots
b. Canned clams
c. Spaghetti with meat sauce
d. Canned sardines

ANS: D

Sardines are rich in calcium. Fresh apricots, canned clams, and spaghetti with meat sauce are not high in calcium.

DIF: Cognitive Level: Understand REF: IMS: 352 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. A 27-year-old pregnant woman had a preconceptual body mass index (BMI) of 19. What is this clients total recommended weight gain during pregnancy?

a. 20 kg (44 lb)
b. 16 kg (35 lb)
c. 12.5 kg (27.5 lb)
d. 10 kg (22 lb)

ANS: C

This woman has a normal BMI and should gain 11.5 to 16 kg during her pregnancy. A weight gain of 20 kg (44 lb) is unhealthy for most women; a weight gain of 16 kg (35 lb) is at the high end of the range of weight this woman should gain in her pregnancy; and a weight gain of 10 kg (22 lb) is appropriate for an obese woman. This woman has a normal BMI, which indicates that her weight is average.

DIF: Cognitive Level: Understand REF: IMS: 348 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

6. A woman has come to the clinic for preconception counseling because she wants to start trying to get pregnant. Which guidance should she expect to receive?

a. Discontinue all contraception now.
b. Lose weight so that you can gain more during pregnancy.
c. You may take any medications you have been regularly taking.
d. Make sure you include adequate folic acid in your diet.

ANS: D

A healthy diet before conception is the best way to ensure that adequate nutrients are available for the developing fetus. A womans folate or folic acid intake is of particular concern in the periconception period. Neural tube defects are more common in infants of women with a poor folic acid intake. Depending on the type of contraception that she has been using, discontinuing all contraception at this time may not be appropriate. Advising this client to lose weight now so that she can gain more during pregnancy is also not appropriate advice. Depending on the type of medications the woman is taking, continuing to take them regularly may not be appropriate.

DIF: Cognitive Level: Apply REF: IMS: 344 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. To prevent gastrointestinal (GI) upset, when should a pregnant client be instructed to take the recommended iron supplements?

a. On a full stomach
b. At bedtime
c. After eating a meal
d. With milk

ANS: B

Iron supplements taken at bedtime may reduce GI upset and should be taken at bedtime if abdominal discomfort occurs when iron supplements are taken between meals. Iron supplements are best absorbed if they are taken when the stomach is empty. Bran, tea, coffee, milk, and eggs may reduce absorption.

DIF: Cognitive Level: Apply REF: IMS: 361 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

8. After the nurse completes nutritional counseling for a pregnant woman, she asks the client to repeat the instructions to assess the clients understanding. Which statement indicates that the client understands the role of protein in her pregnancy?

a. Protein will help my baby grow.
b. Eating protein will prevent me from becoming anemic.
c. Eating protein will make my baby have strong teeth after he is born.
d. Eating protein will prevent me from being diabetic.

ANS: A

Protein is the nutritional element basic to growth. An adequate protein intake is essential to meeting the increasing demands of pregnancy. These demands arise from the rapid growth of the fetus; the enlargement of the uterus, mammary glands, and placenta; the increase in the maternal blood volume; and the formation of the amniotic fluid. Iron intake prevents anemia. Calcium intake is needed for fetal bone and tooth development. Glycemic control is needed in those with diabetes; protein is one nutritional factor to consider for glycemic control but not the primary role of protein intake.

DIF: Cognitive Level: Apply REF: pp. 350-351 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

9. Pregnant adolescents are at greater risk for decreased BMI and fad dieting with which condition?

a. Obesity
b. Gestational diabetes
c. Low-birth-weight babies
d. High-birth-weight babies

ANS: C

Adolescents tend to have lower BMIs. In addition, the fetus and the still-growing mother appear to compete for nutrients. These factors, along with inadequate weight gain, lend themselves to a higher incidence of low-birth-weight babies. Obesity is associated with a higher-than-normal BMI. Unless the teenager has type 1 diabetes, an adolescent with a low BMI is less likely to develop gestational diabetes. High-birth-weight or large-for-gestational age (LGA) babies are most often associated with gestational diabetes.

DIF: Cognitive Level: Apply REF: IMS: 356

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

10. Maternal nutritional status is an especially significant factor of the many that influence the outcome of pregnancy. Why is this the case?

a. Maternal nutritional status is extremely difficult to adjust because of an individuals ingrained eating habits.
b. Adequate nutrition is an important preventive measure for a variety of problems.
c. Women love obsessing about their weight and diets.
d. A womans preconception weight becomes irrelevant.

ANS: B

Nutritional status draws so much attention not only for its effect on a healthy pregnancy and birth but also because significant changes are within relatively easy reach. Pregnancy is a time when many women are motivated to learn about adequate nutrition and make changes to their diet that will benefit their baby. Pregnancy is not the time to begin a weight loss diet. Clients and their caregivers should still be concerned with appropriate weight gain.

DIF: Cognitive Level: Understand REF: IMS: 344 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

11. With regard to weight gain during pregnancy, the nurse should be aware of which important information?

a. In pregnancy, the womans height is not a factor in determining her target weight.
b. Obese women may have their health concerns, but their risk of giving birth to a child with major congenital defects is the same as with women of normal weight.
c. Women with inadequate weight gain have an increased risk of delivering a preterm infant with intrauterine growth restriction (IUGR).
d. Greater than expected weight gain during pregnancy is almost always attributable to old-fashioned overeating.

ANS: C

IUGR is associated with women with inadequate weight gain. The primary factor in making a weight gain recommendation is the appropriateness of the prepregnancy weight for the womans height. Obese women are twice as likely as women of normal weight to give birth to a child with major congenital defects. Overeating is only one of several likely causes.

DIF: Cognitive Level: Remember REF: pp. 347-348 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

12. Which nutritional recommendation regarding fluids is *accurate*?

a. A womans daily intake should be six to eight glasses of water, milk, and/or juice.
b. Coffee should be limited to no more than 2 cups, but tea and cocoa can be consumed without worry.
c. Of the artificial sweeteners, only aspartame has not been associated with any maternity health concerns.
d. Water with fluoride is especially encouraged because it reduces the childs risk of tooth decay.

ANS: A

Six to eight glasses is still the standard for fluids; however, they should be the right fluids. All beverages containing caffeine, including tea, cocoa, and some soft drinks, should be avoided or should be consumed only in limited amounts. Artificial sweeteners, including aspartame, have no ill effects on the normal mother or fetus. However, mothers with phenylketonuria (PKU) should avoid aspartame. Although no evidence indicates that prenatal fluoride consumption reduces childhood tooth decay, fluoride still helps the mother.

DIF: Cognitive Level: Understand REF: IMS: 352 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

13. Which minerals and vitamins are usually recommended as a supplement in a pregnant clients diet?

a. Fat-soluble vitamins A and D
b. Water-soluble vitamins C and B_6
c. Iron and folate
d. Calcium and zinc

ANS: C

Iron should generally be supplemented, and folic acid supplements are often needed because folate is so important in pregnancy. Fat-soluble vitamins should be supplemented as a medical prescription, as vitamin D might be for lactose-intolerant women. Water-soluble vitamin C is

sometimes naturally consumed in excess; vitamin B_6 is prescribed only if the woman has a very poor diet; and zinc is sometimes supplemented. Most women get enough calcium.

DIF: Cognitive Level: Apply REF: pp. 344, 352 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

14. Which vitamins or minerals may lead to congenital malformations of the fetus if taken in excess by the mother?

a. Zinc
b. Vitamin D
c. Folic acid
d. Vitamin A

ANS: D

If taken in excess, vitamin A causes a number of problems. An analog of vitamin A appears in prescribed acne medications, which must not be taken during pregnancy. Zinc, vitamin D, and folic acid are all vital to good maternity and fetal health and are highly unlikely to be consumed in excess.

DIF: Cognitive Level: Understand REF: IMS: 354 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

15. While obtaining a diet history, the nurse might be told that the expectant mother has cravings for ice chips, cornstarch, and baking soda. Which nutritional problem does this behavior indicate?

a. Preeclampsia
b. Pyrosis
c. Pica
d. Purging

ANS: C

The consumption of foods low in nutritional value or of nonfood substances (e.g., dirt, laundry starch) is called *pica.* Preeclampsia is a vasospastic disease process encountered after 20 weeks of gestation. Characteristics of preeclampsia include increasing hypertension, proteinuria, and hemoconcentration. Pyrosis is a burning sensation in the epigastric region, otherwise known as heartburn. Purging refers to self-induced vomiting after consuming large quantities of food.

DIF: Cognitive Level: Remember REF: IMS: 355 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

16. Assessment of a womans nutritional status includes a diet history, medication regimen, physical examination, and relevant laboratory tests. Which finding might require consultation to a higher level of care?

a. Oral contraceptive use may interfere with the absorption of iron.
b. Illnesses that have created nutritional deficits, such as PKU, may require nutritional care before conception.
c. The womans socioeconomic status and educational level are not relevant to her examination; they are the province of the social worker.
d. Testing for diabetes is the only nutrition-related laboratory test most pregnant women need.

ANS: B

A registered dietitian can help with therapeutic diets. Oral contraceptive use may interfere with the absorption of folic acid. Iron deficiency can appear if placement of an intrauterine device (IUD) results in blood loss. A womans finances can affect her access to good nutrition; her education (or lack thereof) can influence the nurses teaching decisions. The nutrition-related laboratory test that pregnant women usually need is a screen for anemia.

DIF: Cognitive Level: Apply REF: IMS: 356

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

17. Which guidance might the nurse provide for a client with severe morning sickness?

a. Trying lemonade and potato chips
b. Drinking plenty of fluids early in the day
c. Immediately brushing her teeth after eating
d. Never snacking before bedtime

ANS: A

Interestingly, some women can tolerate tart or salty foods when they are nauseated. Lemonade and potato chips are an ideal combination. The woman should avoid drinking too much when nausea is most likely, but she should increase her fluid levels later in the day when she feels better. The woman should avoid brushing her teeth immediately after eating. A small snack of cereal and milk or yogurt before bedtime may help the stomach in the morning.

DIF: Cognitive Level: Understand REF: IMS: 362 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. Many clients are concerned about the increased levels of mercury in fish and may be reluctant to include this source of nutrients in their diet. What is the best advice for the nurse to provide?

a. Canned white tuna is a preferred choice.
b. Shark, swordfish, and mackerel should be avoided.
c. Fish caught in local waterways is the safest.
d. Salmon and shrimp contain high levels of mercury.

ANS: B

As a precaution, the pregnant client should avoid eating shark, swordfish, and mackerel, as well as the less common tilefish. High levels of mercury can harm the developing nervous system of the fetus. Assisting the client in understanding the differences between numerous sources of mercury is essential for the nurse. A pregnant client may eat as much as 12 ounces a week of

canned *light* tuna; however, canned white, albacore, or tuna steaks contain higher levels of mercury and should be limited to no more than 6 ounces per week. Pregnant women and mothers of young children should check with local advisories about the safety of fish caught by families and friends in nearby bodies of water. If no information is available, then these fish sources should be avoided, limited to less than 6 ounces per week, or the only fish consumed that week. Commercially caught fish that is low in mercury includes salmon, shrimp, pollock, or catfish. The pregnant client may eat up to 12 ounces of commercially caught fish per week. Additional information on levels of mercury in commercially caught fish is available at www.cfsan.fda.gov.

DIF: Cognitive Level: Understand REF: IMS: 352 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. Nutrition is an alterable and important preventive measure for a variety of potential problems such as low birth weight and prematurity. While completing the physical assessment of the pregnant client, the nurse is able to evaluate the clients nutritional status by observing a number of physical signs. Which physical sign indicates to the nurse that the client has unmet nutritional needs?

a. Normal heart rate, rhythm, and blood pressure
b. Bright, clear, and shiny eyes
c. Alert and responsive with good endurance
d. Edema, tender calves, and tingling

ANS: D

The physiologic changes of pregnancy may complicate the interpretation of physical findings. Lower extremity edema often occurs when caloric and protein deficiencies are present; however, edema in the lower extremities may also be a common physical finding during the third trimester. Completing a thorough health history and physical assessment and requesting further laboratory testing, if indicated, are essential for the nurse. The malnourished pregnant client may display rapid heart rate, abnormal rhythm, enlarged heart, and elevated blood pressure. A client receiving adequate nutrition will have bright, shiny eyes with no sores and moist, pink membranes. Pale or red membranes, dryness, infection, dull appearance of the cornea, or blue

sclerae are signs of poor nutrition. A client who is alert and responsive with good endurance is well nourished. A listless, cachectic, easily fatigued, and tired presentation would be an indication of a poor nutritional status.

DIF: Cognitive Level: Analyze REF: IMS: 358

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

20. A pregnant woman reports that she is still playing tennis at 32 weeks of gestation. Which recommendation would the nurse make for this particular client after a tennis match?

a. Drink several glasses of fluid.
b. Eat extra protein sources such as peanut butter.
c. Enjoy salty foods to replace lost sodium.
d. Consume easily digested sources of carbohydrate.

ANS: A

If no medical or obstetric problems contraindicate physical activity, then pregnant women should get 30 minutes of moderate physical exercise daily. Liberal amounts of fluid should be consumed before, during, and after exercise because dehydration can trigger premature labor. The womans caloric intake should be sufficient to meet the increased needs of pregnancy and the demands of exercise.

DIF: Cognitive Level: Apply REF: IMS: 356 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

21. A woman in the 34th week of pregnancy reports that she is very uncomfortable because of heartburn. Which recommendation would be appropriate for this client?

a. Substitute other calcium sources for milk in her diet.
b. Lie down after each meal.
c. Reduce the amount of fiber she consumes.
d. Eat five small meals daily.

ANS: D

Eating small, frequent meals may help with heartburn, nausea, and vomiting. Substituting other calcium sources for milk, lying down after eating, and reducing fiber intake are inappropriate dietary suggestions for all pregnant women and do not alleviate heartburn.

DIF: Cognitive Level: Apply REF: IMS: 362 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

22. Which information regarding protein in the diet of a pregnant woman is most helpful to the client?

a. Many protein-rich foods are also good sources of calcium, iron, and B vitamins.
b. Many women need to increase their protein intake during pregnancy.
c. As with carbohydrates and fat, no specific recommendations exist for the amount of protein in the diet.
d. High-protein supplements can be used without risk by women on macrobiotic diets.

ANS: A

Good sources for protein, such as meat, milk, eggs, and cheese, have a lot of calcium and iron. Most women already eat a high-protein diet and do not need to increase their intake. Protein is sufficiently important that specific servings of meat and dairy are recommended. High-protein supplements are not recommended because they have been associated with an increased incidence of preterm births.

DIF: Cognitive Level: Remember REF: IMS: 351 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

23. A client states that she plans to breastfeed her newborn infant. What guidance would be useful for this new mother?

a. The mothers intake of vitamin C, zinc, and protein can now be lower than during pregnancy.
b. Caffeine consumed by the mother accumulates in the infant, who may be unusually active and wakeful.
c. Critical iron and folic acid levels must be maintained.
d. Lactating women can go back to their prepregnant caloric intake.

ANS: B

A lactating woman needs to avoid consuming too much caffeine. Vitamin C, zinc, and protein levels need to be moderately higher during lactation than during pregnancy. The recommendations for iron and folic acid are lower during lactation. Lactating women should consume approximately 500 kcal more than their prepregnancy intake, at least 1800 kcal daily overall.

DIF: Cognitive Level: Understand REF: IMS: 365 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

24. The labor and delivery nurse is preparing a client who is severely obese (bariatric) for an elective cesarean birth. Which piece of specialized equipment will *not* likely be needed when providing care for this pregnant woman?

a. Extra-long surgical instruments
b. Wide surgical table
c. Temporal thermometer
d. Increased diameter blood pressure cuff

ANS: C

Obstetricians today are seeing an increasing number of morbidly obese pregnant women weighing 400, 500, and 600 pounds. To manage their conditions and to meet their logistical needs, a new medical subspecialty,*bariatric obstetrics*, has arisen. Extra-wide blood pressure cuffs, scales that can accommodate up to 880 pounds, and extra-wide surgical tables designed to hold the weight of these women are used. Special techniques for ultrasound examination and

longer surgical instruments for cesarean birth are also required. A temporal thermometer can be used for a pregnant client of any size.

DIF: Cognitive Level: Understand REF: IMS: 345 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

25. Which pregnant woman should strictly follow weight gain recommendations during pregnancy?

a. Pregnant with twins
b. In early adolescence
c. Shorter than 62 inches or 157 cm
d. Was 20 pounds overweight before pregnancy

ANS: D

A weight gain of 5 to 9 kg will provide sufficient nutrients for the fetus. Overweight and obese women should be advised to lose weight before conception to achieve the best pregnancy outcomes. A higher weight gain in twin gestations may help prevent low birth weights. Adolescents need to gain weight toward the higher acceptable range, which provides for their own growth, as well as for fetal growth. In the past, women of short stature were advised to restrict their weight gain; however, evidence to support these guidelines has not been found.

DIF: Cognitive Level: Understand REF: IMS: 348

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

26. The major source of nutrients in the diet of a pregnant woman should be composed of what?

a. Simple sugars
b. Fats
c. Fiber
d. Complex carbohydrates

ANS: D

Complex carbohydrates supply the pregnant woman with vitamins, minerals, and fiber. The most common simple carbohydrate is table sugar, which is a source of energy but does not provide any nutrients. Fats provide 9 kcal in each gram, in contrast to carbohydrates and proteins, which provide only 4 kcal in each gram. Fiber is primarily supplied by complex carbohydrates.

DIF: Cognitive Level: Remember REF: IMS: 361

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

27. A pregnant womans diet may not meet her increased need for folates. Which food is a rich source of this nutrient?

a. Chicken
b. Cheese
c. Potatoes
d. Green leafy vegetables

ANS: D

Sources of folates include green leafy vegetables, whole grains, fruits, liver, dried peas, and beans. Chicken and cheese are excellent sources of protein but are poor sources for folates.
Potatoes contain carbohydrates and vitamins and minerals but are poor sources for folates.

DIF: Cognitive Level: Remember REF: IMS: 347

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

28. If a clients normal prepregnancy diet contains 45 g of protein daily, how many more grams of protein should she consume per day during pregnancy?

a. 5
b. 10
c. 25

d. 30

ANS: C

The recommended intake of protein for the pregnant woman is 70 g. Therefore, additional protein intakes of 5, 10, or 15 g would be inadequate to meet protein needs during pregnancy. A protein intake of 30 g is more than would be necessary and would add extra calories.

DIF: Cognitive Level: Understand REF: IMS: 351

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

29. Which action is the first priority for the nurse who is assessing the influence of culture on a clients diet?

a. Evaluate the clients weight gain during pregnancy.
b. Assess the socioeconomic status of the client.
c. Discuss the four food groups with the client.
d. Identify the food preferences and methods of food preparation common to the clients culture.

ANS: D

Understanding the clients food preferences and how she prepares food will assist the nurse in determining whether the clients culture is adversely affecting her nutritional intake. An evaluation of a clients weight gain during pregnancy should be included for all clients, not only for clients from different cultural backgrounds. The socioeconomic status of the client may alter the nutritional intake but not the cultural influence. Teaching the food groups to the client should come after assessing her food preferences.

DIF: Cognitive Level: Apply REF: IMS: 363

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

30. The nurse has formulated a diagnosis of *Imbalanced nutrition: Less than body requirements* for the client. Which goal is most appropriate for this client to obtain?

a. Gain a total of 30 pounds.
b. Consistently take daily supplements.
c. Decrease her intake of snack foods.
d. Increase her intake of complex carbohydrates.

ANS: A

A weight gain of 30 pounds is one indication that the client has gained a sufficient amount for the nutritional needs of pregnancy. A daily supplement is not the best goal for this client and does not meet the basic need of proper nutrition during pregnancy. Decreasing snack foods may be needed and should be assessed; however, assessing weight gain is the best method of monitoring nutritional intake for this pregnant client. Although increasing the intake of complex carbohydrates is important for this client, monitoring the weight gain should be the end goal.

DIF: Cognitive Level: Apply REF: IMS: 360 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

31. Which action is the highest priority for the nurse when educating a pregnant adolescent?

a. Emphasize the need to eliminate common teenage snack foods because they are high in fat and sodium.
b. Determine the weight gain needed to meet adolescent growth, and add 35 pounds.
c. Suggest that she not eat at fast-food restaurants to avoid foods of poor nutritional value.
d. Realize that most adolescents are unwilling to make dietary changes during pregnancy.

ANS: B

Adolescents should gain in the upper range of the recommended weight gain. They also need to gain weight that would be expected for their own normal growth. Changes in the diet should be kept at a minimum. Snack foods can be included in moderation, and other foods can be added to make up for lost nutrients. Eliminating fast foods would make the adolescent appear different to

her peers. The client should be taught to choose foods that add needed nutrients. Adolescents are willing to make changes; however, they still have the need to be similar to their peers.

DIF: Cognitive Level: Apply REF: IMS: 356

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Most women with uncomplicated pregnancies can use the nurse as their primary source for nutritional information. However, the nurse or midwife may need to refer a client to a registered dietitian for in-depth nutritional counseling. Which conditions would require such a consultation? *(Select all that apply.)*

a. Preexisting or gestational illness such as diabetes
b. Ethnic or cultural food patterns
c. Obesity
d. Vegetarian diets
e. Multifetal pregnancy

ANS: A, B, C, D

The nurse should be especially aware that conditions such as diabetes can require in-depth dietary planning and evaluation. To prevent issues with hypoglycemia and hyperglycemia, as well as an increased risk for perinatal morbidity and mortality, the client with a preexisting or gestational illness would benefit from a referral to a dietitian. Consultation with a dietitian may ensure that cultural food beliefs are congruent with modern knowledge of fetal development and that adjustments can be made to ensure that all nutritional needs are met. The obese pregnant client may be under the misapprehension that, because of her excess weight, little or no weight gain is necessary. According to the Institute of Medicine, a client with a BMI in the obese range should gain at least 7 kg to ensure a healthy outcome. This client may require in-depth counseling on the optimal food choices. The vegetarian client needs to have her dietary intake carefully assessed to ensure that the optimal combination of amino acids and protein intake is achieved. Very strict vegetarians (vegans) who consume only plant products may also require

vitamin B and mineral supplementation. A multifetal pregnancy can be managed by increasing the number of servings of complex carbohydrates and proteins.

Chapter 16: Labor and Birth Processes

MULTIPLE CHOICE

1. A new mother asks the nurse when the soft spot on her sons head will go away. What is the nurses best response, based upon her understanding of when the anterior frontal closes?

a. 2 months
b. 8 months
c. 12 months
d. 18 months

ANS: D

The larger of the two fontanels, the anterior fontanel, closes by 18 months after birth. The posterior fontanel closes at 6 to 8 weeks. The remaining three options are too early for the anterior fontanel to close.

DIF: Cognitive Level: Understand REF: IMS: 367

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. The nurse is performing an initial assessment of a client in labor. What is the appropriate terminology for the relationship of the fetal body parts to one another?

a. Lie
b. Presentation
c. Attitude
d. Position

ANS: C

Attitude is the relationship of the fetal body parts to one another. *Lie* is the relationship of the long axis (spine) of the fetus to the long axis (spine) of the mother. *Presentation* refers to the part of the fetus that enters the pelvic inlet first and leads through the birth canal during labor at term. *Position* is the relationship of the presenting part of the fetus to the four quadrants of the mothers pelvis.

DIF: Cognitive Level: Remember REF: IMS: 369

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. When assessing the fetus using Leopolds maneuvers, the nurse feels a round, firm, and movable fetal part in the fundal portion of the uterus and a long, smooth surface in the mothers right side close to midline. What is the position of the fetus?

a. ROA
b. LSP
c. RSA
d. LOA

ANS: C

Fetal position is denoted with a three-letter abbreviation. The first letter indicates the presenting part in either the right or the left side of the maternal pelvis. The second letter indicates the anatomic presenting part of the fetus. The third letter stands for the location of the presenting part in relationship to the anterior, posterior, or transverse portion of the maternal pelvis. Palpation of a round, firm fetal part in the fundal portion of the uterus would be the fetal head, indicating that the fetus is in a breech position with the sacrum as the presenting part in the maternal pelvis. Palpation of the fetal spine along the mothers right side denotes the location of the presenting part in the mothers pelvis. The ability to palpate the fetal spine indicates that the fetus is anteriorly positioned in the maternal pelvis. This fetus is anteriorly positioned in the right side of the maternal pelvis with the sacrum as the presenting part. RSA is the correct three-letter abbreviation to indicate this fetal position. ROA denotes a fetus that is anteriorly positioned in the right side of the maternal pelvis with the occiput as the presenting part. LSP describes a fetus that is posteriorly positioned in the left side of the pelvis with the sacrum as the presenting part.

A fetus that is LOA would be anteriorly positioned in the left side of the pelvis with the occiput as the presenting part.

DIF: Cognitive Level: Apply REF: IMS: 370

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. Which statement by the client would lead the nurse to believe that labor has been established?

a. I passed some thick, pink mucus when I urinated this morning.
b. My bag of waters just broke.
c. The contractions in my uterus are getting stronger and closer together.
d. My baby dropped, and I have to urinate more frequently now.

ANS: C

Regular, strong contractions with the presence of cervical change indicate that the woman is experiencing true labor. Although the loss of the mucous plug (operculum) often occurs during the first stage of labor or before the onset of labor, it is not the indicator of true labor. Spontaneous rupture of membranes often occurs during the first stage of labor; however, it is not an indicator of true labor. The presenting part of the fetus typically becomes engaged in the pelvis at the onset of labor but is not the indicator of true labor.

DIF: Cognitive Level: Understand REF: IMS: 376

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. The nurse has received a report regarding a client in labor. The womans last vaginal examination was recorded as 3 cm, 30%, and 2. What is the nurses interpretation of this assessment?

a. Cervix is effaced 3 cm and dilated 30%; the presenting part is 2 cm above the ischial spines.
b. Cervix is dilated 3 cm and effaced 30%; the presenting part is 2 cm above the ischial spines.

c. Cervix is effaced 3 cm and dilated 30%; the presenting part is 2 cm below the ischial spines.
d. Cervix is dilated 3 cm and effaced 30%; the presenting part is 2 cm below the ischial spines.

ANS: B

The sterile vaginal examination is recorded as centimeters of cervical dilation, percentage of cervical dilation, and the relationship of the presenting part to the ischial spines (either above or below). For this woman, the cervix is dilated 3 cm and effaced 30%, and the presenting part is 2 cm above the ischial spines. The first interpretation of this vaginal examination is incorrect; the cervix is dilated 3 cm and is 30% effaced. However, the presenting part is correct at 2 cm above the ischial spines. The remaining two interpretations of this vaginal examination are incorrect. Although the dilation and effacement are correct at 3 cm and 30%, the presenting part is actually 2 cm above the ischial spines.

DIF: Cognitive Level: Comprehend REF: IMS: 370 | pp. 373-374

TOP: Nursing Process: Assessment | Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

6. A pregnant woman is at 38 weeks of gestation. She wants to know whether there are any signs that labor is getting close to starting. Which finding is an indication that labor may begin soon?

a. Weight gain of 1.5 to 2 kg (3 to 4 lb)
b. Increase in fundal height
c. Urinary retention
d. Surge of energy

ANS: D

Women speak of having a burst of energy before labor. The woman may lose 0.5 to 1.5 kg, as a result of water loss caused by electrolyte shifts that, in turn, are caused by changes in the

estrogen and progesterone levels. When the fetus descends into the true pelvis (called *lightening*), the fundal height may decrease. Urinary frequency may return before labor.

DIF: Cognitive Level: Understand REF: IMS: 376 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. Which stage of labor varies the most in length?

a. First
b. Second
c. Third
d. Fourth

ANS: A

The first stage of labor is considered to last from the onset of regular uterine contractions to the full dilation of the cervix. The first stage is significantly longer than the second and third stages combined. In a first-time pregnancy, the first stage of labor can take up to 20 hours. The second stage of labor lasts from the time the cervix is fully dilated to the birth of the fetus. The average length is 20 minutes for a multiparous woman and 50 minutes for a nulliparous woman. The third stage of labor lasts from the birth of the fetus until the placenta is delivered. This stage may be as short as 3 minutes or as long as 1 hour. The fourth stage of labor, recovery, lasts approximately 2 hours after the delivery of the placenta.

DIF: Cognitive Level: Remember REF: IMS: 376 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. The nurse expects which maternal cardiovascular finding during labor?

a. Increased cardiac output
b. Decreased pulse rate
c. Decreased white blood cell (WBC) count
d. Decreased blood pressure

ANS: A

During each contraction, 400 ml of blood is emptied from the uterus into the maternal vascular system, which increases cardiac output by approximately 10% to 15% during the first stage of labor and by approximately 30% to 50% in the second stage of labor. The heart rate increases slightly during labor. The WBC count can increase during labor. During the first stage of labor, uterine contractions cause systolic readings to increase by approximately 10 mm Hg. During the second stage, contractions may cause systolic pressures to increase by 30 mm Hg and diastolic readings to increase by 25 mm Hg.

DIF: Cognitive Level: Understand REF: IMS: 379 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

9. What is the correct term describing the slight overlapping of cranial bones or shaping of the fetal head during labor?

a. Lightening
b. Molding
c. Ferguson reflex
d. Valsalva maneuver

ANS: B

Molding also permits adaptation to various diameters of the maternal pelvis. *Lightening* is the mothers sensation of decreased abdominal distention, which usually occurs the week before labor. The Ferguson reflex is the contraction urge of the uterus after the stimulation of the cervix. The Valsalva maneuver describes conscious pushing during the second stage of labor.

DIF: Cognitive Level: Remember REF: IMS: 367

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. Which presentation is accurately described in terms of both the resenting part and the frequency of occurrence?

a. Cephalic: occiput, at least 96%
b. Breech: sacrum, 10% to 15%
c. Shoulder: scapula, 10% to 15%
d. Cephalic: cranial, 80% to 85%

ANS: A

In cephalic presentations (head first), the presenting part is the occiput; this presentation occurs in 96% of births. In a breech birth, the sacrum emerges first; this presentation occurs in approximately 3% of births. In shoulder presentations, the scapula emerges first; this presentation occurs in only 1% of births. In a cephalic presentation, the part of the head or cranium that emerges first is the occiput; cephalic presentations occur in 96% of births.

DIF: Cognitive Level: Understand REF: IMS: 368 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

11. A labor and delivery nurse should be cognizant of which information regarding how the fetus moves through the birth canal?

a. Fetal attitude describes the angle at which the fetus exits the uterus.
b. Of the two primary fetal lies, the horizontal lie is that in which the long axis of the fetus is parallel to the long axis of the mother.
c. Normal attitude of the fetus is called *general flexion*.
d. Transverse lie is preferred for vaginal birth.

ANS: C

The normal attitude of the fetus is called *general flexion*. The fetal attitude is the relationship of the fetal body parts to each one another. The horizontal lie is perpendicular to the mother; in the longitudinal (or vertical) lie, the long axes of the fetus and the mother are parallel. Vaginal birth cannot occur if the fetus stays in a transverse lie.

DIF: Cognitive Level: Understand REF: IMS: 369 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. A womans position is an important component of the labor progress. Which guidance is important for the nurse to provide to the laboring client?

a. The supine position, which is commonly used in the United States, increases blood flow.
b. The laboring client positioned on her hands and knees (all fours position) is hard on the womans back.
c. Frequent changes in position help relieve fatigue and increase the comfort of the laboring client.
d. In a sitting or squatting position, abdominal muscles of the laboring client will have to work harder.

ANS: C

Frequent position changes relieve fatigue, increase comfort, and improve circulation. Blood flow can be compromised in the supine position; any upright position benefits cardiac output. The all fours position is used to relieve backache in certain situations. In a sitting or squatting position, the abdominal muscles work in greater harmony with uterine contractions.

DIF: Cognitive Level: Apply REF: IMS: 375

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

13. Certain changes stimulate chemoreceptors in the aorta and carotid bodies to prepare the fetus for initiating respirations immediately after birth. Which change in fetal physiologic activity is *not* part of this process?

a. Fetal lung fluid is cleared from the air passages during labor and vaginal birth.
b. Fetal partial pressure of oxygen (PO_2) decreases.
c. Fetal partial pressure of carbon dioxide in arterial blood ($PaCO_2$) increases.
d. Fetal respiratory movements increase during labor.

ANS: D

Fetal respiratory movements actually decrease during labor. Fetal lung fluid is cleared from the air passages during labor and vaginal birth. Fetal PO_2 decreases, and fetal $PaCO_2$ increases.

DIF: Cognitive Level: Understand REF: IMS: 379

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. Which description of the four stages of labor is *correct* for both the definition and the duration?

a. First stage: onset of regular uterine contractions to full dilation; less than 1 hour to 20 hours
b. Second stage: full effacement to 4 to 5 cm; visible presenting part; 1 to 2 hours
c. Third stage: active pushing to birth; 20 minutes (multiparous woman), 50 minutes (nulliparous woman)
d. Fourth stage: delivery of the placenta to recovery; 30 minutes to 1 hour

ANS: A

Full dilation may occur in less than 1 hour, but in first-time pregnancies full dilation can take up to 20 hours. The second stage of labor extends from full dilation to birth and takes an average of 20 to 50 minutes, although 2 hours is still considered normal. The third stage of labor extends from birth to the expulsion of the placenta and usually takes a few minutes. The fourth stage begins after the expulsion of the placenta and lasts until homeostasis is reestablished (approximately 2 hours).

DIF: Cognitive Level: Understand REF: pp. 376-377 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

15. Nurses should be cognizant of what regarding the mechanism of labor?

a. Seven critical movements must progress in a more or less orderly sequence.
b. Asynclitism is sometimes achieved by means of the Leopolds maneuver.

c. Effects of the forces determining descent are modified by the shape of the womans pelvis and the size of the fetal head.

d. At birth, the baby is said to achieve restitution; that is, a return to the C-shape of the womb.

ANS: C

The size of the maternal pelvis and the ability of the fetal head to mold also affect the process. The seven identifiable movements of the mechanism of labor simultaneously occur in combinations, not in precise sequences. Asynclitism is the deflection of the babys head; the Leopolds maneuver is a means of judging descent by palpating the mothers abdomen. Restitution is the rotation of the babys head after the infant is born.

DIF: Cognitive Level: Understand REF: IMS: 377

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

16. Which statement related to fetal positioning during labor is *correct* and important for the nurse to understand?

a. Position is a measure of the degree of descent of the presenting part of the fetus through the birth canal.

b. Birth is imminent when the presenting part is at +4 to +5 cm below the spine.

c. The largest transverse diameter of the presenting part is the suboccipitobregmatic diameter.

d. *Engagement* is the term used to describe the beginning of labor.

ANS: B

The station of the presenting part should be noted at the beginning of labor to determine the rate of descent. *Position* is the relationship of the presenting part of the fetus to the four quadrants of the mothers pelvis; *station* is the measure of degree of descent. The largest diameter is usually the biparietal diameter. The suboccipitobregmatic diameter is the smallest, although one of the

most critical. Engagement often occurs in the weeks just before labor in nulliparous women and before or during labor in multiparous women.

DIF: Cognitive Level: Understand REF: IMS: 370

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

17. Which basic type of pelvis includes the *correct* description and percentage of occurrence in women?

a. Gynecoid: classic female pelvis; heart shaped; 75%
b. Android: resembling the male pelvis; wide oval; 15%
c. Anthropoid: resembling the pelvis of the ape; narrow; 10%
d. Platypelloid: flattened, wide, and shallow pelvis; 3%

ANS: D

A platypelloid pelvis is flattened, wide, and shallow; approximately 3% of women have this shape. The gynecoid pelvis is the classic female shape, slightly ovoid and rounded; approximately 50% of women have this shape. An android or malelike pelvis is heart shaped; approximately 23% of women have this shape. An anthropoid or apelike pelvis is oval and wide; approximately 24% of women have this shape.

DIF: Cognitive Level: Remember REF: IMS: 374

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

18. What is the nurses understanding of the appropriate role of primary and secondary powers?

a. Primary powers are responsible for the effacement and dilation of the cervix.
b. Effacement is generally well ahead of dilation in women giving birth for the first time; they are closer together in subsequent pregnancies.
c. Scarring of the cervix caused by a previous infection or surgery may make the delivery a bit more painful, but it should not slow or inhibit dilation.
d. Pushing in the second stage of labor is more effective if the woman can breathe deeply and control some of her involuntary needs to push, as the nurse directs.

ANS: A

The primary powers are responsible for dilation and effacement; secondary powers are concerned with expulsion of the fetus. Effacement is generally well ahead of dilation in first-time pregnancies; they are closer together in subsequent pregnancies. Scarring of the cervix may slow dilation. Pushing is more effective and less fatiguing when the woman begins to push only after she has the urge to do so.

DIF: Cognitive Level: Understand REF: IMS: 372 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. Which statement regarding the care of a client in labor is *correct* and important to the nurse as he or she formulates the plan of care?

a. The womans blood pressure will increase during contractions and fall back to prelabor normal levels between contractions.
b. The use of the Valsalva maneuver is encouraged during the second stage of labor to relieve fetal hypoxia.
c. Having the woman point her toes will reduce leg cramps.
d. Endogenous endorphins released during labor will raise the womans pain threshold and produce sedation.

ANS: D

The endogenous endorphins released during labor will raise the womans pain threshold and produce sedation. In addition, physiologic anesthesia of the perineal tissues, caused by the pressure of the presenting part, decreases the mothers perception of pain. Blood pressure levels increase during contractions but remain somewhat elevated between them. The use of the Valsalva maneuver is discouraged during the second stage labor because of a number of unhealthy outcomes, including fetal hypoxia. Pointing the toes can cause leg cramps, as can the process of labor itself.

DIF: Cognitive Level: Understand REF: IMS: 380 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. Which adaptation of the maternal-fetal exchange of oxygen occurs in response to uterine contraction?

a. The maternal-fetal exchange of oxygen and waste products continues except when placental functions are reduced.
b. This maternal-fetal exchange increases as the blood pressure decreases.
c. It diminishes as the spiral arteries are compressed.
d. This exchange of oxygen and waste products is not significantly affected by contractions.

ANS: C

Uterine contractions during labor tend to decrease circulation through the spiral electrodes and subsequent perfusion through the intervillous space. The maternal blood supply to the placenta gradually stops with contractions. The exchange of oxygen and waste products decreases. The exchange of oxygen and waste products is affected by contractions.

DIF: Cognitive Level: Understand REF: IMS: 379

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

21. Which statement is the *best* rationale for assessing the maternal vital signs between uterine contractions?

a. During a contraction, assessing the fetal heart rate is the priority.
b. Maternal circulating blood volume temporarily increases during contractions.
c. Maternal blood flow to the heart is reduced during contractions.
d. Vital signs taken during contractions are not accurate.

ANS: B

During uterine contractions, blood flow to the placenta temporarily stops, causing a relative increase in the mothers blood volume, which, in turn, temporarily increases blood pressure and slows the pulse. Monitoring fetal responses to the contractions is important; however, this

question concerns the maternal vital signs. Maternal blood flow is increased during a contraction. Vital signs are altered by contractions but are considered accurate for that period.

DIF: Cognitive Level: Apply REF: IMS: 379

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

22. What is the primary difference between the labor of a nullipara and that of a multipara?

a. Amount of cervical dilation
b. Total duration of labor
c. Level of pain experienced
d. Sequence of labor mechanisms

ANS: B

In a first-time pregnancy, the descent is usually slow but steady; in subsequent pregnancies, the descent is more rapid, resulting in a shorter duration of labor. Cervical dilation is the same for all labors. The level of pain is individual to the woman, not to the number of labors she has experienced. The sequence of labor mechanisms is the same with all labors.

DIF: Cognitive Level: Understand REF: IMS: 378

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

23. Which nursing assessment indicates that a woman who is in second-stage labor is almost ready to give birth?

a. Fetal head is felt at 0 station during the vaginal examination.
b. Bloody mucous discharge increases.
c. Vulva bulges and encircles the fetal head.
d. Membranes rupture during a contraction.

ANS: C

During the active pushing (descent) phase, the woman has strong urges to bear down as the presenting part of the fetus descends and presses on the stretch receptors of the pelvic floor. The vulva stretches and begins to bulge, encircling the fetal head. Birth of the head occurs when the station is +4. A 0 station indicates engagement. Bloody show occurs throughout the labor process and is not an indication of an imminent birth. Rupture of membranes can occur at any time during the labor process and does not indicate an imminent birth.

DIF: Cognitive Level: Analyze REF: pp. 376-377

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

24. Nurses can help their clients by keeping them informed about the distinctive stages of labor. Which description of the phases of the first stage of labor is *accurate*?

a. Latent: Mild, regular contractions; no dilation; bloody show; duration of 2 to 4 hours
b. Active: Moderate, regular contractions; 4- to 7-cm dilation; duration of 3 to 6 hours
c. Lull: No contractions; dilation stable; duration of 20 to 60 minutes
d. Transition: Very strong but irregular contractions; 8- to 10-cm dilation; duration of 1 to 2 hours

ANS: B

The active phase is characterized by moderate, regular contractions; 4- to 7-cm dilation; and a duration of 3 to 6 hours. The latent phase is characterized by mild-to-moderate and irregular contractions; dilation up to 3 cm; brownish-to-pale pink mucus, and a duration of 6 to 8 hours. No official lull phase exists in the first stage. The transition phase is characterized by strong- to-very strong and regular contractions; 8- to 10-cm dilation; and a duration of 20 to 40 minutes.

DIF: Cognitive Level: Understand REF: IMS: 376 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which changes take place in the womans reproductive system, days or even weeks before the commencement of labor? *(Select all that apply.)*

a. Lightening
b. Exhaustion
c. Bloody show
d. Rupture of membranes
e. Decreased fetal movement

ANS: A, C, D

Signs that precede labor may include lightening, urinary frequency, backache, weight loss, surge of energy, bloody show, and rupture of membranes. Many women experience a burst of energy before labor. A decrease in fetal movement is an ominous sign that does not always correlate with labor.

DIF: Cognitive Level: Understand REF: IMS: 376

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

2. Which factors influence cervical dilation? *(Select all that apply.)*

a. Strong uterine contractions
b. Force of the presenting fetal part against the cervix
c. Size of the woman
d. Pressure applied by the amniotic sac
e. Scarring of the cervix

ANS: A, B, D, E

Dilation of the cervix occurs by the drawing upward of the musculofibrous components of the

cervix, which is caused by strong uterine contractions. Pressure exerted by the amniotic fluid while the membranes are intact or by the force applied by the presenting part can also promote cervical dilation. Scarring of the cervix as a result of a previous infection or surgery may slow cervical dilation. Pelvic size or the size of the woman does not affect cervical dilation.

DIF: Cognitive Level: Understand REF: IMS: 374 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. At least five factors affect the process of labor and birth. These are easily remembered as the five *Ps*. Which factors are included in this process? *(Select all that apply.)*

a. Passenger
b. Passageway
c. Powers
d. Pressure
e. Psychologic response

ANS: A, B, C, E

The five *Ps* are passenger (fetus and placenta), passageway (birth canal), powers (contractions), position of the mother, and psychologic response. Pressure is not one of the five *Ps*.

DIF: Cognitive Level: Understand REF: IMS: 367

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. Because of its size and rigidity, the fetal head has a major effect on the birth process. Which bones comprise the structure of the fetal skull? *(Select all that apply.)*

a. Parietal
b. Temporal
c. Fontanel
d. Occipital

e. Femoral

ANS: A, B, D

The fetal skull has two parietal bones, two temporal bones, an occipital bone, and a frontal bone. The fontanels are membrane-filled spaces.

Chapter 17: Maximizing Comfort for the Laboring Woman

MULTIPLE CHOICE

1. An 18-year-old pregnant woman, gravida 1, para 0, is admitted to the labor and birth unit with moderate contractions every 5 minutes that last 40 seconds. The client states, My contractions are so strong, I dont know what to do. Before making a plan of care, what should the nurses first action be?

a. Assess for fetal well-being.
b. Encourage the woman to lie on her side.
c. Disturb the woman as little as possible.
d. Recognize that pain is personalized for each individual.

ANS: D

Each womans pain during childbirth is unique and is influenced by a variety of physiologic, psychosocial, and environmental factors. A critical issue for the nurse is how support can make a difference in the pain of the woman during labor and birth. This scenario includes no information that would indicate fetal distress or a logical reason to be overly concerned about the well-being of the fetus. The left lateral position is used to alleviate fetal distress, not maternal stress. The nurse has an obligation to provide physical, emotional, and psychosocial care and support to the laboring woman. This client clearly needs support.

DIF: Cognitive Level: Apply REF: IMS: 381 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity, Psychosocial Integrity

2. A woman who is pregnant for the first time is dilated 3 cm and having contractions every 5 minutes. She is groaning and perspiring excessively; she states that she did not attend childbirth classes. What is the optimal intervention for the nurse to provide at this time?

a. Notify the womans health care provider.
b. Administer the prescribed narcotic analgesic.
c. Assure her that her labor will be over soon.
d. Assist her with simple breathing and relaxation instructions.

ANS: D

By reducing tension and stress, both focusing and relaxation techniques will allow the woman in labor to rest and conserve energy for the task of giving birth. For those who have had no preparation, instruction in simple breathing and relaxation can be given in early labor and is often successful. The nurse can independently perform many functions in labor and birth, such as teaching and support. Pain medication may be an option for this client. However, the initial response of the nurse should include teaching the client about her options. The length of labor varies among individuals, but the first stage of labor is the longest. At 3 cm of dilation with contractions every 5 minutes, this woman has a significant amount of labor yet to experience.

DIF: Cognitive Level: Apply REF: IMS: 386

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

3. Nursing care measures are commonly offered to women in labor. Which nursing measure reflects the application of the gate-control theory?

a. Massage the womans back.
b. Change the womans position.
c. Give the prescribed medication.
d. Encourage the woman to rest between contractions.

ANS: A

According to the gate-control theory, pain sensations travel along sensory nerve pathways to the brain, but only a limited number of sensations, or messages, can travel through these nerve pathways at one time. Distraction techniques, such as massage or stroking, music, focal points, and imagery, reduce or completely block the capacity of the nerve pathways to transmit pain. These distractions are thought to work by closing down a hypothetic gate in the spinal cord, thus preventing pain signals from reaching the brain. The perception of pain is thereby diminished. Changing the womans position, administering pain medication, and resting between contractions do not reduce or block the capacity of the nerve pathways to transmit pain using the gate-control theory.

DIF: Cognitive Level: Apply REF: IMS: 383

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

4. Breathing patterns are taught to laboring women. Which breathing pattern should the nurse support for the woman and her coach during the latent phase of the first stage of labor if the couple has attended childbirth preparation classes?

a. Slow-paced breathing
b. Deep abdominal breathing
c. Modified-paced breathing
d. Patterned-paced breathing

ANS: A

Slow-paced breathing is approximately one half the womans normal breathing rate and is used during the early stages of labor when a woman can no longer walk or talk through her contractions. No such pattern called deep abdominal breathing exists in childbirth preparation. Modified-paced breathing is shallow breathing that is twice the womans normal breathing rate. It is used when labor progresses and the woman can no longer maintain relaxation through paced breathing. Patterned-pace breathing is a fast, 4:1 breathe, breathe, breathe, blow pattern that is used during the transitional phase of labor just before pushing and delivery.

DIF: Cognitive Level: Understand REF: IMS: 387

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

5. A laboring woman has received meperidine (Demerol) intravenously (IV), 90 minutes before giving birth. Which medication should be available to reduce the postnatal effects of meperidine on the neonate?

a. Fentanyl (Sublimaze)
b. Promethazine (Phenergan)
c. Naloxone (Narcan)
d. Nalbuphine (Nubain)

ANS: C

An opioid antagonist can be given to the newborn as one part of the treatment for neonatal narcosis, which is a state of central nervous system (CNS) depression in the newborn produced by an opioid. Opioid antagonists, such as naloxone (Narcan), can promptly reverse the CNS depressant effects, especially respiratory depression. Fentanyl (Sublimaze), promethazine (Phenergan), and nalbuphine (Nubain) do not act as opioid antagonists to reduce the postnatal effects of meperidine on the neonate.

DIF: Cognitive Level: Apply REF: IMS: 395

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

6. What should the laboring client who receives an opioid antagonist be told to expect?

a. Her pain will decrease.
b. Her pain will return.
c. She will feel less anxious.
d. She will no longer feel the urge to push.

ANS: B

Opioid antagonists such as naloxone (Narcan) promptly reverse the CNS-depressant effects of opioids. In addition, the antagonist counters the effect of the stress-induced levels of endorphins. An opioid antagonist is especially valuable if the labor is more rapid than expected and the birth is anticipated when the opioid is at its peak effect. The woman should be told that the pain that was relieved by the opioid analgesic will return with the administration of the opioid antagonist. Her pain level will increase rather than decrease. Opioid antagonists have no effect on anxiety levels. They are primarily administered to reverse the excessive CNS depression in the mother, newborn, or both. An opioid antagonist (e.g., naloxone) has no effect on the mothers urge or ability to push. The practice of giving lower doses of IV opioids has reduced the incidence and severity of opioid-induced CNS depression; therefore, opioid antagonists are used less frequently.

DIF: Cognitive Level: Apply REF: IMS: 395 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

7. A client is in early labor, and her nurse is discussing the pain relief options she is considering. The client states that she wants an epidural no matter what! What is the nurses best response?

a. Ill make sure you get your epidural.
b. You may only have an epidural if your physician allows it.
c. You may only have an epidural if you are going to deliver vaginally.
d. The type of analgesia or anesthesia used is determined, in part, by the stage of your labor and the method of birth.

ANS: D

To avoid suppressing the progress of labor, pharmacologic measures for pain relief are generally not implemented until labor has advanced to the active phase of the first stage and the cervix is dilated approximately 4 to 5 cm. A plan of care is developed for each woman that addresses her particular clinical and nursing problems. The nurse collaborates with the primary health care provider and the laboring woman in selecting features of care relevant to the woman and her family. The decision whether to use an epidural to relieve labor pain is multifactorial. The nurse should not make a blanket statement guaranteeing the client one pharmacologic option over another until a complete history and physical examination has been obtained. A physicians order

is required for pharmacologic options for pain management. However, expressing this requirement is not the nurses best response. An epidural is an effective pharmacologic pain management option for many laboring women. It can also be used for anesthesia control if the woman undergoes an operative delivery.

DIF: Cognitive Level: Apply REF: IMS: 392 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. What is the role of the nurse as it applies to informed consent?

a. Inform the client about the procedure, and ask her to sign the consent form.
b. Act as a client advocate, and help clarify the procedure and the options.
c. Call the physician to see the client.
d. Witness the signing of the consent form.

ANS: B

Nurses play a part in the informed consent process by clarifying and describing procedures or by acting as the womans advocate and asking the primary health care provider for further explanations. The physician is responsible for informing the woman of her options, explaining the procedure, and advising the client about potential risk factors. The physician must be present to explain the procedure to the client. However, the nurses responsibilities go further than simply asking the physician to see the client. The nurse may witness the signing of the consent form. However, depending on the states guidelines, the womans husband or another hospital health care employee may sign as a witness.

DIF: Cognitive Level: Understand REF: IMS: 404

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

9. A first-time mother is concerned about the type of medications she will receive during labor. The client is in a fair amount of pain and is nauseated. In addition, she appears to be very

anxious. The nurse explains that opioid analgesics are often used along with sedatives. How should the nurse phrase the rationale for this medication combination?

a. The two medications, together, reduce complications.
b. Sedatives enhance the effect of the pain medication.
c. The two medications work better together, enabling you to sleep until you have the baby.
d. This is what your physician has ordered for you.

ANS: B

Sedatives may be used to reduce the nausea and vomiting that often accompany opioid use. In addition, some ataractic drugs reduce anxiety and apprehension and potentiate the opioid analgesic affects. A potentiator may cause two drugs to work together more effectively, but it does not ensure zero maternal or fetal complications. Sedation may be a related effect of some ataractic drugs; however, sedation is not the goal. Furthermore, a woman is unlikely to be able to sleep through transitional labor and birth. Although the physician may have ordered the medication, This is what your physician has ordered for you is not an acceptable comment for the nurse to make.

DIF: Cognitive Level: Apply REF: IMS: 392

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

10. The nurse should be cognizant of which physiologic effect of pain?

a. Predominant pain of the first stage of labor is visceral pain that is located in the lower portion of the abdomen.
b. Referred pain is the extreme discomfort experienced between contractions.
c. Somatic pain of the second stage of labor is more generalized and related to fatigue.
d. Pain during the third stage is a somewhat milder version of the pain experienced during the second stage.

ANS: A

Predominant pain comes from cervical changes, the distention of the lower uterine segment, and uterine ischemia. Referred pain occurs when the pain that originates in the uterus radiates to the abdominal wall, lumbosacral area of the back, iliac crests, and gluteal area. Second-stage labor pain is intense, sharp, burning, and localized. Third-stage labor pain is similar to that of the first stage.

DIF: Cognitive Level: Remember REF: IMS: 381

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

11. Which statement *correctly* describes the effects of various pain factors?

a. Higher prostaglandin levels arising from dysmenorrhea can blunt the pain of childbirth.
b. Upright positions in labor increase the pain factor because they cause greater fatigue.
c. Women who move around trying different positions experience more pain.
d. Levels of pain-mitigating beta-endorphins are higher during a spontaneous, natural childbirth.

ANS: D

Higher endorphin levels help women tolerate pain and reduce anxiety and irritability. Higher prostaglandin levels correspond to more severe labor pains. Upright positions in labor usually result in improved comfort and less pain. Moving freely to find more comfortable positions is important for reducing pain and muscle tension.

DIF: Cognitive Level: Understand REF: pp. 382-383 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

12. Nurses with an understanding of cultural differences regarding likely reactions to pain may be better able to help their clients. Which clients may initially appear very stoic but then become

quite vocal as labor progresses until late in labor, when they become more vocal and request pain relief?

a. Chinese
b. Arab or Middle Eastern
c. Hispanic
d. African-American

ANS: C

Hispanic women may be stoic early in labor but more vocal and ready for medications later. Chinese women may not show reactions to pain. Medical interventions must be offered more than once. Arab or Middle Eastern women may be vocal in response to labor pain from the start; they may prefer pain medications. African-American women may openly express pain; the use of medications for pain is more likely to vary with the individual.

DIF: Cognitive Level: Remember REF: IMS: 383

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

13. Anxiety is commonly associated with pain during labor. Which statement regarding anxiety is *correct*?

a. Even mild anxiety must be treated.
b. Severe anxiety increases tension, increases pain, and then, in turn, increases fear and anxiety, and so on.
c. Anxiety may increase the perception of pain, but it does not affect the mechanism of labor.
d. Women who have had a painful labor will have learned from the experience and have less anxiety the second time because of increased familiarity.

ANS: B

Anxiety and pain reinforce each other in a negative cycle that will slow the progress of labor. Mild anxiety is normal for a woman in labor and likely needs no special treatment other than the

standard reassurances. Anxiety increases muscle tension and ultimately can sufficiently build to slow the progress of labor. Unfortunately, an anxious, painful first labor is likely to carry over, through expectations and memories, into an anxious and painful experience in the second pregnancy.

DIF: Cognitive Level: Understand REF: IMS: 383

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

14. Which statement is *not* an expected outcome for the client who attends a reputable childbirth preparation program?

a. Childbirth preparation programs increase the womans sense of control.
b. Childbirth preparation programs prepare a support person to help during labor.
c. Childbirth preparation programs guarantee a pain-free childbirth.
d. Childbirth preparation programs teach distraction techniques.

ANS: C

All methods try to increase a womans sense of control, prepare a support person, and train the woman in physical conditioning, which includes breathing techniques. These programs cannot, and reputable ones do not, promise a pain-free childbirth. Increasing a womans sense of control is the goal of all childbirth preparation methods. Preparing a support person to help in labor is a vitally important component of any childbirth education program. The coach may learn how to touch a womans body to detect tense and contracted muscles. The woman then learns how to relax in response to the gentle stroking by the coach. Distraction techniques are a form of care that are effective to some degree in relieving labor pain and are taught in many childbirth programs. These distractions include imagery, feedback relaxation, and attention-focusing behaviors.

DIF: Cognitive Level: Understand REF: pp. 385-386 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity, Psychosocial Integrity

15. Maternity nurses often have to answer questions about the many, sometimes unusual, ways people have tried to make the birthing experience more comfortable. Which information regarding nonpharmacologic pain relief is*accurate*?

a. Music supplied by the support person has to be discouraged because it could disturb others or upset the hospital routine.
b. Women in labor can benefit from sitting in a bathtub, but they must limit immersion to no longer than 15 minutes at a time.
c. Effleurage is permissible, but counterpressure is almost always counterproductive.
d. Electrodes attached to either side of the spine to provide high-intensity electrical impulses facilitate the release of endorphins.

ANS: D

Transcutaneous electrical nerve stimulation (TENS) may help and is most useful for lower back pain that occurs during the first stage of labor. Music may be very helpful for reducing tension and certainly can be accommodated by the hospital. Women can stay in a bath as long as they want, although repeated baths with breaks might be more effective than one long bath. Counterpressure can help the woman cope with lower back pain.

DIF: Cognitive Level: Apply REF: pp. 388-389 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

16. The nurse should be cognizant of which important information regarding nerve block analgesia and anesthesia?

a. Most local agents are chemically related to cocaine and end in the suffix *caine*.
b. Local perineal infiltration anesthesia is effective when epinephrine is added, but it can be injected only once.
c. Pudendal nerve block is designed to relieve the pain from uterine contractions.
d. Pudendal nerve block, if performed correctly, does not significantly lessen the bearing-down reflex.

ANS: A

Common agents include lidocaine and chloroprocaine. Injections can be repeated to prolong the anesthesia. A pudendal nerve block relieves pain in the vagina, vulva, and perineum but not the pain from uterine contractions. A pudendal nerve block lessens or shuts down the bearing-down reflex.

DIF: Cognitive Level: Understand REF: IMS: 396 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

17. A woman in labor is breathing into a mouthpiece just before the start of her regular contractions. As she inhales, a valve opens and gas is released. She continues to inhale the gas slowly and deeply until the contraction starts to subside. When the inhalation stops, the valve closes. Which statement regarding this procedure is *correct*?

a. The application of nitrous oxide gas is not often used anymore.
b. An inhalation of gas is likely to be used in the second stage of labor, not during the first stage.
c. An application of nitrous oxide gas is administered for pain relief.
d. The application of gas is a prelude to a cesarean birth.

ANS: C

A mixture of nitrous oxide with oxygen in a low concentration can be used in combination with other nonpharmacologic and pharmacologic measures for pain relief. This procedure is still commonly used in Canada and in the United Kingdom. Nitrous oxide inhaled in a low concentration will reduce but not eliminate pain during the first and second stages of labor. Nitrous oxide inhalation is not generally used before a caesarean birth. Nitrous oxide does not appear to depress uterine contractions or cause adverse reactions in the newborn.

DIF: Cognitive Level: Understand REF: IMS: 402

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

18. According to professional standards (the Association of Womens Health, Obstetric and Neonatal Nurses [AWHONN], 2007), which action *cannot* be performed by the nonanesthetist registered nurse who is caring for a woman with epidural anesthesia?

a. Monitoring the status of the woman and fetus
b. Initiating epidural anesthesia
c. Replacing empty infusion bags with the same medication and concentrate
d. Stopping the infusion, and initiating emergency measures

ANS: B

Only qualified, licensed anesthesia care providers are permitted to insert a catheter, initiate epidural anesthesia, verify catheter placement, inject medication through the catheter, or alter the medication or medications including type, amount, or rate of infusion. The nonanesthetist nurse is permitted to monitor the status of the woman, the fetus, and the progress of labor. Replacement of the empty infusion bags or syringes with the same medication and concentration is permitted. If the need arises, the nurse may stop the infusion, initiate emergency measures, and remove the catheter if properly educated to do so. Complications can require immediate interventions. Nurses must be prepared to provide safe and effective care during an emergency situation.

DIF: Cognitive Level: Analyze REF: pp. 406-407

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

19. Conscious relaxation is associated with which method of childbirth preparation?

a. Grantly Dick-Read childbirth method
b. Lamaze method
c. Bradley method
d. Psychoprophylactic method

ANS: A

With the Grantly Dick-Read method, women are taught to consciously and progressively relax different muscle groups throughout the body until a high degree of skill at relaxation is achieved. The Lamaze method combines controlled muscular relaxation with breathing techniques. The Bradley method advocates natural labor, without any form of anesthesia or analgesia, assisted by a husband-coach and using breathing techniques for labor. The psychoprophylactic method is another name for the Lamaze method.

DIF: Cognitive Level: Remember REF: IMS: 385 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. A woman in labor has just received an epidural block. What is the *most* important nursing intervention at this time?

a. Limit parenteral fluids.
b. Monitor the fetus for possible tachycardia.
c. Monitor the maternal blood pressure for possible hypotension.
d. Monitor the maternal pulse for possible bradycardia.

ANS: C

The most important nursing intervention for a woman who has received an epidural block is for the nurse to monitor the maternal blood pressure frequently for signs of hypotension. IV fluids are increased for a woman receiving an epidural to prevent hypotension. The nurse also observes for signs of fetal bradycardia and monitors for signs of maternal tachycardia, secondary to hypotension.

DIF: Cognitive Level: Apply REF: IMS: 398

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

21. A woman in the active phase of the first stage of labor is using a shallow pattern of breathing, which is approximately twice the normal adult breathing rate. She starts to complain about

feeling lightheaded and dizzy and states that her fingers are tingling. Which intervention should the nurse immediately initiate?

a. Contact the womans physician.
b. Tell the woman to slow her pace of her breathing.
c. Administer oxygen via a mask or nasal cannula.
d. Help her breathe into a paper bag.

ANS: D

This woman is experiencing the side effects of hyperventilation, which include the symptoms of lightheadedness, dizziness, tingling of the fingers, or circumoral numbness. Having the woman breathe into a paper bag held tightly around her mouth and nose may eliminate respiratory alkalosis and enable her to rebreathe carbon dioxide and replace the bicarbonate ion.

DIF: Cognitive Level: Apply REF: IMS: 387

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

22. A client is experiencing back labor and complains of intense pain in her lower back. Which measure would *best* support this woman in labor?

a. Counterpressure against the sacrum
b. Pant-blow (breaths and puffs) breathing techniques
c. Effleurage
d. Conscious relaxation or guided imagery

ANS: A

Counterpressure is steady pressure applied by a support person to the sacral area with the fist or heel of the hand. This technique helps the woman cope with the sensations of internal pressure and pain in the lower back. The pain management techniques of pant-blow, effleurage, and conscious relaxation or guided imagery are usually helpful for contractions per the gate-control theory.

DIF: Cognitive Level: Apply REF: IMS: 387

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

23. A woman has requested an epidural for her pain. She is 5 cm dilated and 100% effaced. The baby is in a vertex position and is engaged. The nurse increases the womans IV fluid for a preprocedural bolus. The nurse reviews her laboratory values and notes that the womans hemoglobin is 12 g/dl, hematocrit is 38%, platelets are 67,000, and white blood cells (WBCs) are 12,000/mm^3. Which factor would contraindicate an epidural for this woman?

a. She is too far dilated.
b. She is anemic.
c. She has thrombocytopenia.
d. She is septic.

ANS: C

The platelet count indicates a coagulopathy, specifically, thrombocytopenia (low platelets), which is a contraindication to epidural analgesia and anesthesia. Typically, epidural analgesia and anesthesia are used in the laboring woman when a regular labor pattern has been achieved, as evidenced by progressive cervical change. The laboratory values show that the womans hemoglobin and hematocrit levels are in the normal range and show a slight increase in the WBC count that is not uncommon in laboring women.

DIF: Cognitive Level: Analyze REF: IMS: 406 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

24. Which alterations in the perception of pain by a laboring client should the nurse understand?

a. Sensory pain for nulliparous women is often greater than for multiparous women during early labor.
b. Affective pain for nulliparous women is usually less than for multiparous women throughout the first stage of labor.
c. Women with a history of substance abuse experience more pain during labor.

d. Multiparous women have more fatigue from labor and therefore experience more pain.

ANS: A

Sensory pain is greater for nulliparous women because their reproductive tract structures are less supple. Affective pain is greater for nulliparous women during the first stage but decreases for both nulliparous and multiparous during the second stage. Women with a history of substance abuse experience the same amount of pain as those without such a history. Nulliparous women have longer labors and therefore experience more fatigue.

DIF: Cognitive Level: Understand REF: IMS: 383 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

25. The nurse should be aware of what important information regarding systemic analgesics administered during labor?

a. Systemic analgesics cross the maternal blood-brain barrier as easily as they do the fetal blood-brain barrier.
b. Effects on the fetus and newborn can include decreased alertness and delayed sucking.
c. Intramuscular (IM) administration is preferred over IV administration.
d. IV patient-controlled analgesia (PCA) results in increased use of an analgesic.

ANS: B

The effects of analgesics depend on the specific drug administered, the dosage, and the timing. Systemic analgesics cross the fetal blood-brain barrier more readily than the maternal blood-brain barrier. IV administration is preferred over IM administration because the drug acts faster and more predictably. PCA results in a decrease in the use of an analgesic.

DIF: Cognitive Level: Understand REF: IMS: 393 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

26. Developing a realistic birth plan with the pregnant woman regarding her care is important for the nurse. How would the nurse explain the major advantage of nonpharmacologic pain management?

a. Greater and more complete pain relief is possible.
b. No side effects or risks to the fetus are involved.
c. The woman will remain fully alert at all times.
d. Labor will likely be more rapid.

ANS: B

Because nonpharmacologic pain management does not include analgesics, adjunct drugs, or anesthesia, it is harmless to the mother and the fetus. However, pain relief is lessened with nonpharmacologic pain management during childbirth. Although the womans alertness is not altered by medication, the increase in pain may decrease alertness. Pain management may or may not alter the length of labor. At times when pain is decreased, the mother relaxes and labor progresses at a quicker pace.

DIF: Cognitive Level: Remember REF: IMS: 384

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

27. What is the correct terminology for the nerve block that provides anesthesia to the lower vagina and perineum?

a. Epidural
b. Pudendal
c. Local
d. Spinal block

ANS: B

A pudendal block anesthetizes the lower vagina and perineum to provide anesthesia for an episiotomy and the use of low forceps, if needed. An epidural provides anesthesia for the uterus,

perineum, and legs. A local provides anesthesia for the perineum at the site of the episiotomy. A spinal block provides anesthesia for the uterus, perineum, and down the legs.

DIF: Cognitive Level: Remember REF: IMS: 396

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

28. The obstetric nurse is preparing the client for an emergency cesarean birth, with no time to administer spinal anesthesia. The nurse is aware of and prepared for the greatest risk of administering general anesthesia to the client. What is this risk?

a. Respiratory depression
b. Uterine relaxation
c. Inadequate muscle relaxation
d. Aspiration of stomach contents

ANS: D

Aspiration of acidic gastric contents with possible airway obstruction is a potentially fatal complication of general anesthesia. Respirations can be altered during general anesthesia, and the anesthesiologist will take precautions to maintain proper oxygenation. Uterine relaxation can occur with some anesthesia but can be monitored and prevented. Inadequate muscle relaxation can be improved with medication.

DIF: Cognitive Level: Understand REF: IMS: 402

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

29. What is the rationale for the use of a blood patch after spinal anesthesia?

a. Hypotension
b. Headache
c. Neonatal respiratory depression
d. Loss of movement

ANS: B

The subarachnoid block may cause a postspinal headache resulting from the loss of cerebrospinal fluid from the puncture in the dura. When blood is injected into the epidural space in the area of the dural puncture, it forms a seal over the hole to stop the leaking of cerebrospinal fluid. Hypotension is prevented by increasing fluid volume before the procedure. Neonatal respiratory depression is not an expected outcome with spinal anesthesia. Loss of movement is an expected outcome of spinal anesthesia.

DIF: Cognitive Level: Remember REF: IMS: 399

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Maternal hypotension is a potential side effect of regional anesthesia and analgesia. What nursing interventions could the nurse use to increase the clients blood pressure? *(Select all that apply.)*

a. Place the woman in a supine position.
b. Place the woman in a lateral position.
c. Increase IV fluids.
d. Administer oxygen.
e. Perform a vaginal examination.

ANS: B, C, D

Nursing interventions for maternal hypotension arising from analgesia or anesthesia include turning the woman to a lateral position, increasing IV fluids, administering oxygen via face mask, elevating the womans legs, notifying the physician, administering an IV vasopressor, and monitoring the maternal and fetal status at least every 5 minutes until the woman is stable. Placing the client in a supine position causes venous compression, thereby limiting blood flow to and oxygenation of the placenta and fetus. A sterile vaginal examination has no bearing on maternal blood pressure.

DIF: Cognitive Level: Apply REF: IMS: 399

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. Which alternative approaches to relaxation have proven successful when working with the client in labor? *(Select all that apply.)*

a. Aromatherapy
b. Massage
c. Hypnosis
d. Cesarean birth
e. Biofeedback

ANS: A, B, C, E

Approaches to relaxation can include neuromuscular relaxation, aromatherapy, music, massage, imagery, hypnosis, or touch relaxation. Cesarean birth is a method of delivery, not a method of relaxation.

DIF: Cognitive Level: Apply REF: IMS: 385 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A woman has requested an epidural block for her pain. She is 5 cm dilated and 100% effaced. The baby is in a vertex position and is engaged. The nurse increases the womans IV fluid for a preprocedural bolus. Before the initiation of the epidural, the woman should be informed regarding the disadvantages of an epidural block. Which concerns should the nurse share with this client? *(Select all that apply.)*

a. Ability to move freely is limited.
b. Orthostatic hypotension and dizziness may occur.
c. Gastric emptying is not delayed.
d. Higher body temperature may occur.
e. Blood loss is not excessive.

ANS: A, B, D

The womans ability to move freely and to maintain control of her labor is limited, related to the use of numerous medical interventions (IV lines and electronic fetal monitoring [EFM]). Significant disadvantages of an epidural block include the occurrence of orthostatic hypotension, dizziness, sedation, and leg weakness. Women who receive an epidural block have a higher body temperature (38 C or higher), especially when labor lasts longer than 12 hours, and may result in an unnecessary neonatal workup for sepsis. An advantage of an epidural block is that blood loss is not excessive. Other advantages include the following: the woman remains alert and able to participate, good relaxation is achieved, airway reflexes remain intact, and only partial motor paralysis develops.

DIF: Cognitive Level: Analyze REF: pp. 400-401 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

4. The class of drugs known as opioid analgesics (butorphanol, nalbuphine) is not suitable for administration to women with known opioid dependence. The antagonistic activity could precipitate withdrawal symptoms (abstinence syndrome) in both mothers and newborns. Which signs would indicate opioid or narcotic withdrawal in the mother? *(Select all that apply.)*

a. Yawning, runny nose
b. Increase in appetite
c. Chills or hot flashes
d. Constipation
e. Irritability, restlessness

ANS: A, C, E

The woman experiencing maternal opioid withdrawal syndrome will exhibit yawning, runny nose, sneezing, anorexia, chills or hot flashes, vomiting, diarrhea, abdominal pain, irritability, restlessness, muscle spasms, weakness, and drowsiness. Assessing both the mother and the newborn and planning the care accordingly are important steps for the nurse to take.

DIF: Cognitive Level: Apply REF: IMS: 395

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

5. While developing an intrapartum care plan for the client in early labor, which psychosocial factors would the nurse recognize upon the clients pain experience? *(Select all that apply.)*

a. Culture
b. Anxiety and fear
c. Previous experiences with pain
d. Intervention of caregivers
e. Support systems

ANS: A, B, C, E

Culture: A womans sociocultural roots influence how she perceives, interprets, and responds to pain during childbirth. Some cultures encourage loud and vigorous expressions of pain, whereas others value self-control. The nurse should avoid praising some behaviors (stoicism) while belittling others (noisy expression). *Anxiety and fear:* Extreme anxiety and fear magnify the sensitivity to pain and impair a womans ability to tolerate it. Anxiety and fear increase muscle tension in the pelvic area, which counters the expulsive forces of uterine contractions and pushing efforts. *Previous experiences with pain:* Fear and withdrawal are a natural response to pain during labor. Learning about these normal sensations ahead of time helps a woman suppress her natural reactions of fear regarding the impending birth. If a woman previously had a long and difficult labor, she is likely to be anxious. She may also have learned ways to cope and may use these skills to adapt to the present labor experience. *Support systems:* An anxious partner is less able to provide help and support to a woman during labor. A womans family and friends can be an important source of support if they convey realistic and positive information about labor and delivery. Although *the intervention of caregivers* may be necessary for the well-being of the woman and her fetus, some interventions add discomfort to the natural pain of labor (i.e., fetal monitor straps, IV lines).

Chapter 18: Fetal Assessment During Labor

MULTIPLE CHOICE

1. What is the most likely cause for early decelerations in the fetal heart rate (FHR) pattern?

a. Altered fetal cerebral blood flow
b. Umbilical cord compression
c. Uteroplacental insufficiency
d. Spontaneous rupture of membranes

ANS: A

Early decelerations are the fetus response to fetal head compression; these are considered benign, and interventions are not necessary. Variable decelerations are associated with umbilical cord compression. Late decelerations are associated with uteroplacental insufficiency. Spontaneous rupture of membranes has no bearing on the FHR unless the umbilical cord prolapses, which would result in variable or prolonged bradycardia.

DIF: Cognitive Level: Understand REF: IMS: 410

TOP: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity, Health Promotion and Maintenance

2. Which clinical finding or intervention might be considered the rationale for fetal tachycardia to occur?

a. Maternal fever
b. Umbilical cord prolapse
c. Regional anesthesia
d. Magnesium sulfate administration

ANS: A

Fetal tachycardia can be considered an early sign of fetal hypoxemia and may also result from maternal or fetal infection. Umbilical cord prolapse, regional anesthesia, and the administration of magnesium sulfate will each more likely result in fetal bradycardia, not tachycardia.

DIF: Cognitive Level: Understand REF: IMS: 419

TOP: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity, Health Promotion and Maintenance

3. While evaluating an external monitor tracing of a woman in active labor, the nurse notes that the FHR for five sequential contractions begins to decelerate late in the contraction, with the nadir of the decelerations occurring after the peak of the contraction. What is the nurses *first* priority?

a. Change the womans position.
b. Notify the health care provider.
c. Assist with amnioinfusion
d. Insert a scalp electrode.

ANS: A

Late FHR decelerations may be caused by maternal supine hypotension syndrome. These decelerations are usually corrected when the woman turns onto her side to displace the weight of the gravid uterus from the vena cava. If the fetus does not respond to primary nursing interventions for late decelerations, then the nurse should continue with subsequent intrauterine resuscitation measures and notify the health care provider. An amnioinfusion may be used to relieve pressure on an umbilical cord that has not prolapsed. The FHR pattern associated with this situation most likely will reveal variable decelerations. Although a fetal scalp electrode will provide accurate data for evaluating the well-being of the fetus, it is not a nursing intervention that will alleviate late decelerations nor is it the nurses first priority.

DIF: Cognitive Level: Apply REF: IMS: 422

TOP: Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity, Health Promotion and Maintenance

4. What is the most likely cause for variable FHR decelerations?

a. Altered fetal cerebral blood flow
b. Umbilical cord compression
c. Uteroplacental insufficiency
d. Fetal hypoxemia

ANS: B

Variable FHR decelerations can occur at any time during the uterine contracting phase and are caused by compression of the umbilical cord. Altered fetal cerebral blood flow results in early decelerations in the FHR. Uteroplacental insufficiency results in late decelerations in the FHR. Fetal hypoxemia initially results in tachycardia and then bradycardia if hypoxia continues.

DIF: Cognitive Level: Remember REF: IMS: 422

TOP: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity, Health Promotion and Maintenance

5. The nurse providing care for a high-risk laboring woman is alert for late FHR decelerations. Which clinical finding might be the cause for these late decelerations?

a. Altered cerebral blood flow
b. Umbilical cord compression
c. Uteroplacental insufficiency
d. Meconium fluid

ANS: C

Uteroplacental insufficiency results in late FHR decelerations. Altered fetal cerebral blood flow results in early FHR decelerations. Umbilical cord compression results in variable FHR decelerations. Meconium-stained fluid may or may not produce changes in the FHR, depending on the gestational age of the fetus and whether other causative factors associated with fetal distress are present.

DIF: Cognitive Level: Understand REF: IMS: 421

TOP: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity, Health Promotion and Maintenance

6. Which alteration in the FHR pattern would indicate the potential need for an amnioinfusion?

a. Variable decelerations
b. Late decelerations
c. Fetal bradycardia
d. Fetal tachycardia

ANS: A

Amnioinfusion is used during labor to either dilute meconium-stained amniotic fluid or supplement the amount of amniotic fluid to reduce the severity of variable FHR decelerations caused by cord compression. Late decelerations are unresponsive to amnioinfusion. Amnioinfusion is not appropriate for the treatment of fetal bradycardia and has no bearing on fetal tachycardia.

DIF: Cognitive Level: Remember REF: IMS: 425

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

7. Which FHR finding is the most concerning to the nurse who is providing care to a laboring client?

a. Accelerations with fetal movement
b. Early decelerations
c. Average FHR of 126 beats per minute
d. Late decelerations

ANS: D

Late decelerations are caused by uteroplacental insufficiency and are associated with fetal hypoxemia. Late FHR decelerations are considered ominous if they are persistent and left

uncorrected. Accelerations with fetal movement are an indication of fetal well-being. Early decelerations in the FHR are associated with head compression as the fetus descends into the maternal pelvic outlet; they are not generally a concern during normal labor. An FHR finding of 126 beats per minute is normal and not a concern.

DIF: Cognitive Level: Analyze REF: IMS: 421

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

8. What three measures should the nurse implement to provide intrauterine resuscitation?

a. Call the provider, reposition the mother, and perform a vaginal examination.
b. Turn the client onto her side, provide oxygen (O_2) via face mask, and increase intravenous (IV) fluids.
c. Administer O_2 to the mother, increase IV fluids, and notify the health care provider.
d. Perform a vaginal examination, reposition the mother, and provide O_2 via face mask.

ANS: B

Basic interventions for the management of any abnormal FHR pattern include administering O_2 via a nonrebreather face mask at a rate of 8 to 10 L/min, assisting the woman onto a side-lying (lateral) position, and increasing blood volume by increasing the rate of the primary IV infusion. The purpose of these interventions is to improve uterine blood flow and intervillous space blood flow and to increase maternal oxygenation and cardiac output. The term *intrauterine resuscitation* is sometimes used to refer to these interventions. If these interventions do not quickly resolve the abnormal FHR issue, then the primary provider should be immediately notified.

DIF: Cognitive Level: Analyze REF: IMS: 425

TOP: Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance, Physiologic Integrity

9. The nurse who provides care to clients in labor must have a thorough understanding of the physiologic processes of maternal hypotension. Which outcome might occur if the interventions for maternal hypotension are inadequate?

a. Early FHR decelerations
b. Fetal arrhythmias
c. Uteroplacental insufficiency
d. Spontaneous rupture of membranes

ANS: C

Low maternal blood pressure reduces placental blood flow during uterine contractions, resulting in fetal hypoxemia. Maternal hypotension does not result in early FHR decelerations nor is it associated with fetal arrhythmias. Spontaneous rupture of membranes is not a result of maternal hypotension.

DIF: Cognitive Level: Understand REF: IMS: 421

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. What are the legal responsibilities of the perinatal nurses?

a. Correctly interpreting FHR patterns, initiating appropriate nursing interventions, and documenting the outcomes
b. Greeting the client on arrival, assessing her status, and starting an IV line
c. Applying the external fetal monitor and notifying the health care provider
d. Ensuring that the woman is comfortable

ANS: A

Nurses who care for women during childbirth are legally responsible for correctly interpreting FHR patterns, initiating appropriate nursing interventions based on those patterns, and documenting the outcomes of those interventions. Greeting the client on arrival, assessing her, and starting an IV line are activities that should be performed when any client arrives to the maternity unit. The nurse is not the only one legally responsible for performing these functions.

Applying the external fetal monitor and notifying the health care provider is a nursing function that is part of the standard of care for all obstetric clients and falls within the registered nurses scope of practice. Everyone caring for the pregnant woman should ensure that both she and her support partner are comfortable.

DIF: Cognitive Level: Understand REF: IMS: 424

TOP: Nursing Process: Assessment | Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

11. The perinatal nurse realizes that an FHR that is tachycardic, bradycardic, has late decelerations, or loss of variability is nonreassuring and is associated with which condition?

a. Hypotension
b. Cord compression
c. Maternal drug use
d. Hypoxemia

ANS: D

Nonreassuring FHR patterns are associated with fetal hypoxemia. Fetal bradycardia may be associated with maternal hypotension. Variable FHR decelerations are associated with cord compression. Maternal drug use is associated with fetal tachycardia.

DIF: Cognitive Level: Analyze REF: IMS: 411

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. A new client and her partner arrive on the labor, delivery, recovery, and postpartum (LDRP) unit for the birth of their first child. The nurse applies the electronic fetal monitor (EFM) to the woman. Her partner asks you to explain what is printing on the graph, referring to the EFM strip. He wants to know what the babys heart rate should be. What is the nurses *best* response?

a. Dont worry about that machine; thats my job.
b. The babys heart rate will fluctuate in response to what is happening during labor.
c. The top line graphs the babys heart rate, and the bottom line lets me know how strong the contractions are.
d. Your physician will explain all of that later.

ANS: B

Explaining what indicates a normal FHR teaches the partner about fetal monitoring and provides support and information to alleviate his fears. Telling the partner not to worry discredits his feelings and does not provide the teaching he is requesting. Telling the partner that the graph indicates how strong the contractions are provides inaccurate information and does not address the partners concerns about the FHR. The EFM graphs the frequency and duration of the contractions, not their intensity. Nurses should take every opportunity to provide teaching to the client and her family, especially when information is requested.

DIF: Cognitive Level: Apply REF: IMS: 417 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

13. Which statement *best* describes a normal uterine activity pattern in labor?

a. Contractions every 2 to 5 minutes
b. Contractions lasting approximately 2 minutes
c. Contractions approximately 1 minute apart
d. Contraction intensity of approximately 500 mm Hg with relaxation at 50 mm Hg

ANS: A

Overall contraction frequency generally ranges from two to five contractions per 10 minutes of labor, with lower frequencies during the first stage and higher frequencies observed during the second stage. Contraction duration remains fairly stable throughout the first and second stages, ranging from 45 to 80 seconds, generally not exceeding 90 seconds. Contractions 1 minute apart are occurring too often and would be considered an abnormal labor pattern. The intensity of

uterine contractions generally ranges from 25 to 50 mm Hg in the first stage of labor and may rise to more than 80 mm Hg in the second stage.

DIF: Cognitive Level: Remember REF: IMS: 411

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. The nurse is using intermittent auscultation (IA) to locate the fetal heartbeat. Which statement regarding this method of surveillance is *accurate*?

a. The nurse can be expected to cover only two or three clients when IA is the primary method of fetal assessment.
b. The best course is to use the descriptive terms associated with EFM when documenting results.
c. If the heartbeat cannot be immediately found, then a shift must be made to EFM.
d. Ultrasound can be used to find the FHR and to reassure the mother if the initial difficulty is a factor.

ANS: D

Locating fetal heartbeats often takes time. Mothers can be verbally reassured and reassured by viewing the ultrasound pictures if that device is used to help locate the heartbeat. When used as the primary method of fetal assessment, IA requires a nurse-to-client ratio of one to one. Documentation should use only terms that can be numerically defined; the usual visual descriptions of EFM are inappropriate.

DIF: Cognitive Level: Understand REF: IMS: 413

TOP: Nursing Process: Assessment | Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

15. What is a distinct advantage of external EFM?

a. The ultrasound transducer can accurately measure short-term variability and beat-to-beat changes in the FHR.

b. The tocotransducer can measure and record the frequency, regularity, intensity, and approximate duration of uterine contractions.

c. The tocotransducer is especially valuable for measuring uterine activity during the first stage of labor.

d. Once correctly applied by the nurse, the transducer need not be repositioned even when the woman changes positions.

ANS: C

The tocotransducer is valuable for measuring uterine activity during the first stage of labor and is especially true when the membranes are intact. Short-term variability and beat-to-beat changes cannot be measured with this technology. The tocotransducer cannot measure and record the intensity of uterine contractions. The transducer must be repositioned when the woman or the fetus changes position.

DIF: Cognitive Level: Understand REF: pp. 414-415

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

16. Which client would *not* be a suitable candidate for internal EFM?

a. Client who still has intact membranes

b. Woman whose fetus is well engaged in the pelvis

c. Pregnant woman who has a comorbidity of obesity

d. Client whose cervix is dilated to 4 to 5 cm

ANS: A

For internal EFM, the membranes must have ruptured and the cervix must be dilated at least 2 to 3 cm. The presenting part must be low enough to allow placement of the spiral electrode necessary for internal EFM. The accuracy of EFM is not affected by maternal size. However, evaluating fetal well-being using external EFM may be more difficult on an obese client. The client whose cervix is dilated to 4 to 5 cm is indeed a candidate for internal monitoring.

DIF: Cognitive Level: Understand REF: IMS: 416 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. During labor a fetus displays an average FHR of 135 beats per minute over a 10-minute period. Which statement *best* describes the status of this fetus?

a. Bradycardia
b. Normal baseline heart rate
c. Tachycardia
d. Hypoxia

ANS: B

The baseline FHR is measured over 10 minutes; a normal range is 110 to 160 beats per minute. Bradycardia is a FHR less than 110 beats per minute for 10 minutes or longer. Tachycardia is a FHR higher than 160 beats per minutes for 10 minutes or longer. Hypoxia is an inadequate supply of oxygen; no indication of hypoxia exists with a baseline FHR in the normal range.

DIF: Cognitive Level: Remember REF: IMS: 411

TOP: Nursing Process: Assessment

MSC: Client Needs: Health Promotion and Maintenance, Physiologic Integrity

18. A nurse caring for a woman in labor should understand that absent or minimal variability is classified as either abnormal or indeterminate. Which condition related to decreased variability is considered benign?

a. Periodic fetal sleep state
b. Extreme prematurity
c. Fetal hypoxemia
d. Preexisting neurologic injury

ANS: A

When the fetus is temporarily in a sleep state, minimal variability is present. Periodic fetal sleep states usually last no longer than 30 minutes. A woman in labor with extreme prematurity may display a FHR pattern of minimal or absent variability. Abnormal variability may also be related to fetal hypoxemia and metabolic acidemia. Congenital anomalies or a preexisting neurologic injury may also result in absent or minimal variability. Other possible causes might be central nervous system (CNS) depressant medications, narcotics, or general anesthesia.

DIF: Cognitive Level: Understand REF: IMS: 418

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. Which definition of an acceleration in the fetal heart rate (FHR) is *accurate*?

a. FHR accelerations are indications of fetal well-being when they are periodic.
b. FHR accelerations are greater and longer in preterm gestations.
c. FHR accelerations are usually observed with breech presentations when they are episodic.
d. An acceleration in the FHR presents a visually apparent and abrupt peak.

ANS: D

Acceleration of the FHR is defined as a visually apparent abrupt (only to peak 30 seconds) increase in the FHR above the baseline rate. Periodic accelerations occur with uterine contractions and are usually observed with breech presentations. Episodic accelerations occur during fetal movement and are indications of fetal well-being. Preterm accelerations peak at 10 beats per minute above the baseline and last for at least 10 seconds.

DIF: Cognitive Level: Remember REF: IMS: 420

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. Which characteristic *correctly* matches the type of deceleration with its likely cause?

a. Early decelerationumbilical cord compression
b. Late decelerationuteroplacental insufficiency

c. Variable decelerationhead compression

d. Prolonged decelerationunknown cause

ANS: B

Late deceleration is caused by uteroplacental insufficiency. Early deceleration is caused by head compression. Variable deceleration is caused by umbilical cord compression. Prolonged deceleration has a variety of either benign or critical causes.

DIF: Cognitive Level: Remember REF: pp. 420-421

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

21. Which information related to a prolonged deceleration is important for the labor nurse to understand?

a. Prolonged decelerations present a continuing pattern of benign decelerations that do not require intervention.

b. Prolonged decelerations constitute a baseline change when they last longer than 5 minutes.

c. A disruption to the fetal oxygen supply causes prolonged decelerations.

d. Prolonged decelerations require the customary fetal monitoring by the nurse.

ANS: C

Prolonged decelerations are caused by a disruption in the fetal oxygen supply. They usually begin as a reflex response to hypoxia. If the disruption continues, then the fetal cardiac tissue, itself, will become hypoxic, resulting in direct myocardial depression of the FHR. Prolonged decelerations can be caused by prolonged cord compression, uteroplacental insufficiency, or perhaps sustained head compression. Prolonged decelerations lasting longer than 10 minutes are considered a baseline change that may require intervention. A prolonged deceleration is a visually apparent decrease (may be either gradual or abrupt) in the FHR of at least 15 beats per minute below the baseline and lasting longer than 2 minutes but shorter than 10 minutes. Nurses should immediately notify the physician or nurse-midwife and initiate appropriate treatment of abnormal patterns when they see prolonged decelerations.

DIF: Cognitive Level: Understand REF: IMS: 422

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

22. In which situation would the nurse be called on to stimulate the fetal scalp?

a. As part of fetal scalp blood sampling
b. In response to tocolysis
c. In preparation for fetal oxygen saturation monitoring
d. To elicit an acceleration in the FHR

ANS: D

The scalp can be stimulated using digital pressure during a vaginal examination. Fetal scalp blood sampling involves swabbing the scalp with disinfectant before a sample is collected. The nurse stimulates the fetal scalp to elicit an acceleration of the FHR. Tocolysis is relaxation of the uterus. Fetal oxygen saturation monitoring involves the insertion of a sensor.

DIF: Cognitive Level: Apply REF: IMS: 425

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

23. Part of the nurses role is assisting with pushing and positioning. Which guidance should the nurse provide to her client in active labor?

a. Encourage the womans cooperation in avoiding the supine position.
b. Advise the woman to avoid the semi-Fowler position.
c. Encourage the woman to hold her breath and tighten her abdominal muscles to produce a vaginal response.
d. Instruct the woman to open her mouth and close her glottis, letting air escape after the push.

ANS: A

The woman should maintain a side-lying position. The semi-Fowler position is the recommended side-lying position with a lateral tilt to the uterus. Encouraging the woman to hold her breath and

tighten her abdominal muscles is the Valsalva maneuver, which should be avoided. Both the mouth and glottis should be open, allowing air to escape during the push.

DIF: Cognitive Level: Apply REF: IMS: 427

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

24. In which clinical situation would the nurse *most* likely anticipate a fetal bradycardia?

a. Intraamniotic infection
b. Fetal anemia
c. Prolonged umbilical cord compression
d. Tocolytic treatment using terbutaline

ANS: C

Fetal bradycardia can be considered a later sign of fetal hypoxia and is known to occur before fetal death. Bradycardia can result from placental transfer of drugs, prolonged compression of the umbilical cord, maternal hypothermia, and maternal hypotension. Intraamniotic infection, fetal anemia, and tocolytic treatment using terbutaline would most likely result in fetal tachycardia.

DIF: Cognitive Level: Understand REF: IMS: 422

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

25. Which nursing intervention would result in an increase in maternal cardiac output?

a. Change in position
b. Oxytocin administration
c. Regional anesthesia
d. IV analgesic

ANS: A

Maternal supine hypotension syndrome is caused by the weight and pressure of the gravid uterus on the ascending vena cava when the woman is in a supine position. This position reduces venous return to the womans heart, as well as cardiac output, and subsequently reduces her blood pressure. The nurse can encourage the woman to change positions and to avoid the supine position. Oxytocin administration, regional anesthesia, and IV analgesic may reduce maternal cardiac output.

DIF: Cognitive Level: Apply REF: IMS: 425

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

26. The nurse is evaluating the EFM tracing of the client who is in active labor. Suddenly, the FHR drops from its baseline of 125 down to 80 beats per minute. The mother is repositioned, and the nurse provides oxygen, increased IV fluids, and performs a vaginal examination. The cervix has not changed. Five minutes have passed, and the FHR remains in the 80s. What additional nursing measures should the nurse take next?

a. Call for help.
b. Insert a Foley catheter.
c. Start administering Pitocin.
d. Immediately notify the care provider.

ANS: D

To relieve an FHR deceleration, the nurse can reposition the mother, increase IV fluids, and provide oxygen. If oxytocin is infusing, then it should be discontinued. If the FHR does not resolve, then the primary care provider should be immediately notified. Inserting a Foley catheter is an inappropriate nursing action. If the FHR were to continue in a nonreassuring pattern, then a cesarean section could be warranted, which would require a Foley catheter. However, the physician must make that determination. The administration of Pitocin may place additional stress on the fetus.

DIF: Cognitive Level: Analyze REF: IMS: 425

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

27. The nurse observes a sudden increase in variability on the ERM tracing. Which class of medications may cause this finding?

a. Narcotics
b. Barbiturates
c. Methamphetamines
d. Tranquilizers

ANS: C

Narcotics, barbiturates, and tranquilizers may be causes of decreased variability; whereas methamphetamines may cause increased variability.

DIF: Cognitive Level: Understand REF: IMS: 419

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

28. What is the *correct* placement of the tocotransducer for effective EFM?

a. Over the uterine fundus
b. On the fetal scalp
c. Inside the uterus
d. Over the mothers lower abdomen

ANS: A

The tocotransducer monitors uterine activity and should be placed over the fundus, where the most intensive uterine contractions occur. The tocotransducer is for external use.

DIF: Cognitive Level: Understand REF: IMS: 414

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

29. What physiologic change occurs as the result of increasing the infusion rate of nonadditive IV fluids?

a. Maintaining normal maternal temperature
b. Preventing normal maternal hypoglycemia
c. Increasing the oxygen-carrying capacity of the maternal blood
d. Expanding maternal blood volume

ANS: D

Filling the mothers vascular system increases the amount of blood available to perfuse the placenta and may correct hypotension. Increasing fluid volume may alter the maternal temperature only if she is dehydrated. Most IV fluids for laboring women are isotonic and do not provide extra glucose. Oxygen-carrying capacity is increased by adding more red blood cells.

DIF: Cognitive Level: Apply REF: IMS: 425

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

30. The client has delivered by urgent caesarean birth for fetal compromise. Umbilical cord gases were obtained for acid-base determination. The pH is 6.9, partial pressure of carbon dioxide (PCO_2) is elevated, and the base deficit is 11 mmol/L. What type of acidemia is displayed by the infant?

a. Respiratory
b. Metabolic
c. Mixed
d. Turbulent

ANS: A

These findings are evidence of respiratory acidemia. Metabolic acidemia is expressed by a pH <7.20, normal carbon dioxide pressure, and a base excess of 12 mmol/L. Mixed acidemia is evidenced by a pH <7.20, elevated carbon dioxide pressure, and a base excess of 12 mmol/L. There is no such finding as turbulent acidemia.

DIF: Cognitive Level: Analyze REF: IMS: 426

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. In assessing the immediate condition of the newborn after birth, a sample of cord blood may be a useful adjunct to the Apgar score. Cord blood is then tested for pH, carbon dioxide, oxygen, and base deficit or excess. Which clinical situation warrants this additional testing? *(Select all that apply.)*

a. Low 5-minute Apgar score
b. Intrauterine growth restriction (IUGR)
c. Maternal thyroid disease
d. Intrapartum fever
e. Vacuum extraction

ANS: A, B, C, D

The American College of Obstetricians and Gynecologists (ACOG) suggests obtaining cord blood values in all of these clinical situations except for vacuum extractions deliveries. Cord blood gases should also be performed for multifetal pregnancies or abnormal FHR tracings. Samples can be drawn from both the umbilical artery and the umbilical vein. Results may indicate that fetal compromise has occurred.

DIF: Cognitive Level: Understand REF: IMS: 426

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

2. According to the National Institute of Child Health and Human Development (NICHD) Three-Tier System of FHR Classification, category III tracings include all FHR tracings not categorized as category I or II. Which characteristics of the FHR belong in category III? *(Select all that apply.)*

a. Baseline rate of 110 to 160 beats per minute

b. Tachycardia
c. Absent baseline variability *not* accompanied by recurrent decelerations
d. Variable decelerations with other characteristics such as shoulders or overshoots
e. Absent baseline variability with recurrent variable decelerations
f. Bradycardia

ANS: B, D, E, F

Tachycardia, variable decelerations with other characteristics, absent baseline variability with recurrent variable decelerations, and bradycardia are characteristics that are considered nonreassuring or abnormal and belong in category III. A FHR of 110 to 160 beats per minute is considered normal and belongs in category I. Absent baseline variability *not* accompanied by recurrent decelerations is a category II characteristic.

DIF: Cognitive Level: Analyze REF: IMS: 411 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

3. Which FHR decelerations would require the nurse to change the maternal position? *(Select all that apply.)*

a. Early decelerations
b. Late decelerations
c. Variable decelerations
d. Moderate decelerations
e. Prolonged decelerations

ANS: B, C, E

Early decelerations (and accelerations) do not generally need any nursing intervention. Late decelerations suggest that the nurse should change the maternal position (lateral). Variable decelerations also require a maternal position change (side to side). Moderate decelerations are not an accepted category. Prolonged decelerations are late or variable decelerations that last for a prolonged period (longer than 2 minutes) and require intervention.

DIF: Cognitive Level: Understand REF: pp. 422, 423

TOP: Nursing Process: Assessment | Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

4. A tiered system of categorizing FHR has been recommended by professional organizations. Nurses, midwives, and physicians who care for women in labor must have a working knowledge of fetal monitoring standards and understand the significance of each category. What is the correct nomenclature for these categories? *(Select all that apply.)*

a. Reassuring
b. Category I
c. Category II
d. Nonreassuring
e. Category III

ANS: B, C, E

The three-tiered system of FHR tracings include category I, II, and III. Category I is a normal tracing requiring no action. Category II FHR tracings are indeterminate and includes tracings that do not meet category I or III criteria. Category III tracings are abnormal and require immediate intervention.

DIF: Cognitive Level: Understand REF: IMS: 411

TOP: Nursing Process: Assessment | Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. The baseline FHR is the average rate during a 10-minute segment. Changes in FHR are categorized as periodic or episodic. These patterns include both accelerations and decelerations. The labor nurse is evaluating the clients most recent 10-minute segment on the monitor strip and notes a late deceleration. Which is likely to have caused this change? *(Select all that apply.)*

a. Spontaneous fetal movement
b. Compression of the fetal head
c. Placental abruption
d. Cord around the babys neck
e. Maternal supine hypotension

ANS: C, E

Late decelerations are almost always caused by uteroplacental insufficiency. Insufficiency is caused by uterine tachysystole, maternal hypotension, epidural or spinal anesthesia, IUGR, intraamniotic infection, or placental abruption. Spontaneous fetal movement, vaginal examination, fetal scalp stimulation, fetal reaction to external sounds, uterine contractions, fundal pressure, and abdominal palpation are all likely to cause *accelerations* of the FHR. *Early decelerations* are most often the result of fetal head compression and may be caused by uterine contractions, fundal pressure, vaginal examination, and the placement of an internal electrode. A *variable deceleration* is likely caused by umbilical cord compression, which may happen when the umbilical cord is around the babys neck, arm, leg, or other body part or when a short cord, a knot in the cord, or a prolapsed cord is present.

Chapter 19: Nursing Care of the Family During Labor and Birth

MULTIPLE CHOICE

1. Which statement by the client will assist the nurse in determining whether she is in true labor as opposed to false labor?

a. I passed some thick, pink mucus when I urinated this morning.
b. My bag of waters just broke.
c. The contractions in my uterus are getting stronger and closer together.
d. My baby dropped, and I have to urinate more frequently now.

ANS: C

Regular, strong contractions with the presence of cervical change indicate that the woman is experiencing true labor. The loss of the mucous plug (operculum) often occurs during the first stage of labor or before the onset of labor, but it is not the indicator of true labor. Spontaneous rupture of membranes (ROM) often occurs during the first stage of labor, but it is not the indicator of true labor. The presenting part of the fetus typically becomes engaged in the pelvis at the onset of labor, but this is not the indicator of true labor.

DIF: Cognitive Level: Understand REF: IMS: 431

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. When a nulliparous woman telephones the hospital to report that she is in labor, what guidance should the nurse provide or information should the nurse obtain?

a. Tell the woman to stay home until her membranes rupture.
b. Emphasize that food and fluid intake should stop.
c. Arrange for the woman to come to the hospital for labor evaluation.
d. Ask the woman to describe why she believes she is in labor.

ANS: D

Assessment begins at the first contact with the woman, whether by telephone or in person. By asking the woman to describe her signs and symptoms, the nurse can begin her assessment and gather data. The initial nursing activity should be to gather data about the womans status. The amniotic membranes may or may not spontaneously rupture during labor. The client may be instructed to stay home until the uterine contractions become strong and regular. Before instructing the woman to come to the hospital, the nurse should initiate her assessment during the telephone interview. After this assessment has been made, the nurse may want to discuss the appropriate oral intake for early labor, such as light foods or clear liquids, depending on the preference of the client or her primary health care provider.

DIF: Cognitive Level: Apply REF: IMS: 434

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is caring for a client in early labor. Membranes ruptured approximately 2 hours earlier. This client is at increased risk for which complication?

a. Intrauterine infection
b. Hemorrhage
c. Precipitous labor
d. Supine hypotension

ANS: A

When the membranes rupture, microorganisms from the vagina can ascend into the amniotic sac, causing chorioamnionitis and placentitis. ROM is not associated with fetal or maternal bleeding. Although ROM may increase the intensity of the contractions and facilitate active labor, it does not result in precipitous labor. ROM has no correlation with supine hypotension.

DIF: Cognitive Level: Apply REF: IMS: 444

TOP: Nursing Process: Planning | Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

4. The uterine contractions of a woman early in the active phase of labor are assessed by an internal uterine pressure catheter (IUPC). The uterine contractions occur every 3 to 4 minutes and last an average of 55 to 60 seconds. They are becoming more regular and are moderate to strong. Based on this information, what would a prudent nurse do next?

a. Immediately notify the womans primary health care provider.
b. Prepare to administer an oxytocic to stimulate uterine activity.
c. Document the findings because they reflect the expected contraction pattern for the active phase of labor.
d. Prepare the woman for the onset of the second stage of labor.

ANS: C

The nurse is responsible for monitoring the uterine contractions to ascertain whether they are powerful and frequent enough to accomplish the work of expelling the fetus and the placenta. In addition, the nurse documents these findings in the clients medical record. This labor pattern indicates that the client is in the active phase of the first stage of labor. Nothing indicates a need to notify the primary health care provider at this time. Oxytocin augmentation is not needed for this labor pattern; this contraction pattern indicates that the woman is in active labor. Her contractions will eventually become stronger, last longer, and come closer together during the transition phase of the first stage of labor. The transition phase precedes the second stage of labor, or delivery of the fetus.

DIF: Cognitive Level: Apply REF: IMS: 436

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

5. Which action is *correct* when palpation is used to assess the characteristics and pattern of uterine contractions?

a. Placing the hand on the abdomen below the umbilicus and palpating uterine tone with the fingertips
b. Determining the frequency by timing from the end of one contraction to the end of the next contraction
c. Evaluating the intensity by pressing the fingertips into the uterine fundus
d. Assessing uterine contractions every 30 minutes throughout the first stage of labor

ANS: C

The nurse or primary health care provider may assess uterine activity by palpating the fundal section of the uterus using the fingertips. Many women may experience labor pain in the lower segment of the uterus, which may be unrelated to the firmness of the contraction detectable in the uterine fundus. The frequency of uterine contractions is determined by palpating from the beginning of one contraction to the beginning of the next contraction. Assessment of uterine activity is performed in intervals based on the stage of labor. As labor progresses, this assessment is performed more frequently.

DIF: Cognitive Level: Apply REF: pp. 440-441

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. When assessing a woman in the first stage of labor, which clinical finding will alert the nurse that uterine contractions are effective?

a. Dilation of the cervix
b. Descent of the fetus to 2 station
c. Rupture of the amniotic membranes
d. Increase in bloody show

ANS: A

The vaginal examination reveals whether the woman is in true labor. Cervical change, especially dilation, in the presence of adequate labor, indicates that the woman is in true labor. Engagement and descent of the fetus are not synonymous and may occur before labor. ROM may occur with or without the presence of labor. Bloody show may indicate a slow, progressive cervical change (e.g., effacement) in both true and false labor.

DIF: Cognitive Level: Understand REF: IMS: 431

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

7. The nurse performs a vaginal examination to assess a clients labor progress. Which action should the nurse take next?

a. Perform an examination at least once every hour during the active phase of labor.
b. Perform the examination with the woman in the supine position.
c. Wear two clean gloves for each examination.
d. Discuss the findings with the woman and her partner.

ANS: D

The nurse should discuss the findings of the vaginal examination with the woman and her partner, as well as report the findings to the primary care provider. A vaginal examination should be performed only when indicated by the status of the woman and her fetus. The woman should be positioned so as to avoid supine hypotension. The examiner should wear a sterile glove while performing a vaginal examination for a laboring woman.

DIF: Cognitive Level: Apply REF: IMS: 444

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. A multiparous woman has been in labor for 8 hours. Her membranes have just ruptured. What is the nurses *highest* priority in this situation?

a. Prepare the woman for imminent birth.
b. Notify the womans primary health care provider.
c. Document the characteristics of the fluid.
d. Assess the fetal heart rate (FHR) and pattern.

ANS: D

The umbilical cord may prolapse when the membranes rupture. The FHR and pattern should be closely monitored for several minutes immediately after the ROM to ascertain fetal well-being, and the findings should be documented. The ROM may increase the intensity and frequency of the uterine contractions, but it does not indicate that birth is imminent. The nurse may notify the primary health care provider after ROM occurs and the fetal well-being and response to ROM have been assessed. The nurses priority is to assess fetal well-being. The nurse should document the characteristics of the amniotic fluid, but the initial response is to assess fetal well-being and the response to ROM.

DIF: Cognitive Level: Apply REF: IMS: 444

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. Under which circumstance should the nurse assist the laboring woman into a hands-and-knees position?

a. Occiput of the fetus is in a posterior position.
b. Fetus is at or above the ischial spines.
c. Fetus is in a vertex presentation.
d. Membranes have ruptured.

ANS: A

The hands-and-knees position is effective in helping to rotate the fetus from a posterior to an anterior position. Many women experience the irresistible urge to push when the fetus is at the level of the ischial spines. In some cases, this urge is felt before the woman is fully dilated. The woman should be instructed not to push until complete cervical dilation has occurred. No one position is correct for childbirth. The two most common positions assumed by women are the sitting and side-lying positions. The woman may be encouraged into a hands-and-knees position if the umbilical cord prolapsed when the membranes ruptured.

DIF: Cognitive Level: Apply REF: IMS: 449

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

10. A nulliparous woman has just begun the latent phase of the second stage of her labor. The nurse should anticipate which behavior?

a. A nulliparous woman will experience a strong urge to bear down.
b. Perineal bulging will show.
c. A nulliparous woman will remain quiet with her eyes closed between contractions.
d. The amount of bright red bloody show will increase.

ANS: C

The woman is able to relax and close her eyes between contractions as the fetus passively descends. The woman may be very quiet during this phase. During the latent phase of the second stage of labor, the urge to bear down is often absent or only slight during the acme of the contractions. Perineal bulging occurs during the transition phase of the second stage of labor, not

at the beginning of the second stage. An increase in bright red bloody show occurs during the descent phase of the second stage of labor.

DIF: Cognitive Level: Understand REF: IMS: 454 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

11. Which clinical finding indicates that the client has reached the second stage of labor?

a. Amniotic membranes rupture.
b. Cervix cannot be felt during a vaginal examination.
c. Woman experiences a strong urge to bear down.
d. Presenting part of the fetus is below the ischial spines.

ANS: C

During the descent phase of the second stage of labor, the woman may experience an increase in the urge to bear down. The ROM has no significance in determining the stage of labor. The second stage of labor begins with full cervical dilation. Many women may have an urge to bear down when the presenting fetal part is below the level of the ischial spines. This urge can occur during the first stage of labor, as early as with 5 cm dilation.

DIF: Cognitive Level: Understand REF: IMS: 454 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. Through a vaginal examination, the nurse determines that a woman is 4 cm dilated. The external fetal monitor shows uterine contractions every to 4 minutes. The nurse reports this as what stage of labor?

a. First stage, latent phase
b. First stage, active phase
c. First stage, transition phase
d. Second stage, latent phase

ANS: B

This maternal progress indicates that the woman is in the active phase of the first stage of labor. During the latent phase of the first stage of labor, the expected maternal progress is 0 to 3 cm dilation with contractions every 5 to 30 minutes. During the transition phase of the first stage of labor, the expected maternal progress is 8 to 10 cm dilation with contractions every 2 to 3 minutes. During the latent phase of the second stage of labor, the woman is completely dilated and experiences a restful period of laboring down.

DIF: Cognitive Level: Understand REF: IMS: 436

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. What is the *most* critical nursing action in caring for the newborn immediately after the birth?

a. Keeping the airway clear
b. Fostering parent-newborn attachment
c. Drying the newborn and wrapping the infant in a blanket
d. Administering eye drops and vitamin K

ANS: A

The care given immediately after the birth focuses on assessing and stabilizing the newborn. Although fostering parent-newborn attachment is an important task for the nurse, it is not the most critical nursing action in caring for the newborn immediately after birth. The care given immediately after birth focuses on assessing and stabilizing the newborn. The nursing activities are (in order of importance) to maintain a patent airway, to support respiratory effort, and to prevent cold stress by drying the newborn and covering him or her with a warmed blanket or placing the newborn under a radiant warmer. After the newborn has been stabilized, the nurse assesses the newborns physical condition, weighs and measures the newborn, administers prophylactic eye ointment and a vitamin K injection, affixes an identification bracelet, wraps the newborn in warm blankets, and then gives the newborn to the partner or to the mother of the infant.

DIF: Cognitive Level: Apply REF: IMS: 464

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

14. What is the rationale for the administration of an oxytocic (e.g., Pitocin, Methergine) after expulsion of the placenta?

a. To relieve pain
b. To stimulate uterine contraction
c. To prevent infection
d. To facilitate rest and relaxation

ANS: B

Oxytocics stimulate uterine contractions, which reduce blood loss after the third stage of labor. Oxytocics are not used to treat pain, do not prevent infection, and do not facilitate rest and relaxation.

DIF: Cognitive Level: Remember REF: IMS: 466

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

15. Which description of the phases of the first stage of labor is *most* accurate?

a. Latent: mild, regular contractions; no dilation; bloody show
b. Active: moderate, regular contractions; 4 to 7 cm dilation
c. Lull: no contractions; dilation stable
d. Transition: very strong but irregular contractions; 8 to 10 cm dilation

ANS: B

The active phase is characterized by moderate and regular contractions, 4 to 7 cm dilation, and duration of 3 to 6 hours. The latent phase is characterized by mild-to-moderate and irregular contractions, dilation up to 3 cm, brownish-to-pale pink mucus, and duration of 6 to 8 hours. No

official lull phase exists in the first stage. The transition phase is characterized by strong to very strong and regular contractions, 8 to 10 cm dilation, and duration of 20 to 40 minutes.

DIF: Cognitive Level: Understand REF: IMS: 436 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

16. Which information regarding the procedures and criteria for admitting a woman to the hospital labor unit is important for the nurse to understand?

a. Client is considered to be in active labor when she arrives at the facility with contractions.
b. Client can have only her male partner or predesignated doula with her at assessment.
c. Children are not allowed on the labor unit.
d. NonEnglish speaking client must bring someone to translate.

ANS: A

According to the Emergency Medical Treatment and Active Labor Act (EMTALA), a woman is entitled to active labor care and is presumed to be in *true labor* until a qualified health care provider certifies otherwise. A woman may have anyone she wishes present for her support. An interpreter must be provided by the hospital, either in person or by a telephonic service. Siblings of the new infant may be allowed at the delivery, depending on hospital policy and adequate preparation and supervision.

DIF: Cognitive Level: Understand REF: IMS: 432 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. Which component of the physical examination are Leopolds maneuvers unable to determine?

a. Gender of the fetus
b. Number of fetuses
c. Fetal lie and attitude

d. Degree of the presenting parts descent into the pelvis

ANS: A

Leopolds maneuvers help identify the number of fetuses, the fetal lie and attitude, and the degree of descent of the presenting part into the pelvis. The gender of the fetus cannot be determined by performing Leopolds maneuvers.

DIF: Cognitive Level: Remember REF: pp. 439, 440

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

18. Where is the point of maximal intensity (PMI) of the FHR located?

a. Usually directly over the fetal abdomen
b. In a vertex position, heard above the mothers umbilicus
c. Heard lower and closer to the midline of the mothers abdomen as the fetus descends and internally rotates
d. In a breech position, heard below the mothers umbilicus

ANS: C

Nurses should be prepared for the shift. The PMI of the FHR is usually directly over the fetal back. In a vertex position, the PMI of the FHR is heard below the mothers umbilicus. In a breech position, it is heard above the mothers umbilicus.

DIF: Cognitive Level: Understand REF: IMS: 440

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. The nurse should be aware of which information related to a womans intake and output during labor?

a. Traditionally, restricting the laboring woman to clear liquids and ice chips is being challenged because regional anesthesia is used more often than general anesthesia.

b. Intravenous (IV) fluids are usually necessary to ensure that the laboring woman stays hydrated.

c. Routine use of an enema empties the rectum and is very helpful for producing a clean, clear delivery.

d. When a nulliparous woman experiences the urge to defecate, it often means birth will quickly follow.

ANS: A

Women are awake with regional anesthesia and are able to protect their own airway, which reduces the worry over aspiration. Routine IV fluids during labor are unlikely to be beneficial and may be harmful. The routine use of an enema is, at best, ineffective and may be harmful. Having the urge to defecate followed by the birth of her fetus is true for a multiparous woman but not for a nulliparous woman.

DIF: Cognitive Level: Understand REF: IMS: 445 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. Which technique is an adequate means of controlling the birth of the fetal head during delivery in a vertex presentation?

a. Ritgen maneuver

b. Fundal pressure

c. Lithotomy position

d. De Lee apparatus

ANS: A

The Ritgen maneuver extends the head during the actual birth and protects the perineum. Gentle, steady pressure against the fundus of the uterus facilitates vaginal birth. The lithotomy position has been commonly used in Western cultures, partly because it is convenient for the health care provider. The De Lee apparatus is used to suction fluid from the infants mouth.

DIF: Cognitive Level: Remember REF: IMS: 464

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

21. Which collection of risk factors will *most likely* result in damaging lacerations, including episiotomies?

a. Dark-skinned woman who has had more than one pregnancy, who is going through prolonged second-stage labor, and who is attended by a midwife
b. Reddish-haired mother of two who is going through a breech birth
c. Dark-skinned first-time mother who is going through a long labor
d. First-time mother with reddish hair whose rapid labor was overseen by an obstetrician

ANS: D

Reddish-haired women have tissue that is less distensible than darker-skinned women and therefore may have less efficient healing. First-time mothers are also at greater risk, especially with breech births, long second-stage labors, or rapid labors during which the time for the perineum to stretch is insufficient. The rate of episiotomies is higher when obstetricians rather than midwives attend the births. The woman in the first scenario (a) is at low risk for either damaging lacerations or an episiotomy. She is multiparous, has dark skin, and is being attended by a midwife, who is less likely to perform an episiotomy. Reddish-haired women have tissue that is less distensible than that of darker-skinned women. Consequently, the client in the second scenario (b) is at increased risk for lacerations; however, she has had two previous deliveries, which result in a lower likelihood of an episiotomy. The fact that the woman in the third scenario (c) is experiencing a prolonged labor might increase her risk for lacerations. Fortunately, she is dark skinned, which indicates that her tissue is more distensible than that of fair-skinned women and therefore less susceptible to injury.

DIF: Cognitive Level: Apply REF: IMS: 465 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

22. Which statement concerning the third stage of labor is *correct*?

a. The placenta eventually detaches itself from a flaccid uterus.

b. An expectant or active approach to managing this stage of labor reduces the risk of complications.
c. It is important that the dark, roughened maternal surface of the placenta appears before the shiny fetal surface.
d. The major risk for women during the third stage is a rapid heart rate.

ANS: B

Active management facilitates placental separation and expulsion, reducing the risk of complications. The placenta cannot detach itself from a flaccid (relaxed) uterus. Which surface of the placenta comes out first is not clinically important. The major risk for women during the third stage of labor is postpartum hemorrhaging.

DIF: Cognitive Level: Understand REF: IMS: 466

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

23. A 25-year-old gravida 3, para 2 client gave birth to a 9-pound, 7-ounce boy, 4 hours ago after augmentation of labor with oxytocin (Pitocin). She presses her call light, and asks for her nurse right away, stating Im bleeding a lot. What is the *most* likely cause of postpartum hemorrhaging in this client?

a. Retained placental fragments
b. Unrepaired vaginal lacerations
c. Uterine atony
d. Puerperal infection

ANS: C

This woman gave birth to a macrosomic infant after oxytocin augmentation. Combined with these risk factors, uterine atony is the most likely cause of bleeding 4 hours after delivery. Although retained placental fragments may cause postpartum hemorrhaging, it is typically detected within the first hour after delivery of the placenta and is not the most likely cause of the

hemorrhaging in this woman. Although unrepaired vaginal lacerations may also cause bleeding, it typically occurs in the period immediately after birth. Puerperal infection can cause subinvolution and subsequent bleeding that is, however, typically detected 24 hours postpartum.

DIF: Cognitive Level: Analyze REF: IMS: 466

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

24. In recovery, if a woman is asked to either raise her legs (knees extended) off the bed or flex her knees, and then place her feet flat on the bed and raise her buttocks well off the bed, the purpose of this exercise is to assess what?

a. Recovery from epidural or spinal anesthesia
b. Hidden bleeding underneath her
c. Flexibility
d. Whether the woman is a candidate to go home after 6 hours

ANS: A

If the numb or prickly sensations are gone from her legs after these movements, then she has likely recovered from the epidural or spinal anesthesia. Assessing the client for bleeding beneath her buttocks before discharge from the recovery is always important; however, she should be rolled to her side for this assessment. The nurse is not required to assess the woman for flexibility. This assessment is performed to evaluate whether the client has recovered from spinal anesthesia, *not* to determine if she is a candidate for early discharge.

DIF: Cognitive Level: Understand REF: IMS: 468 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity, Reduction of Risk Potential

25. A woman who has a history of sexual abuse may have a number of traumatic memories triggered during labor. She may fight the labor process and react with pain or anger. The nurse can implement a number of care measures to help her client view the childbirth experience in a positive manner. Which intervention is key for the nurse to use while providing care?

a. Tell the client to relax and that it wont hurt much.
b. Limit the number of procedures that invade her body.
c. Reassure the client that, as the nurse, you know what is best.
d. Allow unlimited care providers to be with the client.

ANS: B

The number of invasive procedures such as vaginal examinations, internal monitoring, and IV therapy should be limited as much as possible. The nurse should always avoid words and phrases that may result in the clients recalling the phrases of her abuser (i.e., Relax, this wont hurt or Just open your legs). The womans sense of control should be maintained at all times. The nurse should explain procedures at the clients pace and wait for permission to proceed. Protecting the clients environment by providing privacy and limiting the number of staff who observe the client will help to make her feel safe.

DIF: Cognitive Level: Understand REF: IMS: 435

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

26. As the United States and Canada continue to become more culturally diverse, recognizing a wide range of varying cultural beliefs and practices is increasingly important for the nursing staff. A client is from which country if she requests to have the babys father in attendance?

a. Mexico
b. China
c. Iran
d. India

ANS: A

Hispanic women routinely have fathers and female relatives in attendance during the second stage of labor. The father of the baby is expected to provide encouragement, support, and reassurance that all will be well. In China, fathers are usually not present. The side-lying position is preferred for labor and birth because it is believed that this will reduce trauma to the infant. In

China, the client has a stoic response to pain. In Iran, the father will not be present. Female support persons and female health care providers are preferred. For many, a male caregiver is unacceptable. In India, the father is usually not present, but female relatives are usually in attendance. Natural childbirth methods are preferred.

DIF: Cognitive Level: Apply REF: IMS: 437 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

27. The Valsalva maneuver can be described as the process of making a forceful bearing-down attempt while holding ones breath with a closed glottis and a tightening of the abdominal muscles. When is it appropriate to instruct the client to use this maneuver?

a. During the second stage to enhance the movement of the fetus
b. During the third stage to help expel the placenta
c. During the fourth stage to expel blood clots
d. Not at all

ANS: D

The client should not be instructed to use this maneuver. This process stimulates the parasympathetic division of the autonomic nervous system and produces a vagal response (decrease in heart rate and blood pressure.) An alternative method includes instructing the client to perform open-mouth and open-glottis breathing and pushing.

DIF: Cognitive Level: Apply REF: IMS: 458

TOP: Nursing Process: Implementation

MSC: Client Needs: Physiologic and Psychologic Integrity

28. The first 1 to 2 hours after birth is sometimes referred to as what?

a. Bonding period
b. Third stage of labor

c. Fourth stage of labor
d. Early postpartum period

ANS: C

The first 2 hours of the birth are a critical time for the mother and her baby and is often called the *fourth stage of labor*. Maternal organs undergo their initial readjustment to a nonpregnant state. The third stage of labor lasts from the birth of the baby to the expulsion of the placenta. Bonding will occur over a much longer period, although it may be initiated during the fourth stage of labor.

DIF: Cognitive Level: Understand REF: IMS: 468

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

29. When managing the care of a woman in the second stage of labor, the nurse uses various measures to enhance the progress of fetal descent. Which instruction *best* describes these measures?

a. Encouraging the woman to try various upright positions, including squatting and standing
b. Telling the woman to start pushing as soon as her cervix is fully dilated
c. Continuing an epidural anesthetic so pain is reduced and the woman can relax
d. Coaching the woman to use sustained, 10- to 15-second, closed-glottis bearing-down efforts with each contraction

ANS: A

Both upright and squatting positions may enhance the progress of fetal descent. Many factors dictate when a woman should begin pushing. Complete cervical dilation is necessary, but complete dilation is only one factor. If the fetal head is still in a higher pelvic station, then the physician or midwife may allow the woman to labor down if the woman is able (allowing more time for fetal descent and thereby reducing the amount of pushing needed). The epidural may mask the sensations and muscle control needed for the woman to push effectively. Closed glottic breathing may trigger the Valsalva maneuver, which increases intrathoracic and cardiovascular

pressures, reducing cardiac output and inhibiting perfusion of the uterus and placenta. In addition, holding her breath for longer than 5 to 7 seconds diminishes the perfusion of oxygen across the placenta and results in fetal hypoxia.

DIF: Cognitive Level: Comprehend REF: IMS: 449

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

30. When assessing a multiparous woman who has just given birth to an 8-pound boy, the nurse notes that the womans fundus is firm and has become globular in shape. A gush of dark red blood comes from her vagina. What is the nurses assessment of the situation?

a. The placenta has separated.
b. A cervical tear occurred during the birth.
c. The woman is beginning to hemorrhage.
d. Clots have formed in the upper uterine segment.

ANS: A

Placental separation is indicated by a firmly contracting uterus, a change in the uterus from a discoid to a globular ovoid shape, a sudden gush of dark red blood from the introitus, an apparent lengthening of the umbilical cord, and a finding of vaginal fullness. Cervical tears that do not extend to the vagina result in minimal blood loss. Signs of hemorrhage are a boggy uterus, bright red vaginal bleeding, alterations in vital signs, pallor, lightheadedness, restlessness, decreased urinary output, and alteration in the level of consciousness. If clots have formed in the upper uterine segment, then the nurse would expect to find the uterus boggy and displaced to the side.

DIF: Cognitive Level: Understand REF: IMS: 467

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

31. After an emergency birth, the nurse encourages the woman to breastfeed her newborn. What is the primary purpose of this activity?

a. To facilitate maternal-newborn interaction
b. To stimulate the uterus to contract
c. To prevent neonatal hypoglycemia
d. To initiate the lactation cycle

ANS: B

Stimulation of the nipples through breastfeeding or manual stimulation causes the release of oxytocin and prevents maternal hemorrhage. Breastfeeding facilitates maternal-newborn interaction, but it is not the primary reason a woman is encouraged to breastfeed after an emergency birth. The primary intervention for preventing neonatal hypoglycemia is thermoregulation. Cold stress can result in hypoglycemia. The woman is encouraged to breastfeed after an emergency birth to stimulate the release of oxytocin, which prevents hemorrhaging. Breastfeeding is encouraged to initiate the lactation cycle, but it is not the primary reason for this activity after an emergency birth.

DIF: Cognitive Level: Understand REF: IMS: 469

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

32. A woman who is 39 weeks pregnant expresses fear about her impending labor and how she will manage. What is the nurses ideal response?

a. Dont worry about it. Youll do fine.
b. Its normal to be anxious about labor. Lets discuss what makes you afraid.
c. Labor is scary to think about, but the actual experience isnt.
d. You can have an epidural. You wont feel anything.

ANS: B

Its normal to be anxious about labor. Lets discuss what makes you afraid is a statement that allows the woman to share her concerns with the nurse and is a therapeutic communication tool. Dont worry about it. Youll do fine negates the womans fears and is not therapeutic. Labor is scary to think about, but the actual experience isnt negates the womans fears and offers a false

sense of security. To suggest that every woman can have an epidural is untrue. A number of criteria must be met before an epidural is considered. Furthermore, many women still experience the feeling of pressure with an epidural.

DIF: Cognitive Level: Apply REF: IMS: 435 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

33. Which characteristic of a uterine contraction is not routinely documented?

a. Frequency: how often contractions occur
b. Intensity: strength of the contraction at its peak
c. Resting tone: tension in the uterine muscle
d. Appearance: shape and height

ANS: D

Uterine contractions are described in terms of frequency, intensity, duration, and resting tone. Appearance is not routinely charted.

DIF: Cognitive Level: Remember REF: IMS: 440

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

34. Under which circumstance would it be unnecessary for the nurse to perform a vaginal examination?

a. Admission to the hospital at the start of labor
b. When accelerations of the FHR are noted
c. On maternal perception of perineal pressure or the urge to bear down
d. When membranes rupture

ANS: B

An accelerated FHR is a positive sign; therefore, a vaginal examination would not be necessary. A vaginal examination should be performed when the woman is admitted to the hospital, when she perceives perineal pressure or the urge to bear down, when her membranes rupture, when a significant change in her uterine activity has occurred, or when variable decelerations of the FHR are noted.

DIF: Cognitive Level: Remember REF: IMS: 442

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

35. Which description of the phases of the second stage of labor is *most accurate*?

a. Latent phase: Feeling sleepy; fetal station 2+ to 4+; duration of 30 to 45 minutes
b. Active phase: Overwhelmingly strong contractions; Ferguson reflux activated; duration of 5 to 15 minutes
c. Descent phase: Significant increase in contractions; Ferguson reflux activated; average duration varies
d. Transitional phase: Woman laboring down; fetal station 0; duration of 15 minutes

ANS: C

The descent phase begins with a significant increase in contractions; the Ferguson reflex is activated, and the duration varies, depending on a number of factors. The latent phase is the lull or laboring down period at the beginning of the second stage and lasts 10 to 30 minutes on average. The second stage of labor has no active phase. The transition phase is the final phase in the second stage of labor; contractions are strong and painful.

DIF: Cognitive Level: Understand REF: IMS: 454

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

36. A woman who is gravida 3 para 2 arrives on the intrapartum unit. What is the *most* important nursing assessment at this time?

a. Contraction pattern, amount of discomfort, and pregnancy history
b. FHR, maternal vital signs, and the womans nearness to birth

c. Identification of ruptured membranes, womans gravida and para, and her support person
d. Last food intake, when labor began, and cultural practices the couple desires

ANS: B

All options describe relevant intrapartum nursing assessments; however, this focused assessment has a priority. If the maternal and fetal conditions are normal and birth is not imminent, then other assessments can be performed in an unhurried manner; these include: gravida, para, support person, pregnancy history, pain assessment, last food intake, and cultural practices.

DIF: Cognitive Level: Apply REF: IMS: 460

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

37. A primigravida at 39 weeks of gestation is observed for 2 hours in the intrapartum unit. The FHR has been normal. Contractions are 5 to 9 minutes apart, 20 to 30 seconds in duration, and of mild intensity. Cervical dilation is 1 to 2 cm and uneffaced (unchanged from admission). Membranes are intact. What disposition would the nurse anticipate?

a. Admitted and prepared for a cesarean birth
b. Admitted for extended observation
c. Discharged home with a sedative
d. Discharged home to await the onset of true labor

ANS: D

This situation describes a woman with normal assessments who is probably in false labor and will likely not deliver rapidly once true labor begins. No further assessments or observations are indicated; therefore, the client will be discharged along with instructions to return when contractions increase in intensity and frequency. Neither a cesarean birth nor a sedative is required at this time.

DIF: Cognitive Level: Analyze REF: IMS: 431

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe and Effective Care Environment

38. A laboring woman is reclining in the supine position. What is the *most* appropriate nursing action at this time?

a. Ask her to turn to one side.
b. Elevate her feet and legs.
c. Take her blood pressure.
d. Determine whether fetal tachycardia is present.

ANS: A

The womans supine position may cause the heavy uterus to compress her inferior vena cava, thus reducing blood return to her heart and reducing placental blood flow. Elevating her legs will not relieve the pressure from the inferior vena cava. If the woman is allowed to stay in the supine position and blood flow to the placental is reduced significantly, then fetal tachycardia may occur. The most appropriate nursing action is to prevent this from occurring by turning the woman to her side. Blood pressure readings may be obtained when the client is in the appropriate and safest position.

DIF: Cognitive Level: Apply REF: IMS: 439

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

39. Which nursing assessment indicates that a woman who is in second-stage labor is almost ready to give birth?

a. Fetal head is felt at 0 station during vaginal examination.
b. Bloody mucous discharge increases.
c. Vulva bulges and encircles the fetal head.
d. Membranes rupture during a contraction.

ANS: C

A bulging vulva that encircles the fetal head describes crowning, which occurs shortly before birth. Birth of the head occurs when the station is +4. A 0 station indicates engagement. Bloody show occurs throughout the labor process and is not an indication of an imminent birth. ROM can occur at any time during the labor process and does not indicate an imminent birth.

DIF: Cognitive Level: Analyze REF: IMS: 456

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

40. What is the primary rationale for the thorough drying of the infant immediately after birth?

a. Stimulates crying and lung expansion
b. Removes maternal blood from the skin surface
c. Reduces heat loss from evaporation
d. Increases blood supply to the hands and feet

ANS: C

Infants are wet with amniotic fluid and blood at birth, and this accelerates evaporative heat loss. The primary purpose of drying the infant is to prevent heat loss. Although rubbing the infant stimulates crying, it is not the main reason for drying the infant. This process does not remove all the maternal blood.

DIF: Cognitive Level: Understand REF: IMS: 457

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Emergency conditions during labor that would require immediate nursing intervention can arise with startling speed. Which situations are examples of such an emergency? *(Select all that apply.)*

a. Nonreassuring or abnormal FHR pattern
b. Inadequate uterine relaxation

c. Vaginal bleeding
d. Prolonged second stage
e. Prolapse of the cord

ANS: A, B, C, E

A nonreassuring or abnormal FHR pattern, inadequate uterine relaxation, vaginal bleeding, infection, and cord prolapse all constitute an emergency during labor that requires immediate nursing intervention. A prolonged second stage of labor after the upper limits for duration is reached. This is 3 hours for nulliparous women and 2 hours for multiparous women.

DIF: Cognitive Level: Understand REF: pp. 453-454

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

2. Women who have participated in childbirth education classes often bring a birth plan with them to the hospital. Which items might this plan include? *(Select all that apply.)*

a. Presence of companions
b. Clothing to be worn
c. Care and handling of the newborn
d. Medical interventions
e. Date of delivery

ANS: A, B, C, D

The presence of companions, clothing to be worn, care and handling of the newborn, medical interventions, and environmental modifications all might be included in the couples birth plan. Other items include the presence of nonessential medical personnel (students), labor activities such as the tub or ambulation, preferred comfort and relaxation methods, and any cultural or religious requirements. The expected date of delivery would not be part of a birth plan unless the client is scheduled for an elective cesarean birth.

Chapter 20: Postpartum Physiologic Changes

MULTIPLE CHOICE

1. A woman gave birth to an infant boy 10 hours ago. Where does the nurse expect to locate this womans fundus?

a. 1 centimeter above the umbilicus
b. 2 centimeters below the umbilicus
c. Midway between the umbilicus and the symphysis pubis
d. Nonpalpable abdominally

ANS: A

The fundus descends approximately 1 to 2 cm every 24 hours. Within 12 hours after delivery the fundus may be approximately 1 cm above the umbilicus. By the sixth postpartum week the fundus is normally halfway between the symphysis pubis and the umbilicus. The fundus should be easily palpated using the maternal umbilicus as a reference point.

DIF: Cognitive Level: Understand REF: IMS: 473

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. What are the most common causes for subinvolution of the uterus?

a. Postpartum hemorrhage and infection
b. Multiple gestation and postpartum hemorrhage
c. Uterine tetany and overproduction of oxytocin
d. Retained placental fragments and infection

ANS: D

Subinvolution is the failure of the uterus to return to a nonpregnant state. The most common causes of subinvolution are retained placental fragments and infection. Subinvolution may be

caused by an infection and result in hemorrhage. Multiple gestations may cause uterine atony, resulting in postpartum hemorrhaging. Uterine tetany and overproduction of oxytocin do not cause subinvolution.

DIF: Cognitive Level: Understand REF: IMS: 473 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. Which client is *most* likely to experience strong and uncomfortable afterpains?

a. A woman who experienced oligohydramnios
b. A woman who is a gravida 4, para 4-0-0-4
c. A woman who is bottle-feeding her infant
d. A woman whose infant weighed 5 pounds, 3 ounces

ANS: B

Afterpains are more common in multiparous women. In a woman who experienced polyhydramnios, afterpains are more noticeable because the uterus was greatly distended. Breastfeeding may cause the afterpains to intensify. In a woman who delivered a large infant, afterpains are more noticeable because the uterus was greatly distended.

DIF: Cognitive Level: Understand REF: IMS: 474

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. A woman gave birth to a healthy infant boy 5 days ago. What type of lochia does the nurse expect to find when evaluating this client?

a. Lochia rubra
b. Lochia sangra
c. Lochia alba
d. Lochia serosa

ANS: D

Lochia serosa, which consists of blood, serum, leukocytes, and tissue debris, generally occurs around day 3 or 4 after childbirth. Lochia rubra consists of blood and decidual and trophoblastic debris. The flow generally lasts 3 to 4 days and pales, becoming pink or brown. Lochia sangra is not a real term. Lochia alba occurs in most women after day 10 and can continue up to 6 weeks after childbirth.

DIF: Cognitive Level: Understand REF: IMS: 474

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. Which hormone remains elevated in the immediate postpartum period of the breastfeeding woman?

a. Estrogen
b. Progesterone
c. Prolactin
d. Human placental lactogen

ANS: C

Prolactin levels in the blood progressively increase throughout pregnancy. In women who breastfeed, prolactin levels remain elevated into the sixth week after birth. Estrogen levels decrease significantly after expulsion of the placenta, reaching their lowest levels 1 week into the postpartum period. Progesterone levels decrease significantly after expulsion of the placenta, reaching their lowest levels 1 week into the postpartum period. Human placental lactogen levels dramatically decrease after expulsion of the placenta.

DIF: Cognitive Level: Remember REF: IMS: 476

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Two days ago a woman gave birth to a full-term infant. Last night she awakened several times to urinate and noted that her gown and bedding were wet from profuse diaphoresis. Which physiologic alteration is the cause for the diaphoresis and diuresis that this client is experiencing?

a. Elevated temperature caused by postpartum infection
b. Increased basal metabolic rate after giving birth
c. Loss of increased blood volume associated with pregnancy
d. Increased venous pressure in the lower extremities

ANS: C

Within 12 hours of birth, women begin to lose the excess tissue fluid that has accumulated during pregnancy. One mechanism for reducing these retained fluids is the profuse diaphoresis that often occurs, especially at night, for the first 2 or 3 days after childbirth. Postpartal diuresis is another mechanism by which the body rids itself of excess fluid. An elevated temperature causes chills and possibly dehydration, not diaphoresis and diuresis. Diaphoresis and diuresis are sometimes referred to as reversal of the water metabolism of pregnancy, not as the basal metabolic rate. Postpartal diuresis may be caused by the removal of increased venous pressure in the lower extremities.

DIF: Cognitive Level: Understand REF: IMS: 476 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

7. Which term best describes the interval between the birth of the newborn and the return of the reproductive organs to their normal nonpregnant state?

a. Involutionary period because of what happens to the uterus
b. Lochia period because of the nature of the vaginal discharge
c. Mini-tri period because it lasts only 3 to 6 weeks
d. Puerperium, or fourth trimester of pregnancy

ANS: D

The puerperium, also called the *fourth trimester* or the *postpartum period of pregnancy,* is the final period of pregnancy and lasts approximately 3 to 6 weeks. Involution marks the end of the puerperium. Lochia refers to the various vaginal discharges during the puerperium.

DIF: Cognitive Level: Remember REF: IMS: 473

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

8. A woman gave birth to a 7-pound, 6-ounce infant girl 1 hour ago. The birth was vaginal and the estimated blood loss (EBL) was 1500 ml. When evaluating the womans vital signs, which finding would be of greatest concern to the nurse?

a. Temperature 37.9 C, heart rate 120 beats per minute (bpm), respirations 20 breaths per minute, and blood pressure 90/50 mm Hg
b. Temperature 37.4 C, heart rate 88 bpm, respirations 36 breaths per minute, and blood pressure 126/68 mm Hg
c. Temperature 38 C, heart rate 80 bpm, respirations 16 breaths per minute, and blood pressure 110/80 mm Hg
d. Temperature 36.8 C, heart rate 60 bpm, respirations 18 breaths per minute, and blood pressure 140/90 mm Hg

ANS: A

An EBL of 1500 ml with tachycardia and hypotension suggests hypovolemia caused by excessive blood loss. Temperature 37.4 C, heart rate 88 bpm, respirations 36 breaths per minute, and blood pressure 126/68 mm Hg are normal vital signs except for an increased respiratory rate, which may be secondary to pain from the birth. Temperature 38 C, heart rate 80 bpm, respirations 16 breaths per minute, and blood pressure 110/80 mm Hg are normal vital signs except for the temperature, which may increase to 38 C during the first 24 hours as a result of the dehydrating effects of labor. Temperature 36.8 C, heart rate 60 bpm, respirations 18 breaths per minute, and blood pressure 140/90 mm Hg are normal vital signs, although the blood pressure is slightly elevated, which may be attributable to the use of oxytocic medications.

DIF: Cognitive Level: Analyze REF: pp. 477, 478

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

9. A client is concerned that her breasts are engorged and uncomfortable. What is the nurses explanation for this physiologic change?

a. Overproduction of colostrum
b. Accumulation of milk in the lactiferous ducts and glands
c. Hyperplasia of mammary tissue
d. Congestion of veins and lymphatic vessels

ANS: D

Breast engorgement is caused by the temporary congestion of veins and lymphatic vessels. An overproduction of colostrum, an accumulation of milk in the lactiferous ducts and glands, and hyperplasia of mammary tissue do not cause breast engorgement.

DIF: Cognitive Level: Apply REF: IMS: 477

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. After delivery, excess hypertrophied tissue in the uterus undergoes a period of self-destruction. What is the *correct* term for this process?

a. Autolysis
b. Subinvolution
c. Afterpains
d. Diastasis

ANS: A

Autolysis is caused by a decrease in hormone levels. *Subinvolution* is failure of the uterus to return to a nonpregnant state. *Afterpains* are caused by uterine cramps 2 to 3 days after birth. *Diastasis* refers to the separation of muscles.

DIF: Cognitive Level: Remember REF: IMS: 473

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

11. Which statement regarding the postpartum uterus is *correct*?

a. At the end of the third stage of labor, the postpartum uterus weighs approximately 500 g.
b. After 2 weeks postpartum, it should be abdominally nonpalpable.
c. After 2 weeks postpartum, it weighs 100 g.
d. Postpartum uterus returns to its original (prepregnancy) size by 6 weeks postpartum.

ANS: B

The uterus does not return to its original size. At the end of the third stage of labor, the uterus weighs approximately 1000 g. After 2 weeks postpartum, the uterus weighs approximately 350 g. The normal self-destruction of excess hypertrophied tissue accounts for the slight increase in uterine size after each pregnancy.

DIF: Cognitive Level: Understand REF: IMS: 473

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. A client asks the nurse when her ovaries will begin working again. Which explanation by the nurse is *most* accurate?

a. Almost 75% of women who do not breastfeed resume menstruating within 1 month after birth.
b. Ovulation occurs slightly earlier for breastfeeding women.
c. Because of menstruation and ovulation schedules, contraception considerations can be postponed until after the puerperium.
d. The first menstrual flow after childbirth usually is heavier than normal.

ANS: D

The first flow is heavier, but within three or four cycles, the flow is back to normal. Ovulation can occur within the first month, but for 70% of nonlactating women, it returns in approximately 3 months. Women who are breastfeeding take longer to resume ovulation. Because many women

ovulate before their first postpartum menstrual period, contraceptive options need to be discussed early in the puerperium.

DIF: Cognitive Level: Apply REF: IMS: 476 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

13. The nurse should be cognizant of which postpartum physiologic alteration?

a. Cardiac output, pulse rate, and stroke volume all return to prepregnancy normal values within a few hours of childbirth.
b. Respiratory function returns to nonpregnant levels by 6 to 8 weeks after childbirth.
c. Lowered white blood cell count after pregnancy can lead to false-positive results on tests for infections.
d. Hypercoagulable state protects the new mother from thromboembolism, especially after a cesarean birth.

ANS: B

Respirations should decrease to within the womans normal prepregnancy range by 6 to 8 weeks after childbirth. Stroke volume increases and cardiac output remains high for a couple of days. However, the heart rate and blood pressure quickly return to normal. Leukocytosis increases 10 to 12 days after childbirth, which can obscure the diagnosis of acute infections, producing false-negative test results. The hypercoagulable state increases the risk of thromboembolism, especially after a cesarean birth.

DIF: Cognitive Level: Understand REF: IMS: 478 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

14. Which condition, not uncommon in pregnancy, is likely to require careful medical assessment during the puerperium?

a. Varicosities of the legs
b. Carpal tunnel syndrome

c. Periodic numbness and tingling of the fingers
d. Headaches

ANS: D

Headaches in the postpartum period can have a number of causes, some of which deserve medical attention. Total or nearly total regression of varicosities is expected after childbirth. Carpal tunnel syndrome is relieved in childbirth when the compression on the median nerve is lessened. Periodic numbness of the fingers usually disappears after childbirth unless carrying the baby aggravates the condition.

DIF: Cognitive Level: Understand REF: IMS: 479 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

15. Several delivery changes in the integumentary system that appear during pregnancy disappear after birth, although not always completely. What change is almost certain to be completely reversed?

a. Nail brittleness
b. Darker pigmentation of the areolae and linea nigra
c. Striae gravidarum on the breasts, abdomen, and thighs
d. Spider nevi

ANS: A

The nails return to their prepregnancy consistency and strength. Some women have permanent darker pigmentation of the areolae and linea nigra. Striae gravidarum (stretch marks) usually do not completely disappear. For some women, spider nevi persist indefinitely.

DIF: Cognitive Level: Understand REF: IMS: 480 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

16. Pelvic floor exercises, also known as Kegel exercises, will help to strengthen the perineal muscles and encourage healing after childbirth. The nurse requests the client to repeat back instructions for this exercise. Which response by the client indicates successful learning?

a. I contract my thighs, buttocks, and abdomen.
b. I perform 10 of these exercises every day.
c. I stand while practicing this new exercise routine.
d. I pretend that I am trying to stop the flow of urine in midstream.

ANS: D

The woman can pretend that she is attempting to stop the passing of gas or the flow of urine midstream, which will replicate the sensation of the muscles drawing upward and inward. Each contraction should be as intense as possible without contracting the abdomen, buttocks, or thighs. Guidelines suggest that these exercises should be performed 24 to 100 times per day. Positive results are shown with a minimum of 24 to 45 repetitions per day. The best position to learn Kegel exercises is to lie supine with the knees bent. A secondary position is on the hands and knees.

DIF: Cognitive Level: Analyze REF: IMS: 475 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance, Self-Care

17. Which statement by a newly delivered woman indicates that she knows what to expect regarding her menstrual activity after childbirth?

a. My first menstrual cycle will be lighter than normal and then will get heavier every month thereafter.
b. My first menstrual cycle will be heavier than normal and will return to my prepregnant volume within three or four cycles.
c. I will not have a menstrual cycle for 6 months after childbirth.
d. My first menstrual cycle will be heavier than normal and then will be light for several months after.

ANS: B

My first menstrual cycle will be heavier than normal and will return to my prepregnant volume within three or four cycles is an accurate statement and indicates her understanding of her expected menstrual activity. She can expect her first menstrual cycle to be heavier than normal, which occurs by 3 months after childbirth, and the volume of her subsequent cycles will return to prepregnant levels within three to four cycles.

DIF: Cognitive Level: Apply REF: IMS: 476 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

18. The nurse is providing instruction to the newly delivered client regarding postbirth uterine and vaginal discharge, called *lochia.* Which statement is the *most* appropriate?

a. Lochia is similar to a light menstrual period for the first 6 to 12 hours.
b. It is usually greater after cesarean births.
c. Lochia will usually decrease with ambulation and breastfeeding.
d. It should smell like normal menstrual flow unless an infection is present.

ANS: D

An offensive odor usually indicates an infection. Lochia flow should approximate a heavy menstrual period for the first 2 hours and then steadily decrease. Less lochia is usually seen after cesarean births and usually increases with ambulation and breastfeeding.

DIF: Cognitive Level: Understand REF: IMS: 475

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. Which description of postpartum restoration or healing times is *accurate*?

a. The cervix shortens, becomes firm, and returns to form within a month postpartum.
b. Vaginal rugae reappear by 3 weeks postpartum.
c. Most episiotomies heal within a week.
d. Hemorrhoids usually decrease in size within 2 weeks of childbirth.

ANS: B

Vaginal rugae reappear by 3 weeks postpartum; however, they are never as prominent as in nulliparous women. The cervix regains its form within days; the cervical os may take longer. Most episiotomies take 2 to 3 weeks to heal. Hemorrhoids can take 6 weeks to decrease in size.

DIF: Cognitive Level: Understand REF: IMS: 475 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. Which statement, related to the reconditioning of the urinary system after childbirth, should the nurse understand?

a. Kidney function returns to normal a few days after birth.
b. Diastasis recti abdominis is a common condition that alters the voiding reflex.
c. Fluid loss through perspiration and increased urinary output accounts for a weight loss of more than 2 kg during the puerperium.
d. With adequate emptying of the bladder, bladder tone is usually restored 2 to 3 weeks after childbirth.

ANS: C

Excess fluid loss through other means besides perspiration and increased urinary output occurs as well. Kidney function usually returns to normal in approximately 1 month. Diastasis recti abdominis is the separation of muscles in the abdominal wall and has no effect on the voiding reflex. Bladder tone is usually restored 5 to 7 days after childbirth.

DIF: Cognitive Level: Understand REF: IMS: 476 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

21. What should the nurses next action be if the clients white blood cell (WBC) count is 25,000/mm^3 on her second postpartum day?

a. Immediately inform the physician.
b. Have the laboratory draw blood for reanalysis.

c. Recognize that this count is an acceptable range at this point postpartum.
d. Immediately begin antibiotic therapy.

ANS: C

During the first 10 to 12 days after childbirth, WBC values between 20,000 and 25,000/mm^3 are common. Because a WBC count of 25,000/mm^3 on her second postpartum day is normal, alerting the physician is not warranted nor is reassessment or antibiotics needed; the WBC count is not elevated.

Chapter 21: Nursing Care of the Family During the Postpartum Period

MULTIPLE CHOICE

1. A woman gave birth vaginally to a 9-pound, 12-ounce girl yesterday. Her primary health care provider has written orders for perineal ice packs, use of a sitz bath three times daily, and a stool softener. Which information regarding the clients condition is *most* closely correlated with these orders?

a. Woman is a gravida 2, para 2.
b. Woman had a vacuum-assisted birth.
c. Woman received epidural anesthesia.
d. Woman has an episiotomy.

ANS: D

These orders are typical interventions for a woman who has had an episiotomy, lacerations, and hemorrhoids. A multiparous classification is not an indication for these orders. A vacuum-assisted birth may be used in conjunction with an episiotomy, which would indicate these interventions. The use of an epidural anesthesia has no correlation with these orders.

DIF: Cognitive Level: Understand REF: IMS: 489 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. The laboratory results for a postpartum woman are as follows: blood type, A; Rh status, positive; rubella titer, 1:8 (enzyme immunoassay [EIA] 0.8); hematocrit, 30%. How should the nurse *best* interpret these data?

a. Rubella vaccine should be administered.
b. Blood transfusion is necessary.
c. Rh immune globulin is necessary within 72 hours of childbirth.
d. Kleihauer-Betke test should be performed.

ANS: A

This clients rubella titer indicates that she is not immune and needs to receive a vaccine. These data do not indicate that the client needs a blood transfusion. Rh immune globulin is indicated only if the client has an Rh-negative status and the infant has an Rh-positive status. A Kleihauer-Betke test should be performed if a large fetomaternal transfusion is suspected, especially if the mother is Rh negative. However, the data provided do not indicate a need for performing this test.

DIF: Cognitive Level: Understand REF: IMS: 493 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A woman gave birth 48 hours ago to a healthy infant girl. She has decided to bottle feed. During the assessment, the nurse notices that both breasts are swollen, warm, and tender on palpation. Which guidance should the nurse provide to the client at this time?

a. Run warm water on her breasts during a shower.
b. Apply ice to the breasts for comfort.
c. Express small amounts of milk from the breasts to relieve the pressure.
d. Wearing a loose-fitting bra to prevent nipple irritation.

ANS: B

Applying ice packs and cabbage leaves to the breasts for comfort is an appropriate intervention for treating engorgement in a mother who is bottle feeding. The ice packs should be applied for 15 minutes on and 45 minutes off to avoid rebound engorgement. A bottle-feeding mother should avoid any breast stimulation, including pumping or expressing milk. A bottle-feeding mother should continuously wear a well-fitted support bra or breast binder for at least the first 72 hours after giving birth. A loose-fitting bra will not aid lactation suppression. Furthermore, the shifting of the bra against the breasts may stimulate the nipples and thereby stimulate lactation.

DIF: Cognitive Level: Apply REF: IMS: 493

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. A 25-year-old multiparous woman gave birth to an infant boy 1 day ago. Today her husband brings a large container of brown seaweed soup to the hospital. When the nurse enters the room, the husband asks for help with warming the soup so that his wife can eat it. What is the nurses *most* appropriate response?

a. Didnt you like your lunch?
b. Does your physician know that you are planning to eat that?
c. What is that anyway?
d. Ill warm the soup in the microwave for you.

ANS: D

Offering to warm the food shows cultural sensitivity to the dietary preferences of the woman and is the most appropriate response. Cultural dietary preferences must be respected. Women may request that family members bring favorite or culturally appropriate foods to the hospital. Asking the woman to identify her food does not show cultural sensitivity.

DIF: Cognitive Level: Apply REF: IMS: 496

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

5. A primiparous woman is to be discharged from the hospital the following day with her infant girl. Which behavior indicates a need for further intervention by the nurse before the woman can be discharged?

a. The woman is disinterested in learning about infant care.
b. The woman continues to hold and cuddle her infant after she has fed her.
c. The woman reads a magazine while her infant sleeps.
d. The woman changes her infants diaper and then shows the nurse the contents of the diaper.

ANS: A

The client should be excited, happy, and interested or involved in infant care. A woman who is sad, tearful, or disinterested in caring for her infant may be exhibiting signs of depression or postpartum blues and may require further intervention. Holding and cuddling her infant after feeding is an appropriate parent-infant interaction. Taking time for herself while the infant is sleeping is an appropriate maternal action. Showing the nurse the contents of the diaper is appropriate because the mother is seeking approval from the nurse and notifying the nurse of the infants elimination patterns.

DIF: Cognitive Level: Understand REF: IMS: 486 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

6. The trend in the United States is for women to remain hospitalized no longer than 1 or 2 days after giving birth. Which scenario is *not* a contributor to this model of care?

a. Wellness orientation model of care rather than a sick-care model
b. Desire to reduce health care costs
c. Consumer demand for fewer medical interventions and more family-focused experiences
d. Less need for nursing time as a result of more medical and technologic advances and devices available at home that can provide information

ANS: D

Nursing time and care are in demand as much as ever; the nurse simply has to do things more quickly. A wellness orientation model of care seems to focus on getting clients out the door sooner. In most cases, less hospitalization results in lower costs. People believe that the family gives more nurturing care than the institution.

DIF: Cognitive Level: Understand REF: IMS: 481

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

7. Under the Newborns and Mothers Health Protection Act, all health plans are required to allow new mothers and newborns to remain in the hospital for a minimum of _____ hours after a normal vaginal birth and for _____ hours after a cesarean birth. What is the *correct* interpretation of this legislation?

a. 24; 72
b. 24; 96
c. 48; 96
d. 48; 120

ANS: C

The specified stays are 48 hours (2 days) for a vaginal birth and 96 hours (4 days) for a cesarean birth. The attending provider and the mother together can decide on an earlier discharge. A client may be discharged either 24 hours after a vaginal birth or 72 hours after a cesarean birth if she is stable and her provider is in agreement. A client is unlikely to remain in the hospital for 120 hours after a cesarean birth unless complications have developed.

DIF: Cognitive Level: Remember REF: IMS: 483 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

8. A hospital has a number of different perineal pads available for use. A nurse is observed soaking several of them and writing down what she sees. What goal is the nurse attempting to achieve by performing this practice?

a. To improve the accuracy of blood loss estimation, which usually is a subjective assessment
b. To determine which pad is best
c. To demonstrate that other nurses usually underestimate blood loss
d. To reveal to the nurse supervisor that one of them needs some time off

ANS: A

Saturation of perineal pads is a critical indicator of excessive blood loss; anything done to help in the assessment is valuable. The nurse is noting the saturation volumes and soaking appearances. Instead of determining which pad is best, the nurse is more likely noting saturation volumes and soaking appearances to improve the accuracy of estimated blood loss. Nurses usually overestimate blood loss. Soaking perineal pads and writing down the results does not indicate the need for time off of work.

DIF: Cognitive Level: Apply REF: IMS: 487

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

9. Because a full bladder prevents the uterus from contracting normally, nurses intervene to help the woman spontaneously empty her bladder as soon as possible. If all else fails, what tactic might the nurse use?

a. Pouring water from a squeeze bottle over the womans perineum
b. Placing oil of peppermint in a bedpan under the woman
c. Asking the physician to prescribe analgesic agents
d. Inserting a sterile catheter

ANS: D

Invasive procedures are usually the last to be tried, especially with so many other simple and easy methods available (e.g., water, peppermint vapors, pain pills). Pouring water over the perineum may stimulate voiding. It is easy, noninvasive, and should be tried first. The oil of peppermint releases vapors that may relax the necessary muscles. It, too, is easy, noninvasive, and should be tried early on. If the woman is anticipating pain from voiding, then pain medications may be helpful. Other nonmedical means should be tried first, but medications still come before the insertion of a catheter.

DIF: Cognitive Level: Apply REF: IMS: 488

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

10. What information should the nurse understand fully regarding rubella and Rh status?

a. Breastfeeding mothers cannot be vaccinated with the live attenuated rubella virus.
b. Women should be warned that the rubella vaccination is teratogenic and that they must avoid pregnancy for at least 1 month after vaccination.
c. Rh immunoglobulin is safely administered intravenously because it cannot harm a nursing infant.
d. Rh immunoglobulin boosts the immune system and thereby enhances the effectiveness of vaccinations.

ANS: B

Women should understand that they must practice contraception for at least 1 month after being vaccinated. Because the live attenuated rubella virus is not communicable in breast milk, breastfeeding mothers can be vaccinated. Rh immunoglobulin is administered intramuscular (IM); it should never be administered to an infant. Rh immunoglobulin suppresses the immune system and therefore might thwart the rubella vaccination.

DIF: Cognitive Level: Understand REF: IMS: 493 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

11. A recently delivered mother and her baby are at the clinic for a 6-week postpartum checkup. Which response by the client alerts the nurse that psychosocial outcomes have *not* been met?

a. The woman excessively discusses her labor and birth experience.
b. The woman feels that her baby is more attractive and clever than any others.
c. The woman has not given the baby a name.
d. The woman has a partner or family members who react very positively about the baby.

ANS: C

If the mother is having difficulty naming her new infant, it may be a signal that she is not adapting well to parenthood. Other red flags include a refusal to hold or feed the baby, a lack of interaction with the infant, and becoming upset when the baby vomits or needs a diaper change. A new mother who is having difficulty is unwilling to discuss her labor and birth experience. An appropriate nursing diagnosis might be *Impaired parenting, related to a long, difficult labor or unmet expectations of birth*. A mother who is willing to discuss her birth experience is making a healthy personal adjustment. The mother who is not coping well finds her baby unattractive and messy. She may also be overly disappointed in the babys sex. The client might voice concern that the baby reminds her of a family member whom she does not like. Having a partner and/or other family members react positively is an indication that this new mother has a good support system in place. This support system helps reduce anxiety related to her new role as a mother.

DIF: Cognitive Level: Analyze REF: IMS: 495 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

12. Parents who have not already done so need to make time for newborn follow-up of the discharge. According to the American Academy of Pediatrics (AAP), when should a breastfeeding infant first need to be seen for a follow-up examination?

a. 2 weeks of age
b. 7 to 10 days after childbirth
c. 4 to 5 days after hospital discharge
d. 48 to 72 hours after hospital discharge

ANS: D

Breastfeeding infants are routinely seen by the pediatric health care provider clinic within 3 to 5 days after birth or 48 to 72 hours after hospital discharge and again at 2 weeks of age. Formula-feeding infants may be seen for the first time at 2 weeks of age.

DIF: Cognitive Level: Understand REF: IMS: 498 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. On examining a woman who gave birth 5 hours ago, the nurse finds that the woman has completely saturated a perineal pad within 15 minutes. What is the nurses *highest* priority at this time?

a. Beginning an intravenous (IV) infusion of Ringers lactate solution
b. Assessing the womans vital signs
c. Calling the womans primary health care provider
d. Massaging the womans fundus

ANS: D

The nurse should first assess the uterus for atony by massaging the womans fundus. Uterine tone must be established to prevent excessive blood loss. The nurse may begin an IV infusion to restore circulatory volume, but this would not be the first action. Blood pressure is not a reliable indicator of impending shock from impending hemorrhage; assessing vital signs should not be the nurses first action. The physician would be notified after the nurse completes the assessment of the woman.

DIF: Cognitive Level: Apply REF: IMS: 487

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

14. In many hospitals, new mothers are routinely presented with gift bags containing samples of infant formula. This practice is inconsistent with what?

a. Baby Friendly Hospital Initiative
b. Promotion of longer periods of breastfeeding

c. Perception of being supportive to both bottle feeding and breastfeeding mothers
d. Association with earlier cessation of breastfeeding

ANS: A

Infant formula should not be given to mothers who are breastfeeding. Such gifts are associated with early cessation of breastfeeding. Baby Friendly USA prohibits the distribution of any gift bags or formula to new mothers.

DIF: Cognitive Level: Understand REF: pp. 497-498

TOP: Nursing Process: Assessment

MSC: Client Needs: Safe and Effective Care Environment

15. When should discharge instruction, or the teaching plan that tells the woman what she needs to know to care for herself and her newborn, officially begin?

a. At the time of admission to the nurses unit
b. When the infant is presented to the mother at birth
c. During the first visit with the physician in the unit
d. When the take-home information packet is given to the couple

ANS: A

Discharge planning, the teaching of maternal and newborn care, begins on the womans admission to the unit, continues throughout her stay, and actually never ends as long as she has contact with medical personnel.

DIF: Cognitive Level: Apply REF: IMS: 482 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

16. Postpartum overdistention of the bladder and urinary retention can lead to which complications?

a. Postpartum hemorrhage and eclampsia
b. Fever and increased blood pressure
c. Postpartum hemorrhage and urinary tract infection
d. Urinary tract infection and uterine rupture

ANS: C

Incomplete emptying and overdistention of the bladder can lead to urinary tract infection. Overdistention of the bladder displaces the uterus and prevents contraction of the uterine muscle, thus leading to postpartum hemorrhage. No correlation exists between bladder distention and high blood pressure or eclampsia. The risk of uterine rupture decreases after the birth of the infant.

DIF: Cognitive Level: Understand REF: IMS: 486

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

17. Rh_o immune globulin will be ordered postpartum if which situation occurs?

a. Mother Rh, baby Rh+
b. Mother Rh, baby Rh
c. Mother Rh+, baby Rh+
d. Mother Rh+, baby Rh

ANS: A

An Rh mother delivering an Rh+ baby may develop antibodies to fetal cells that entered her bloodstream when the placenta separated. The Rh_o immune globulin works to destroy the fetal cells in the maternal circulation before sensitization occurs. If mother and baby are both Rh+ or Rh the blood types are alike, so no antibody formation would be anticipated. If the Rh+ blood of the mother comes in contact with the Rh blood of the infant, no antibodies would develop because the antigens are in the mothers blood, not in the infants.

DIF: Cognitive Level: Apply REF: IMS: 493

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

18. Which nursing action is *most* appropriate to correct a boggy uterus that is displaced above and to the right of the umbilicus?

a. Notify the physician of an impending hemorrhage.
b. Assess the blood pressure and pulse.
c. Evaluate the lochia.
d. Assist the client in emptying her bladder.

ANS: D

Urinary retention may cause overdistention of the urinary bladder, which lifts and displaces the uterus. Nursing actions need to be implemented before notifying the physician. Evaluating blood pressure, pulse, and lochia is important if the bleeding continues; however, the focus at this point is to assist the client in emptying her bladder.

DIF: Cognitive Level: Apply REF: IMS: 488

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

19. When caring for a newly delivered woman, what is the *best* measure to prevent abdominal distention after a cesarean birth?

a. Rectal suppositories
b. Early and frequent ambulation
c. Tightening and relaxing abdominal muscles
d. Carbonated beverages

ANS: B

Activity will aid the movement of accumulated gas in the gastrointestinal tract. Rectal suppositories can be helpful after distention occurs; however, they do not prevent it. Ambulation is the best prevention. Carbonated beverages may increase distention.

DIF: Cognitive Level: Knowledge REF: IMS: 491 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Many new mothers experience some type of nipple pain during the first weeks of initiating breastfeeding. Should this pain be severe or persistent, it may discourage or inhibit breastfeeding altogether. Which factors might contribute to this pain? *(Select all that apply.)*

a. Improper feeding position
b. Large-for-gestational age infant
c. Fair skin
d. Progesterone deficiency
e. Flat or retracted nipples

ANS: A, C, E

Nipple lesions may manifest as chapped, cracked, bleeding, sore, erythematous, edematous, or blistered nipples. Factors that contribute to nipple pain include improper positioning or a failure to break suction before removing the baby from the breast. Flat or retracted nipples along with the use of nipple shields, breast shells, or plastic breast pads also contribute to nipple pain. Women with fair skin are more likely to develop sore and cracked nipples. Preventing nipple soreness is preferable to treating soreness after it appears. Vigorous feeding may be a contributing factor, which may be the case with any size infant, not just infants who are large for gestational age. Estrogen or dietary deficiencies can contribute to nipple soreness.

DIF: Cognitive Level: Remember REF: IMS: 484

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. Which practices contribute to the prevention of postpartum infection? *(Select all that apply.)*

a. Not allowing the mother to walk barefoot at the hospital
b. Educating the client to wipe from back to front after voiding

c. Having staff members with conditions such as strep throat, conjunctivitis, and diarrhea stay home
d. Instructing the mother to change her perineal pad from front to back each time she voids or defecates
e. Not permitting visitors with cough or colds to enter the postpartum unit

ANS: A, C, D

Proper perineal care helps prevent infection and aids in the healing process. Educating the woman to wipe from front to back (urethra to anus) after voiding or defecating is a simple first step. Walking barefoot and getting back into bed can contaminate the linens. Clients should wear shoes or slippers. Staff members with infections need to stay home until they are no longer contagious. The client should also wash her hands before and after these functions. Visitors with any signs of illness should not be allowed entry to the postpartum unit.

DIF: Cognitive Level: Apply REF: IMS: 488

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

3. Which physiologic factors are reliable indicators of impending shock from postpartum hemorrhage? *(Select all that apply.)*

a. Respirations
b. Skin condition
c. Blood pressure
d. Level of consciousness
e. Urinary output

ANS: A, B, D, E

Blood pressure is not a reliable indicator; several more sensitive signs are available. Blood pressure does not drop until 30% to 40% of blood volume is lost. Respirations, pulse, skin

condition, urinary output, and level of consciousness are more sensitive means of identifying hypovolemic shock.

DIF: Cognitive Level: Knowledge REF: IMS: 487 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. If a woman is at risk for thrombus and is not ready to ambulate, which nursing intervention would the nurse use? *(Select all that apply.)*

a. Putting her in antiembolic stockings (thromboembolic deterrent [TED] hose) and/or sequential compression device (SCD) boots
b. Having her flex, extend, and rotate her feet, ankles, and legs
c. Having her sit in a chair
d. Immediately notifying the physician if a positive Homans sign occurs
e. Promoting bed rest

ANS: A, B, D

Sitting immobile in a chair does not help; bed exercise and prophylactic footwear might. TED hose and SCD boots are recommended. The client should be encouraged to ambulate with assistance, not remain in bed. Bed exercises are useful. A positive Homans sign (calf muscle pain or warmth, redness, tenderness) requires the physicians immediate attention.

DIF: Cognitive Level: Apply REF: IMS: 491

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

5. Postpartum fatigue (PPF) is more than just feeling tired. It is a complex phenomenon affected by physiologic, psychologic, and situational variables. Which factors contribute to this phenomenon? *(Select all that apply.)*

a. Precipitous labor
b. Hospital routines
c. Bottle feeding

d. Anemia
e. Excitement

ANS: B, D, E

Physical fatigue and exhaustion are often associated with a long labor or cesarean birth, hospital routines, breastfeeding, and infant care. PPF is also attributed to anemia, infection, or thyroid dysfunction. The excitement and exhilaration of delivering a new infant along with well-intentioned visitors may make rest difficult.

DIF: Cognitive Level: Understand REF: IMS: 490

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

6. Nurses play a critical role in educating parents regarding measures to prevent infant abduction. Which instructions contribute to infant safety and security? *(Select all that apply.)*

a. The mother should check the photo identification (ID) of any person who comes to her room.
b. The baby should be carried in the parents arms from the room to the nursery.
c. Because of infant security systems, the baby can be left unattended in the clients room.
d. Parents should use caution when posting photographs of their infant on the Internet.
e. The mom should request that a second staff member verify the identity of any questionable person.

ANS: A, D, E

Nurses must discuss infant security precautions with the mother and her family because infant abduction continues to be a concern. The mother should be taught to check the identity of any person who comes to remove the baby from her room. Hospital personnel usually wear picture identification patches. On some units, staff members also wear matching scrubs or special badges that are unique to the perinatal unit. As a rule, the baby is never carried in arms between the mothers room and the nursery, but rather the infant is always wheeled in a bassinet. The

infant should never be left unattended, even if the facility has an infant security system. Parents should be instructed to use caution when posting photographs of their new baby on the Internet and on other public forums.

Chapter 22: Transition to Parenthood

MULTIPLE CHOICE

1. After giving birth to a healthy infant boy, a primiparous client, 16 years of age, is admitted to the postpartum unit. An appropriate nursing diagnosis for her at this time is Deficient knowledge of infant care. What should the nurse be certain to include in the plan of care as he or she prepares the client for discharge?

a. Teach the client how to feed and bathe her infant.
b. Give the client written information on bathing her infant.
c. Advise the client that all mothers instinctively know how to care for their infants.
d. Provide time for the client to bathe her infant after she views a demonstration of infant bathing.

ANS: D

Having the mother demonstrate infant care is a valuable method of assessing the clients understanding of her newly acquired knowledge, especially in this age group, because she may inadvertently neglect her child. Although verbalizing how to care for the infant is a form of client education or providing written information might be useful, neither is the most developmentally appropriate teaching method for a teenage mother. Advising the young woman that all mothers instinctively know how to care for their infants is inappropriate; it is belittling and false.

DIF: Cognitive Level: Apply REF: IMS: 520 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. A 30-year-old multiparous woman has a boy who is years old and has recently delivered an infant girl. She tells the nurse, I dont know how Ill ever manage both children when I get home. Which suggestion would assist this new mother in alleviating sibling rivalry?

a. Tell the older child that he is a big boy now and should love his new sister.
b. Let the older child stay with his grandparents for the first 6 weeks to allow him to adjust to the newborn.
c. Ask friends and relatives not to bring gifts to the older sibling because you do not want to spoil him.
d. Realize that the regression in habits and behaviors in the older child is a typical reaction and that he needs extra love and attention at this time.

ANS: D

The older child may regress in habits or behaviors (e.g., toileting, sleep habits) as a method of seeking attention. Parents need to distribute their attention in an equitable manner. Telling the older child that he should love his new sister is a negative approach to facilitating sibling acceptance of the new infant. Reactions of siblings may result from temporary separation from the mother. Removing the older child from the home when the new infant arrives may enhance negative behaviors from the older child caused by a separation from the mother. Providing small gifts from the infant to the older child is a strategy for facilitating sibling acceptance of the new infant.

DIF: Cognitive Level: Analyze REF: IMS: 517 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. The nurse observes that a first-time mother appears to ignore her newborn. Which strategy should the nurse use to facilitate mother-infant attachment?

a. Tell the mother she must pay attention to her infant.
b. Show the mother how the infant initiates interaction and attends to her.
c. Demonstrate for the mother different positions for holding her infant while feeding.
d. Arrange for the mother to watch a video on parent-infant interaction.

ANS: B

Pointing out the responsiveness of the infant is a positive strategy for facilitating parent-infant attachment. Telling the mother that she must pay attention to her infant may be perceived as derogatory and is not appropriate. Educating the young mother in infant care is important, but pointing out the responsiveness of her baby is a better tool for facilitating mother-infant attachment. Videos are an educational tool that can demonstrate parent-infant attachment, but encouraging the mother to recognize the infants responsiveness is more appropriate.

DIF: Cognitive Level: Apply REF: IMS: 502

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. A nurse hears a primiparous woman talking to her son and telling him that his chin is just like his dads. This statement is *most* descriptive of which process?

a. Mutuality
b. Synchrony
c. Claiming
d. Reciprocity

ANS: C

Claiming refers to the process by which the child is identified in terms of likeness to other family members. *Mutuality* occurs when the infants behaviors and characteristics call forth a corresponding set of maternal behaviors and characteristics. *Synchrony* refers to the fit between the infants cues and the parents responses. *Reciprocity* is a type of body movement or behavior that provides the observer with cues.

DIF: Cognitive Level: Understand REF: pp. 502, 504 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

5. New parents express concern that because of the mothers emergency cesarean birth under general anesthesia, they did not have the opportunity to hold and bond with their daughter immediately after her birth. Which information should the nurses response convey?

a. Attachment, or bonding, is a process that occurs over time and does not require early contact.
b. Time immediately after birth is a critical period for humans.
c. Early contact is essential for optimal parent-infant relationships.
d. These new parents should just be happy that the infant is healthy.

ANS: A

Attachment occurs over time and does not require early contact. Although a delay in contact does not necessarily mean that attachment is inhibited, additional psychologic energy may be necessary to achieve the same effect. The formerly accepted definition of bonding held that the period immediately after birth was critical for bonding to occur. Research since has indicated that parent-infant attachment occurs over time. A delay does not inhibit the process. Parent-infant attachment involves activities such as touching, holding, and gazing; it is not exclusively eye contact. Telling the parents that they should be happy that the infant is healthy is inappropriate; it may be received as derogatory and belittling.

DIF: Cognitive Level: Apply REF: IMS: 505

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

6. During a telephone follow-up conversation with a woman who is 4 days postpartum, the woman tells the nurse, I dont know whats wrong. I love my son, but I feel so let down. I seem to cry for no reason! Which condition might this new mother be experiencing?

a. Letting-go
b. Postpartum depression (PPD)
c. Postpartum blues
d. Attachment difficulty

ANS: C

During the postpartum blues, women are emotionally labile, often crying easily and for no apparent reason. This lability seems to peak around the fifth postpartum day. The letting-go phase is the period that occurs several weeks after childbirth. During this phase the woman wants to move forward as a family unit with all members, appropriately interacting to their new roles. PPD is an intense, pervasive sadness marked by severe, labile mood swings; it is more serious and persistent than the postpartum blues. Crying is not a maladaptive attachment response; it indicates postpartum blues.

DIF: Cognitive Level: Understand REF: IMS: 509

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

7. Which statement by the nurse can assist a new father in his transition to parenthood?

a. Pointing out that the infant turned at the sound of his voice
b. Encouraging him to go home to get some sleep
c. Telling him to tape the infants diaper a different way
d. Suggesting that he let the infant sleep in the bassinet

ANS: A

Infants respond to the sound of voices. Because attachment involves a reciprocal interchange, observing the interaction between parent and infant is very important. Separation of the parent and infant does not encourage parent-infant attachment. Educating the parent in infant care techniques is important, but the manner in which a diaper is taped is not relevant and does not enhance parent-infant interactions. Parent-infant attachment involves touching, holding, and cuddling. It is appropriate for a father to want to hold the infant as the baby sleeps.

DIF: Cognitive Level: Apply REF: IMS: 506

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

8. A nurse notes that an Eskimo woman does not cuddle or interact with her newborn other than to feed him, change his diapers or soiled clothes, and put him to bed. While evaluating this clients behavior with her infant, what realization does the nurse make?

a. What appears to be a lack of interest in the newborn is, in fact, the cultural way of demonstrating intense love by attempting to ward off evil spirits.
b. The woman is inexperienced in caring for a newborn.
c. The woman needs a referral to a social worker for further evaluation of her parenting behaviors once she goes home with the newborn.
d. Extra time needs to be planned for assisting the woman in bonding with her newborn.

ANS: A

The nurse may observe an Eskimo mother who gives minimal care to her infant and refuses to cuddle or interact with her infant. The apparent lack of interest in the newborn is this cultural groups attempt to ward off evil spirits and actually reflects an intense love and concern for the infant. Inexperience in caring for newborns is not an issue. Cultural beliefs are important determinates of parenting behaviors. The womans lack of interest is an Eskimo cultural behavior. Referring the woman to a social worker is not necessary in this situation. The lack of infant interaction is not a form of infant neglect; rather, it is a demonstration of love and concern for the infant. The nurse may observe the woman and may be concerned by the apparent lack of interest in the newborn when in fact her behavior is a cultural display of love and concern for the infant. Teaching the woman infant care is important, but acknowledging her cultural beliefs and practices is equally important.

DIF: Cognitive Level: Understand REF: IMS: 516 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

9. Many first-time parents do not plan on having their parents help immediately after the newborn arrives. Which statement by the nurse is the *most* appropriate when counseling new parents regarding the involvement of grandparents?

a. You should tell your parents to leave you alone.

b. Grandparents can help you with parenting skills.
c. Grandparent involvement can be very disruptive to the family.
d. They are getting old. You should let them be involved while they can.

ANS: B

Telling the parents that grandparents can help with parenting skills and therefore help preserve family traditions is the most appropriate response. Intergenerational help may be perceived as interference, but telling the parents that their parents should be told to leave them alone is not therapeutic to the adaptation of the family. Telling the parents that grandparent involvement can be disruptive to the family is an invalid statement and not an appropriate nursing response. Regardless of age, grandparents can help with parenting skills and preserve family traditions.

DIF: Cognitive Level: Analyze REF: IMS: 518 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

10. In follow-up appointments or visits with parents and their new baby, it is useful if the nurse can identify infant behaviors that can either facilitate or inhibit attachment. What is an inhibiting behavior?

a. The infant cries only when hungry or wet.
b. The infants activity is somewhat predictable.
c. The infant clings to the parents.
d. The infant seeks attention from any adult in the room.

ANS: D

Parents want to be the focus of the infants existence, just as the infant is the focus of their existence. Facilitating and inhibiting behaviors build or discourage bonding (attitudes); they do not reflect any value judgments on what might be healthy or unhealthy. The infant who shows no preference for his or her parents over other adults is exhibiting an inhibiting behavior. An infant who cries only when hungry or wet is exhibiting a facilitating behavior. An infant who has a predictable attention span is exhibiting a facilitating behavior. The infant who clings to his or her

parents, enjoys being cuddled and held, and is easily consoled is displaying facilitating behaviors.

DIF: Cognitive Level: Understand REF: IMS: 503

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

11. In addition to eye contact, other early sensual contacts between the infant and mother involve sound and smell. What other statement regarding the senses is *correct*?

a. High-pitched voices irritate newborns.
b. Infants can learn to distinguish their mothers voice from others soon after birth.
c. All babies in the hospital smell alike.
d. Mothers breast milk has no distinctive odor.

ANS: B

Infants know the sound of their mothers voice at an early age. Infants positively respond to high-pitched voices. Each infant has a unique odor. Infants quickly learn to distinguish the odor of their mothers breast milk.

DIF: Cognitive Level: Remember REF: IMS: 506 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. After birth, a crying infant may be soothed by being held in a position in which the newborn can hear the mothers heartbeat. This phenomenon is known as what?

a. Entrainment
b. Reciprocity
c. Synchrony
d. Biorhythmicity

ANS: D

The newborn is in rhythm with the mother. The infant develops a personal biorhythm with the parents help over time. *Entrainment* is the movement of a newborn in time to the structure of adult speech. *Reciprocity* is body movement or behavior that gives cues to the persons desires. These take several weeks to develop with a new baby. *Synchrony* is the fit between the infants behavioral cues and the parents responses.

DIF: Cognitive Level: Remember REF: IMS: 507

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

13. The postpartum nurse should be cognizant of what with regard to the adaptation of other family members (primarily siblings and grandparents) to the newborn?

a. Sibling rivalry cannot be dismissed as overblown psychobabble; negative feelings and behaviors can take a long time to blow over.
b. Participation in preparation classes helps both siblings and grandparents.
c. In the United States, paternal and maternal grandparents consider themselves of equal importance and status.
d. Since 1990, the number of grandparents providing permanent care to their grandchildren has been declining.

ANS: B

Preparing older siblings, as well as grandparents, helps with everyones adaptation. Sibling rivalry should be initially expected, but the negative behaviors associated with it have been overemphasized and stop in a comparatively short time. In the United States, in contrast to other cultures, paternal grandparents frequently consider themselves secondary to maternal grandparents. The number of grandparents providing permanent child care has been rising.

DIF: Cognitive Level: Understand REF: pp. 517, 519 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

14. While providing routine mother-baby care, which activities should the nurse encourage to facilitate the parent-infant attachment?

a. The baby is able to return to the nursery at night so that the new mother can sleep.

b. Routine times for care are established to reassure the parents.

c. The father should be encouraged to go home at night to prepare for discharge of the mother and baby.

d. An environment that fosters as much privacy as possible should be created.

ANS: D

Care providers need to knock before gaining entry. Nursing care activities should be grouped. Once the baby has demonstrated an adjustment to extrauterine life (either in the mothers room or the transitional nursery), all care should be provided in one location. This important principle of family-centered maternity care fosters attachment by offering parents the opportunity to learn about their infant 24 hours a day. One nurse should provide care to both mother and baby in this couplet care or rooming-in model. It is not necessary for the baby to return to the nursery at night. In fact, the mother will sleep better with the infant close by. Care should be individualized to meet the parents needs, not the routines of the staff. Teaching goals should be developed in collaboration with the parents. The father or significant other should be permitted to sleep in the room with the mother. The maternity unit should develop policies that allow for the presence of significant others as much as the new mother desires.

DIF: Cognitive Level: Apply REF: IMS: 504

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

15. A primiparous woman is in the taking-in stage of psychosocial recovery and adjustment after childbirth. Recognizing the needs of women during this stage, how should the nurse respond?

a. Foster an active role in the babys care.

b. Provide time for the mother to reflect on the events of her labor and delivery.

c. Recognize the womans limited attention span by giving her written materials to read when she gets home rather than doing a teaching session while she is in the hospital.

d. Promote maternal independence by encouraging her to meet her own hygiene and comfort needs.

ANS: B

During this stage, the new mother is excited and talkative. It is important that she be able to fulfill her desire to review her birth experience. During this stage, the new mother still relies upon others to meet her physical needs. Once these are met, she will be more able to take an active role, not only in her own care but also in the care of her newborn, which happens during the taking-hold stage. Short teaching sessions, using written materials to reinforce the content presented, is a more effective approach. The focus of the taking-in or dependency stage is to nurture the new mother by meeting her dependency needs for rest, comfort, hygiene, and nutrition.

DIF: Cognitive Level: Apply REF: IMS: 508

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Psychosocial Integrity

16. The nurse observes several interactions between a postpartum woman and her new son. What behavior, if exhibited by this woman, would the nurse identify as a possible maladaptive behavior regarding parent-infant attachment?

a. The postpartum woman talks and coos to her son.
b. She seldom makes eye contact with her son.
c. The mother cuddles her son close to her.
d. She tells visitors how well her son is feeding.

ANS: B

The mother should be encouraged to hold her infant in the en face position and make eye contact with the infant. Normal infant-parent interactions include talking and cooing to her son, cuddling her son close to her, and telling visitors how well her son is feeding.

DIF: Cognitive Level: Apply REF: IMS: 503

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

17. When the infants behaviors and characteristics call forth a corresponding set of maternal behaviors and characteristics, what is the correct term for this behavior?

a. Mutuality
b. Bonding
c. Claiming
d. Acquaintance

ANS: A

Mutuality extends the concept of attachment and includes a shared set of behaviors as part of the bonding process. *Bonding* is the process during which parents form an emotional attachment to their infant over time.*Claiming* is the process during which parents identify their new baby in terms of the infants likeness to other family members and their differences and uniqueness. Similar to mutuality, *acquaintance* is part of attachment. It describes how parents get to know their baby during the immediate postpartum period through eye contact, touching, and talking.

DIF: Cognitive Level: Remember REF: IMS: 502 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

18. In follow-up appointments or visits with parents and their new baby, it may be useful if the nurse can identify parental behaviors that can either facilitate or inhibit attachment. Which is a facilitating behavior?

a. Parents have difficulty naming the infant.
b. Parents hover around the infant, directing attention to and pointing at the infant.
c. Parents make no effort to interpret the actions or needs of the infant.
d. Parents do not move from fingertip touch to palmar contact and holding.

ANS: B

Hovering over the infant and obviously paying attention to the baby are facilitating behaviors. Inhibiting behaviors include difficulty naming the infant, making no effort to interpret the actions or needs of the infant, and not moving from fingertip touch to palmar contact and holding.

DIF: Cognitive Level: Understand REF: IMS: 503

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. The early postpartum period is a time of emotional and physical vulnerability. Many mothers can easily become psychologically overwhelmed by the reality of their new parental responsibilities. Fatigue compounds these issues. Although the baby blues are a common occurrence in the postpartum period, approximately 500,000 women in America experience a more severe syndrome known as PPD. Which statement regarding PPD is essential for the nurse to be aware of when attempting to formulate a nursing diagnosis?

a. PPD symptoms are consistently severe.
b. This syndrome affects only new mothers.
c. PPD can easily go undetected.
d. Only mental health professionals should teach new parents about this condition.

ANS: C

PPD can go undetected because parents do not voluntarily admit to this type of emotional distress out of embarrassment, fear, or guilt. PPD symptoms range from mild to severe, with women having both good and bad days. PPD may also affect new fathers. Therefore, both mothers and fathers should be screened. The nurse should include information on PPD and how to differentiate it from the baby blues for all clients before discharge. Nurses can also urge new parents to report symptoms and to seek follow-up care promptly if symptoms occur.

DIF: Cognitive Level: Analyze REF: IMS: 510 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

20. The postpartum woman continually repeats the story of her labor, delivery, and recovery experience. What is this new mother attempting to achieve with this behavior?

a. Providing others with her knowledge of events
b. Making the birth experience *real*
c. Taking hold of the events leading up to her labor and delivery
d. Accepting her response to labor and delivery

ANS: B

Reliving the birth experience makes the event real and helps the mother realize that the pregnancy is over and that the infant is born and is now a separate individual. The retelling of the story satisfies her needs, not the needs of others. This new mother is in the taking-in phase, trying to make the birth experience seem real and separate the infant from herself.

DIF: Cognitive Level: Understand REF: IMS: 508

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

21. A nurse is observing a family. The mother is holding the baby she delivered less than 24 hours ago. Her husband is watching his wife and asking questions about newborn care. The 4-year-old brother is punching his mother on the back. How should the nurse react to this situation?

a. Report the incident to the social services department.
b. Advise the parents that the toddler needs to be reprimanded.
c. Report to oncoming staff that the mother is probably not a good disciplinarian.
d. Realize that this is a normal family unit adjusting to a major family change.

ANS: D

The observed behaviors are normal variations of a family adjusting to change. Reporting this one incident is not needed. Offering advice at this point would make the parents feel inadequate.

DIF: Cognitive Level: Analyze REF: pp. 517-518

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

22. During which phase of maternal adjustment will the mother relinquish the baby of her fantasies and accept the real baby?

a. Letting go
b. Taking hold
c. Taking in
d. Taking on

ANS: A

Accepting the real infant and relinquishing the fantasy infant occurs during the letting-go phase of maternal adjustment. During the taking-hold phase, the mother assumes responsibility for her own care and shifts her attention to the infant. In the taking-in phase, the mother is primarily focused on her own needs. A taking-on phase of maternal adjustment does not exist.

DIF: Cognitive Level: Understand REF: IMS: 508

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

23. A 25-year-old gravida 1 para 1 who had an emergency cesarean birth 3 days ago is scheduled for discharge. As the nurse prepares her for discharge, she begins to cry. The nurses next action should be what?

a. Assess her for pain.
b. Point out how lucky she is to have a healthy baby.
c. Explain that she is experiencing postpartum blues.
d. Allow her time to express her feelings.

ANS: D

Although many women experience transient postpartum blues, they need assistance in expressing their feelings. Postpartum blues affects 50% to 80% of new mothers. An assumption that the client is in pain should not be made when, in fact, she may have no pain whatsoever. Making this

assumption would be *blocking* communication and inappropriate in this situation. The client needs the opportunity to express her feelings first; client teaching can occur later.

DIF: Cognitive Level: Apply REF: IMS: 509

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

24. A new father states, I know nothing about babies; however, he seems to be interested in learning. How would the nurse *best* respond to this father?

a. Continue to observe his interaction with the newborn.
b. Tell him when he does something wrong.
c. Show no concern; he will learn on his own.
d. Include him in teaching sessions.

ANS: D

The nurse must be sensitive to the fathers needs and include him whenever possible. As fathers take on their new role, the nurse should praise every attempt, even if his early care is awkward. Although noting the bonding process of the mother and the father is important, it does not satisfy the expressed needs of the father. The new father should be encouraged to care for his baby by pointing out the things that he does right. Criticizing him will discourage him.

DIF: Cognitive Level: Apply REF: IMS: 511 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which concerns regarding parenthood are often expressed by visually impaired mothers? *(Select all that apply.)*

a. Infant safety
b. Transportation
c. Ability to care for the infant

d. Visually missing out
e. Needing extra time for parenting activities to accommodate the visual limitations

ANS: A, B, D, E

Concerns expressed by visually impaired mothers include infant safety, extra time needed for parenting activities, transportation, handling other peoples reactions, providing proper discipline, and missing out visually. Blind people sense a reluctance on the part of others to acknowledge that they have a right to be parents. However, blind parents are fully capable of caring for their infants.

DIF: Cognitive Level: Understand REF: IMS: 517 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

2. In the United States, the en face position is preferred immediately after birth. Which actions by the nurse can facilitate this process? *(Select all that apply.)*

a. Washing both the infants face and the mothers face
b. Placing the infant on the mothers abdomen or breast with their heads on the same plane
c. Dimming the lights
d. Delaying the instillation of prophylactic antibiotic ointment in the infants eyes
e. Placing the infant in the grandmothers arms

ANS: B, C, D

As newborns become functionally able to sustain eye contact with their parents, they spend time in mutual gazing, often in the en face position, a position in which the faces of the parent and infant are approximately 20 cm apart and on the same plane. Washing the faces of the infant or mother is not necessary at this time and would interrupt the process. Nurses and physicians or midwives can facilitate eye contact immediately after birth by placing the infant on the mothers abdomen or breasts with the mother and the infants faces on the same plane. Dimming the lights encourages the infants eyes to stay open. To promote eye contact, the instillation of prophylactic antibiotic ointment into the infants eyes can be delayed until after the infant and parents have had

some time together during the first hour after birth. Having the grandmother hold the infant is important; however, it will not necessarily promote eye contact between the parent and infant.

DIF: Cognitive Level: Apply REF: IMS: 506

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

3. Which societal factors have a strong influence on parental response to their infant? *(Select all that apply.)*

a. An adolescent mothers egocentricity and unmet developmental needs interfere with her ability to parent effectively.
b. An adolescent mother is likely to use less verbal instruction, be less responsive, and interact less positively than other mothers.
c. Adolescent mothers have a higher documented incidence of child abuse.
d. Mothers older than 35 years of age often deal with more stress related to work and career issues, as well as decreasing libido.
e. Relationships between adolescent mothers and fathers are more stable than older adults.

ANS: A, B, D

Adolescent mothers are more inclined to have a number of parenting difficulties that can benefit from counseling, but a higher incidence of child abuse is not one of them. As adolescent mothers move through the transition to parenthood, they can feel *different* from their peers, excluded from *fun* activities, and prematurely forced to enter the adult role. The conflict between their own desires and the infants demands further contribute to the normal psychosocial stress of childbirth and parenting. Adolescent mothers provide warm and attentive physical care; however, they use less verbal interaction than older parents, and adolescents tend to be less responsive and to interact less positively with their infants than older mothers. Midlife mothers have many competencies; however, they are more likely to have to deal with career and sexual issues than are younger mothers. Relationships between adolescent parents tend to be less stable than among adults.

DIF: Cognitive Level: Understand REF: pp. 513, 514 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

4. The transition to parenting for same-sex couples can present unique challenges. How can the nurse foster adjustment to parenting for these clients? *(Select all that apply.)*

a. Use a supplemental feeding device to simulate breastfeeding.
b. Allow the partner to cut the cord.
c. Gay fathers should meet their new infant soon after the birth mother has recovered.
d. Understand that strong social sanctions remain.
e. Provide information regarding support groups.

ANS: A, B, D, E

In a lesbian couple, the nonchildbearing partner may have a desire to breastfeed. This can be achieved using a supplemental nursing device. The female partner should be offered the same right as a heterosexual partner including cutting the cord. A gay couple may adopt a baby or use a surrogate. If the latter method is chosen, then they should be present at the birth if at all possible. The nurse can refer these men to available support groups. Same-sex couples continue to face strong social sanction in their efforts to parent.

DIF: Cognitive Level: Apply REF: IMS: 515

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

5. A parent who has a hearing impairment is presented with a number of challenges in parenting. Which nursing approaches are appropriate for working with hearing-impaired new parents? *(Select all that apply.)*

a. Using devices that transform sound into light
b. Assuming that the client knows sign language
c. Speaking quickly and loudly
d. Ascertaining whether the client can read lips before teaching
e. Writing messages that aid in communication

ANS: A, D, E

Section 504 of the Rehabilitation Act of 1973 requires that hospitals use various communication techniques and resources with the deaf and hard of hearing client. These resources include devices such as door alarms, cry alarms, and amplifiers. Before initiating communication, the nurse needs to be aware of the parents preferences for communication. Not all hearing-impaired clients know sign language. Do they wear a hearing aid? Do they read lips? Do they wish to have a sign language interpreter? If the parent relies on lip reading, then the nurse should sit close enough to enable the parent to visualize lip movements. The nurse should speak clearly in a regular voice volume, in short, simple sentences. Written messages such as on a black or white erasable board can be useful. Written materials should be reviewed with the parents before discharge.

Chapter 23: Physiologic and Behavioral Adaptations of the Newborn

MULTIPLE CHOICE

1. A woman gave birth to a healthy 7-pound, 13-ounce infant girl. The nurse suggests that the client place the infant to her breast within 15 minutes after birth. The nurse is aware that the initiation of breastfeeding is most effective during the first 30 minutes after birth. What is the correct term for this phase of alertness?

a. Transition period
b. First period of reactivity
c. Organizational stage
d. Second period of reactivity

ANS: B

The first period of reactivity is the first phase of transition and lasts up to 30 minutes after birth. The infant is highly alert during this phase. The transition period is the phase between intrauterine and extrauterine existence. An organizational stage is not a valid stage. The second period of reactivity occurs approximately between 4 and 8 hours after birth, after a period of sleep.

DIF: Cognitive Level: Understand REF: IMS: 523 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. Part of the health assessment of a newborn is observing the infants breathing pattern. What is the predominate pattern of newborns breathing?

a. Abdominal with synchronous chest movements
b. Chest breathing with nasal flaring
c. Diaphragmatic with chest retraction
d. Deep with a regular rhythm

ANS: A

In a normal infant respiration, the chest and abdomen synchronously rise and infant breaths are shallow and irregular. Breathing with nasal flaring is a sign of respiratory distress. Diaphragmatic breathing with chest retraction is also a sign of respiratory distress.

DIF: Cognitive Level: Understand REF: IMS: 524

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. The nurse is assessing a full term, quiet, and alert newborn. What is the average expected apical pulse range (in beats per minute)?

a. 80 to 100
b. 100 to 120
c. 120 to 160
d. 150 to 180

ANS: C

The average infant heart rate while awake is 120 to 160 beats per minute. The newborns heart rate may be approximately 85 to 100 beats per minute while sleeping and typically a little higher

than 100 to 120 beats per minute when alert but quiet. A heart rate of 150 to 180 beats per minute is typical when the infant cries.

DIF: Cognitive Level: Understand REF: IMS: 523

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. A newborn is placed under a radiant heat warmer. The nurse understands that thermoregulation presents a problem for the newborn. What is the rationale for this difficulty?

a. The renal function of a newborn is not fully developed, and heat is lost in the urine.
b. The small body surface area of a newborn favors more rapid heat loss than does an adults body surface area.
c. Newborns have a relatively thin layer of subcutaneous fat that provides poor insulation.
d. Their normal flexed posture favors heat loss through perspiration.

ANS: C

The newborn has little thermal insulation. Furthermore, the blood vessels are closer to the surface of the skin. Changes in environmental temperature alter the temperature of the blood, thereby influencing temperature regulation centers in the hypothalamus. Heat loss does not occur through urination. Newborns have a higher body surface-to-weight ratio than adults. The flexed position of the newborn helps guard against heat loss, because it diminishes the amount of body surface exposed to the environment.

DIF: Cognitive Level: Understand REF: IMS: 528 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. An African-American woman noticed some bruises on her newborn daughters buttocks. The client asks the nurse what causes these. How would the nurse best explain this integumentary finding to the client?

a. Lanugo

b. Vascular nevus
c. Nevus flammeus
d. Mongolian spot

ANS: D

A Mongolian spot is a bluish-black area of pigmentation that may appear over any part of the exterior surface of the infants body and is more commonly noted on the back and buttocks and most frequently observed on infants whose ethnic origins are Mediterranean, Latin American, Asian, or African. Lanugo is the fine, downy hair observed on a term newborn. A vascular nevus, commonly called a *strawberry mark,* is a type of capillary hemangioma. A nevus flammeus, commonly called a *port wine stain,* is most frequently found on the face.

DIF: Cognitive Level: Apply REF: IMS: 535 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

6. While examining a newborn, the nurse notes uneven skinfolds on the buttocks and a clunk when performing the Ortolani maneuver. These findings are likely indicative of what?

a. Polydactyly
b. Clubfoot
c. Hip dysplasia
d. Webbing

ANS: C

The Ortolani maneuver is used to detect the presence of hip dysplasia. Polydactyly is the presence of extra digits. Clubfoot (talipes equinovarus) is a deformity in which the foot turns inward and is fixed in a plantar-flexion position. Webbing, or syndactyly, is a fusing of the fingers or toes.

DIF: Cognitive Level: Apply REF: IMS: 539 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

7. A new mother states that her infant must be cold because the babys hands and feet are blue. This common and temporary condition is called what?

a. Acrocyanosis
b. Erythema toxicum neonatorum
c. Harlequin sign
d. Vernix caseosa

ANS: A

Acrocyanosis, or the appearance of slightly cyanotic hands and feet, is caused by vasomotor instability, capillary stasis, and a high hemoglobin level. Acrocyanosis is normal and intermittently appears over the first 7 to 10 days after childbirth. Erythema toxicum neonatorum (also called *erythema neonatorum*) is a transient newborn rash that resembles flea bites. The harlequin sign is a benign, transient color change in newborns. One half of the body is pale, and the other one half is ruddy or bluish-red with a line of demarcation. Vernix caseosa is a cheeselike, whitish substance that serves as a protective covering for the newborn.

DIF: Cognitive Level: Remember REF: IMS: 534 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

8. What is the most critical physiologic change required of the newborn after birth?

a. Closure of fetal shunts in the circulatory system
b. Full function of the immune defense system
c. Maintenance of a stable temperature
d. Initiation and maintenance of respirations

ANS: D

The most critical adjustment of a newborn at birth is the establishment of respirations. The cardiovascular system changes significantly after birth as a result of fetal respirations, which reduce pulmonary vascular resistance to the pulmonary blood flow and initiate a chain of cardiac

changes that support the cardiovascular system. After the establishment of respirations, heat regulation is critical to newborn survival. The infant relies on passive immunity received from the mother for the first 3 months of life.

DIF: Cognitive Level: Understand REF: IMS: 523

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

9. A primiparous woman is watching her newborn sleep. She wants him to wake up and respond to her. The mother asks the nurse how much he will sleep every day. What is an appropriate response by the nurse?

a. He will only wake up to be fed, and you should not bother him between feedings.
b. The newborn sleeps approximately 17 hours a day, with periods of wakefulness gradually increasing.
c. He will probably follow your same sleep and wake patterns, and you can expect him to be awake soon.
d. He is being stubborn by not waking up when you want him to. You should try to keep him awake during the daytime so that he will sleep through the night.

ANS: B

Telling the woman that the newborn sleeps approximately 17 hours a day with periods of wakefulness that gradually increase is both accurate and the most appropriate response by the nurse. Periods of wakefulness are dictated by hunger, but the need for socializing also appears. Telling the woman that her infant is stubborn and should be kept awake during the daytime is an inappropriate nursing response.

DIF: Cognitive Level: Apply REF: IMS: 544 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

10. The parents of a newborn ask the nurse how much the newborn can see. The parents specifically want to know what type of visual stimuli they should provide for their newborn. What information provided by the nurse would be most useful to these new parents?

a. Infants can see very little until approximately 3 months of age.
b. Infants can track their parents eyes and can distinguish patterns; they prefer complex patterns.
c. The infants eyes must be protected. Infants enjoy looking at brightly colored stripes.
d. Its important to shield the newborns eyes. Overhead lights help them see better.

ANS: B

Telling the parents that infants can track their parents eyes and can distinguish patterns is an accurate statement. Development of the visual system continues for the first 6 months of life. Visual acuity is difficult to determine, but the clearest visual distance for the newborn appears to be 19 cm. Infants prefer to look at complex patterns, regardless of the color. They prefer low illumination and withdraw from bright lights.

DIF: Cognitive Level: Apply REF: IMS: 545 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

11. While assessing the integument of a 24-hour-old newborn, the nurse notes a pink papular rash with vesicles superimposed on the thorax, back, and abdomen. What action is the highest priority for the nurse to take at this time?

a. Immediately notify the physician.
b. Move the newborn to an isolation nursery.
c. Document the finding as erythema toxicum neonatorum.
d. Take the newborns temperature, and obtain a culture of one of the vesicles.

ANS: C

Erythema toxicum neonatorum (or erythema neonatorum) is a newborn rash that resembles flea bites. Notification of the physician, isolation of the newborn, or additional interventions are not necessary when erythema toxicum neonatorum is present.

DIF: Cognitive Level: Apply REF: IMS: 536

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

12. A client is warm and asks for a fan in her room for her comfort. The nurse enters the room to assess the mother and her infant and finds the infant unwrapped in his crib with the fan blowing over him on high. The nurse instructs the mother that the fan should not be directed toward the newborn and that the newborn should be wrapped in a blanket. The mother asks why. How would the nurse respond?

a. Your baby may lose heat by convection, which means that he will lose heat from his body to the cooler ambient air. You should keep him wrapped, and should prevent cool air from blowing on him.
b. Your baby may lose heat by conduction, which means that he will lose heat from his body to the cooler ambient air. You should keep him wrapped, and should prevent cool air from blowing on him.
c. Your baby may lose heat by evaporation, which means that he will lose heat from his body to the cooler ambient air. You should keep him wrapped, and should prevent cool air from blowing on him.
d. Your baby will easily get cold stressed and needs to be bundled up at all times.

ANS: A

Convection is the flow of heat from the body surface to cooler ambient air. Because of heat loss by convection, all newborns in open bassinets should be wrapped to protect them from the cold. Conduction is the loss of heat from the body surface to cooler surfaces, not air, in direct contact with the newborn. Evaporation is a loss of heat that occurs when a liquid is converted into a vapor. In the newborn, heat loss by evaporation occurs as a result of vaporization of moisture from the skin. Cold stress may occur from excessive heat loss; however, this does not imply that the infant will become stressed if not bundled at all times. Furthermore, excessive bundling may result in a rise in the infants temperature.

DIF: Cognitive Level: Apply REF: IMS: 528

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

13. A first-time father is changing the diaper of his 1-day-old daughter. He asks the nurse, What is this black, sticky stuff in her diaper? What is the nurses *best* response?

a. Thats meconium, which is your babys first stool. Its normal.
b. Thats transitional stool.
c. That means your baby is bleeding internally.
d. Oh, dont worry about that. Its okay.

ANS: A

Explaining what meconium is and that it is normal is an accurate statement and the most appropriate response. Transitional stool is greenish-brown to yellowish-brown and usually appears by the third day after the initiation of feeding. Telling the father that the baby is internally bleeding is not an accurate statement. Telling the father not to worry is not appropriate. Such responses are belittling to the father and do not teach him about the normal stool patterns of his daughter.

DIF: Cognitive Level: Apply REF: IMS: 531

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

14. Which statement *best* describes the transition period between intrauterine and extrauterine existence for the newborn?

a. Consists of four phases, two reactive and two of decreased responses
b. Lasts from birth to day 28 of life
c. Applies to full-term births only
d. Varies by socioeconomic status and the mothers age

ANS: B

Changes begin immediately after birth; the cutoff time when the transition is considered over (although the baby keeps changing) is 28 days. This transition period has three phases: first reactivity, decreased response, and second reactivity. All newborns experience this transition period, regardless of age or type of birth. Although stress can cause variations in the phases, the mothers age and wealth do not disturb the pattern.

DIF: Cognitive Level: Understand REF: IMS: 523 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

15. Which information related to the newborns developing cardiovascular system should the nurse fully comprehend?

a. The heart rate of a crying infant may rise to 120 beats per minute.
b. Heart murmurs heard after the first few hours are a cause for concern.
c. The point of maximal impulse (PMI) is often visible on the chest wall.
d. Persistent bradycardia may indicate respiratory distress syndrome (RDS).

ANS: C

The newborns thin chest wall often allows the PMI to be observed. The normal heart rate for infants who are not sleeping is 120 to 160 beats per minute. However, a crying infant could temporarily have a heart rate of 180 beats per minute. Heart murmurs during the first few days of life have no pathologic significance; however, an irregular heart rate beyond the first few hours should be further evaluated. Persistent tachycardia may indicate RDS; bradycardia may be a sign of congenital heart blockage.

DIF: Cognitive Level: Understand REF: IMS: 526

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. Which information about variations in the infants blood counts is important for the nurse to explain to the new parents?

a. A somewhat lower-than-expected red blood cell count could be the result of a delay in clamping the umbilical cord.
b. An early high white blood cell (WBC) count is normal at birth and should rapidly decrease.
c. Platelet counts are higher in the newborn than in adults for the first few months.
d. Even a modest vitamin K deficiency means a problem with the bloods ability to properly clot.

ANS: B

The WBC count is normally high on the first day of birth and then rapidly declines. Delayed cord clamping results in an increase in hemoglobin and the red blood cell count. The platelet count is essentially the same for newborns and adults. Clotting is sufficient to prevent hemorrhage unless the deficiency of vitamin K is significant.

DIF: Cognitive Level: Understand REF: IMS: 527 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. Which infant response to cool environmental conditions is either *not* effective or *not* available to them?

a. Constriction of peripheral blood vessels
b. Metabolism of brown fat
c. Increased respiratory rates
d. Unflexing from the normal position

ANS: D

The newborns flexed position guards against heat loss, because it reduces the amount of body surface exposed to the environment. The newborns body is able to constrict the peripheral blood vessels to reduce heat loss. Burning brown fat generates heat. The respiratory rate may rise to stimulate muscular activity, which generates heat.

DIF: Cognitive Level: Understand REF: IMS: 528 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. The nurse caring for a newborn checks the record to note clinical findings that occurred before her shift. Which finding related to the renal system would be of increased significance and require further action?

a. The pediatrician should be notified if the newborn has not voided in 24 hours.

b. Breastfed infants will likely void more often during the first days after birth.
c. *Brick dust* or blood on a diaper is always cause to notify the physician.
d. Weight loss from fluid loss and other normal factors should be made up in 4 to 7 days.

ANS: A

A newborn who has not voided in 24 hours may have any of a number of problems, some of which deserve the attention of the pediatrician. Formula-fed infants tend to void more frequently in the first 3 days; breastfed infants will void less during this time because the mothers breast milk has not yet come in. Brick dust may be uric acid crystals; blood spotting could be attributable to the withdrawal of maternal hormones (pseudomenstruation) or a circumcision. The physician must be notified only if the cause of bleeding is not apparent. Weight loss from fluid loss might take 14 days to regain.

DIF: Cognitive Level: Apply REF: IMS: 529

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

19. What is the correct term for the cheeselike, white substance that fuses with the epidermis and serves as a protective coating?

a. Vernix caseosa
b. Surfactant
c. Caput succedaneum
d. Acrocyanosis

ANS: A

The protection provided by *vernix caseosa* is needed because the infants skin is so thin. *Surfactant* is a protein that lines the alveoli of the infants lungs. *Caput succedaneum* is the swelling of the tissue over the presenting part of the fetal head. *Acrocyanosis* is cyanosis of the hands and feet, resulting in a blue coloring.

DIF: Cognitive Level: Remember REF: IMS: 534

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. What marks on a babys skin may indicate an underlying problem that requires notification of a physician?

a. Mongolian spots on the back
b. Telangiectatic nevi on the nose or nape of the neck
c. Petechiae scattered over the infants body
d. Erythema toxicum neonatorum anywhere on the body

ANS: C

Petechiae (bruises) scattered over the infants body should be reported to the pediatrician because they may indicate underlying problems. Mongolian spots are bluish-black spots that resemble bruises but gradually fade over months and have no clinical significance. Telangiectatic nevi (stork bites, angel kisses) fade by the second year and have no clinical significance. Erythema toxicum neonatorum is an appalling-looking rash; however, it has no clinical significance and requires no treatment.

DIF: Cognitive Level: Understand REF: IMS: 536

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

21. The brain is vulnerable to nutritional deficiencies and trauma in early infancy. What is the rationale for this physiologic adaptation in the newborn?

a. Incompletely developed neuromuscular system
b. Primitive reflex system
c. Presence of various sleep-wake states
d. Cerebellum growth spurt

ANS: D

The vulnerability of the brain is likely due to the cerebellum growth spurt. By the end of the first year, the cerebellum ends its growth spurt that began at approximately 30 weeks of gestation. The neuromuscular system is almost completely developed at birth. The reflex system is not relevant to the cerebellum growth spurt. The various sleep-wake states are not relevant to the cerebellum growth spurt.

DIF: Cognitive Level: Understand REF: IMS: 540 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

22. How would the nurse optimally reassure the parents of an infant who develops a cephalhematoma?

a. A cephalhematoma may occur with a spontaneous vaginal birth.
b. A cephalhematoma only happens as a result of a forceps- or vacuum-assisted delivery.
c. It is present immediately after birth.
d. The blood will gradually absorb over the first few months of life.

ANS: A

The nurse should explain that bleeding between the skull and the periosteum of a newborn may occur during a spontaneous vaginal delivery as a result of the pressure against the maternal bony pelvis. Low forceps and other difficult extractions may result in bleeding. However, a cephalhematoma can also spontaneously occur. Swelling may appear unilaterally or bilaterally, is usually minimal or absent at birth, and increases over the first 2 to 3 days of life. Cephalhematomas gradually disappear over 2 to 3 weeks. A less common condition results in the calcification of the hematoma, which may persist for months.

DIF: Cognitive Level: Apply REF: IMS: 538 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

23. The nurse is circulating during a cesarean birth of a preterm infant. The obstetrician requests that cord clamping be delayed. What is the rationale for this directive?

a. To reduce the risk for jaundice
b. To reduce the risk of intraventricular hemorrhage
c. To decrease total blood volume
d. To improve the ability to fight infection

ANS: B

Delayed cord clamping provides the greatest benefits to the preterm infant. These benefits include a significant reduction in intraventricular hemorrhage, a reduced need for a blood transfusion, and improved blood cell volume. The risk of jaundice can increase, requiring phototherapy. Although no difference in the newborns infection fighting ability occurs, iron status is improved, which can provide benefits for 6 months.

DIF: Cognitive Level: Analyze REF: IMS: 527

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

24. While evaluating the reflexes of a newborn, the nurse notes that with a loud noise the newborn symmetrically abducts and extends his arms, his fingers fan out and form a C with the thumb and forefinger, and he has a slight tremor. The nurse would document this finding as a positive _____ reflex.

a. tonic neck
b. glabellar (Myerson)
c. Babinski
d. Moro

ANS: D

The characteristics displayed by the infant are associated with a positive Moro reflex. The tonic neck reflex occurs when the infant extends the leg on the side to which the infants head simultaneously turns. The glabellar (Myerson) reflex is elicited by tapping on the infants head while the eyes are open. A characteristic response is blinking for the first few taps. The Babinski reflex occurs when the sole of the foot is stroked upward along the lateral aspect of the sole and

then across the ball of the foot. A positive response occurs when all the toes hyperextend, with dorsiflexion of the big toe.

DIF: Cognitive Level: Comprehend REF: IMS: 542

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

25. The nurse should be cognizant of which important information regarding the gastrointestinal (GI) system of the newborn?

a. The newborns cheeks are full because of normal fluid retention.
b. The nipple of the bottle or breast must be placed well inside the babys mouth because teeth have been developing in utero, and one or more may even be through.
c. Regurgitation during the first day or two can be reduced by burping the infant and slightly elevating the babys head.
d. Bacteria are already present in the infants GI tract at birth because they traveled through the placenta.

ANS: C

Avoiding overfeeding can also reduce regurgitation. The newborns cheeks are full because of well-developed sucking pads. Teeth do develop in utero, but the nipple is placed deep because the baby cannot move food from the lips to the pharynx. Bacteria are not present at birth, but they soon enter through various orifices.

DIF: Cognitive Level: Understand REF: IMS: 530 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

26. Which component of the sensory system is the *least* mature at birth?

a. Vision
b. Hearing
c. Smell
d. Taste

ANS: A

The visual system continues to develop for the first 6 months after childbirth. As soon as the amniotic fluid drains from the ear (in minutes), the infants hearing is similar to that of an adult. Newborns have a highly developed sense of smell and can distinguish and react to various tastes.

DIF: Cognitive Level: Remember REF: IMS: 545 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

27. A nursing student is helping the nursery nurses with morning vital signs. A baby born 10 hours ago by cesarean section is found to have moist lung sounds. What is the *best* interpretation of these data?

a. The nurse should immediately notify the pediatrician for this emergency situation.
b. The neonate must have aspirated surfactant.
c. If this baby was born vaginally, then a pneumothorax could be indicated.
d. The lungs of a baby delivered by cesarean section may sound moist during the first 24 hours after childbirth.

ANS: D

Moist lung sounds will resolve within a few hours. A surfactant acts to keep the expanded alveoli partially open between respirations for this common condition of newborns. In a vaginal birth, absorption of the remaining lung fluid is accelerated by the process of labor and delivery. The remaining lung fluid will move into interstitial spaces and be absorbed by the circulatory and lymphatic systems. Moist lung sounds are particularly common in infants delivered by cesarean section. The surfactant is produced by the lungs; therefore, aspiration is not a concern.

DIF: Cognitive Level: Understand REF: IMS: 524

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

28. Which intervention can nurses use to prevent evaporative heat loss in the newborn?

a. Drying the baby after birth, and wrapping the baby in a dry blanket
b. Keeping the baby out of drafts and away from air conditioners
c. Placing the baby away from the outside walls and windows
d. Warming the stethoscope and the nurses hands before touching the baby

ANS: A

Because the infant is wet with amniotic fluid and blood, heat loss by evaporation quickly occurs. Heat loss by convection occurs when drafts come from open doors and air currents created by people moving around. If the heat loss is caused by placing the baby near cold surfaces or equipment, it is referred to as a radiation heat loss. Conduction heat loss occurs when the baby comes in contact with cold surfaces.

DIF: Cognitive Level: Apply REF: IMS: 528

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

29. A first-time dad is concerned that his 3-day-old daughters skin looks yellow. In the nurses explanation of physiologic jaundice, what fact should be included?

a. Physiologic jaundice occurs during the first 24 hours of life.
b. Physiologic jaundice is caused by blood incompatibilities between the mother and the infant blood types.
c. Physiologic jaundice becomes visible when serum bilirubin levels peak between the second and fourth days of life.
d. Physiologic jaundice is also known as *breast milk jaundice*.

ANS: C

Physiologic jaundice becomes visible when the serum bilirubin reaches a level of 5 mg/dl or higher when the baby is approximately 3 days old. This finding is within normal limits for the newborn. Pathologic jaundice, not physiologic jaundice, occurs during the first 24 hours of life and is caused by blood incompatibilities that result in excessive destruction of erythrocytes; this condition must be investigated. Breast milk jaundice occurs in one third of breastfed infants at 2 weeks and is caused by an insufficient intake of fluids.

DIF: Cognitive Level: Remember REF: IMS: 532

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

30. Which cardiovascular changes cause the foramen ovale to close at birth?

a. Increased pressure in the right atrium
b. Increased pressure in the left atrium
c. Decreased blood flow to the left ventricle
d. Changes in the hepatic blood flow

ANS: B

With the increase in the blood flow to the left atrium from the lungs, the pressure is increased, and the foramen ovale is functionally closed. The pressure in the right atrium decreases at birth and is higher during fetal life. Blood flow increases to the left ventricle after birth. The hepatic blood flow changes but is not the reason for the closure of the foramen ovale.

DIF: Cognitive Level: Understand REF: IMS: 525

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

31. Under which circumstance should the nurse immediately alert the pediatric provider?

a. Infant is dusky and turns cyanotic when crying.
b. Acrocyanosis is present 1 hour after childbirth.
c. The infants blood glucose level is 45 mg/dl.
d. The infant goes into a deep sleep 1 hour after childbirth.

ANS: A

An infant who is dusky and becomes cyanotic when crying is showing poor adaptation to extrauterine life. Acrocyanosis is an expected finding during the early neonatal life and is within the normal range for a newborn.Infants enter the period of deep sleep when they are approximately 1 hour old.

DIF: Cognitive Level: Apply REF: IMS: 525

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

32. The nurse is cognizant of which information related to the administration of vitamin K?

a. Vitamin K is important in the production of red blood cells.
b. Vitamin K is necessary in the production of platelets.
c. Vitamin K is not initially synthesized because of a sterile bowel at birth.
d. Vitamin K is responsible for the breakdown of bilirubin and the prevention of jaundice.

ANS: C

The bowel is initially sterile in the newborn, and vitamin K cannot be synthesized until food is introduced into the bowel. Vitamin K is necessary to activate blood-clotting factors. The platelet count in term newborns is near adult levels. Vitamin K is necessary to activate prothrombin and other blood-clotting factors.

DIF: Cognitive Level: Understand REF: IMS: 527

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

33. How would the nurse differentiate a meconium stool from a transitional stool in the healthy newborn?

a. Observed at age 3 days
b. Is residue of a milk curd
c. Passes in the first 12 hours of life
d. Is lighter in color and looser in consistency

ANS: C

Meconium stool is usually passed in the first 12 hours of life, and 99% of newborns have their first stool within 48 hours. If meconium is not passed by 48 hours, then obstruction is suspected.

Meconium stool is the first stool of the newborn and is made up of matter remaining in the intestines during intrauterine life. Meconium is dark and sticky.

DIF: Cognitive Level: Understand REF: IMS: 531

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

34. The process during which bilirubin is changed from a fat-soluble product to a water-soluble product is known as what?

a. Enterohepatic circuit
b. Conjugation of bilirubin
c. Unconjugated bilirubin
d. Albumin binding

ANS: B

Conjugation of bilirubin is the process of changing the bilirubin from a fat-soluble to a water-soluble product and is the route by which part of the bile produced by the liver enters the intestine, is reabsorbed by the liver, and is then recycled into the intestine. Unconjugated bilirubin is a fat-soluble product. Albumin binding is the process during which something attaches to a protein molecule.

DIF: Cognitive Level: Remember REF: IMS: 532

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

35. Which newborn reflex is elicited by stroking the lateral sole of the infants foot from the heel to the ball of the foot?

a. Babinski
b. Tonic neck
c. Stepping
d. Plantar grasp

ANS: A

The Babinski reflex causes the toes to flare outward and the big toe to dorsiflex. The tonic neck reflex (also called the *fencing reflex*) refers to the posture assumed by newborns when in a supine position. The stepping reflex occurs when infants are held upright with their heel touching a solid surface and the infant appears to be walking. Plantar grasp reflex is similar to the palmar grasp reflex; when the area below the toes is touched, the infants toes curl over the nurses finger.

DIF: Cognitive Level: Remember REF: IMS: 543

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

36. The condition during which infants are at an increased risk for subgaleal hemorrhage is called what?

a. Infection
b. Jaundice
c. Caput succedaneum
d. Erythema toxicum neonatorum

ANS: B

Subgaleal hemorrhage is bleeding into the subgaleal compartment and is the result of the transition from a forceps or vacuum application. Because of the breakdown of the red blood cells within a hematoma, infants are at greater risk for jaundice. Subgaleal hemorrhage does not increase the risk for infections. Caput succedaneum is an edematous area on the head caused by pressure against the cervix. Erythema toxicum neonatorum is a benign rash of unknown cause that consists of blotchy red areas.

DIF: Cognitive Level: Understand REF: IM: 538

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

37. What is the rationale for evaluating the plantar crease within a few hours of birth?

a. Newborn has to be footprinted.
b. As the skin dries, the creases will become more prominent.
c. Heel sticks may be required.
d. Creases will be less prominent after 24 hours.

ANS: B

As the infants skin begins to dry, the creases will appear more prominent, and the infants gestation could be misinterpreted. Footprinting nor heel sticks will not interfere with the creases. The creases will appear more prominent after 24 hours.

DIF: Cognitive Level: Understand REF: IM: 535

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. What are the various modes of heat loss in the newborn? *(Select all that apply.)*

a. Perspiration
b. Convection
c. Radiation
d. Conduction
e. Urination

ANS: B, C, D

Convection, radiation, evaporation, and conduction are the four modes of heat loss in the newborn.

DIF: Cognitive Level: Understand REF: IM: 528 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

2. Which statements describe the first stage of the neonatal transition period*? (Select all that apply.)*

a. The neonatal transition period lasts no longer than 30 minutes.
b. It is marked by spontaneous tremors, crying, and head movements.
c. Passage of the meconium occurs during the neonatal transition period.
d. This period may involve the infant suddenly and briefly sleeping.
e. Audible grunting and nasal flaring may be present during this time.

ANS: A, B, C, E

The first stage is an active phase during which the baby is alert; this stage is referred to as the *first period of reactivity*. Decreased activity and sleep mark the second stage, the period of decreased responsiveness. The first stage is the shortest, lasting less than 30 minutes. Such exploratory behaviors include spontaneous startle reactions. Audible grunting, nasal flaring, and chest retractions may be present; however, these behaviors usually resolve within 1 hour of life.

DIF: Cognitive Level: Understand REF: IM: 523

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Which statements regarding physiologic jaundice are *accurate*? *(Select all that apply.)*

a. Neonatal jaundice is common; however, kernicterus is rare.
b. Appearance of jaundice during the first 24 hours or beyond day 7 indicates a pathologic process.
c. Because jaundice may not appear before discharge, parents need instruction on how to assess for jaundice and when to call for medical help.
d. Jaundice is caused by reduced levels of serum bilirubin.
e. Breastfed babies have a lower incidence of jaundice.

ANS: A, B, C

Neonatal jaundice occurs in 60% of term newborns and in 80% of preterm infants. The complication called *kernicterus* is rare. Jaundice in the first 24 hours or that persists past day 7 is

cause for medical concern. Parents need to be taught how to evaluate their infant for signs of jaundice. Jaundice is caused by elevated levels of serum bilirubin. Breastfeeding is associated with an increased incidence of jaundice.

DIF: Cognitive Level: Understand REF: IM: 533 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

4. During life in utero, oxygenation of the fetus occurs through transplacental gas exchange. When birth occurs, four factors combine to stimulate the respiratory center in the medulla. The initiation of respiration then follows. What are these four essential factors?

a. Chemical
b. Mechanical
c. Thermal
d. Psychologic
e. Sensory

ANS: A, B, C, E

Chemical factors are essential to initiate breathing. During labor, decreased levels of oxygen and increased levels of carbon dioxide seem to have a cumulative effect that is involved in the initiation of breathing. Clamping of the cord may also contribute to the start of respirations and results in a drop in the level of prostaglandins, which are known to inhibit breathing. Mechanical factors are also necessary to initiate respirations. As the infant passes through the birth canal, the chest is compressed. After the birth, the chest is relaxed, which allows for negative intrathoracic pressure that encourages air to flow into the lungs. The profound change in temperature between intrauterine and extrauterine life stimulates receptors in the skin to communicate with the receptors in the medulla. The stimulation of these receptors also contributes to the initiation of breathing. Sensory factors include handling by the health care provider, drying by the nurse, lights, smells, and sounds. Psychologic factors do not contribute to the initiation of respirations.

Chapter 24: Nursing Care of the Newborn and Family

MULTIPLE CHOICE

1. An infant boy was delivered minutes ago. The nurse is conducting the initial assessment. Part of the assessment includes the Apgar score. When should the Apgar assessment be performed?

a. Only if the newborn is in obvious distress
b. Once by the obstetrician, just after the birth
c. At least twice, 1 minute and 5 minutes after birth
d. Every 15 minutes during the newborns first hour after birth

ANS: C

Apgar scoring is performed at 1 minute and at 5 minutes after birth. Scoring may continue at 5-minute intervals if the infant is in distress and requires resuscitation efforts. The Apgar score is performed on all newborns. Apgar score can be completed by the nurse or the birth attendant. The Apgar score permits a rapid assessment of the newborns transition to extrauterine life. An interval of every 15 minutes is too long to wait to complete this assessment.

DIF: Cognitive Level: Understand REF: IM: 550

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

2. A new father wants to know what medication was put into his infants eyes and why it is needed. How does the nurse explain the purpose of the erythromycin (Ilotycin) ophthalmic ointment?

a. Erythromycin (Ilotycin) ophthalmic ointment destroys an infectious exudate caused by*Staphylococcus* that could make the infant blind.
b. This ophthalmic ointment prevents gonorrheal and chlamydial infection of the infants eyes, potentially acquired from the birth canal.
c. Erythromycin (Ilotycin) prevents potentially harmful exudate from invading the tear ducts of the infants eyes, leading to dry eyes.
d. This ointment prevents the infants eyelids from sticking together and helps the infant see.

ANS: B

The nurse should explain that prophylactic erythromycin ophthalmic ointment is instilled in the eyes of all neonates to prevent gonorrheal and chlamydial infection that potentially could have been acquired from the birth canal. This prophylactic ophthalmic ointment is not instilled to prevent dry eyes and has no bearing on vision other than to protect against infection that may lead to vision problems.

DIF: Cognitive Level: Apply REF: IM: 568 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A nurse is assessing a newborn girl who is 2 hours old. Which finding warrants a call to the health care provider?

a. Blood glucose of 45 mg/dl using a Dextrostix screening method
b. Heart rate of 160 beats per minute after vigorously crying
c. Laceration of the cheek
d. Passage of a dark black-green substance from the rectum

ANS: C

Accidental lacerations can be inflicted by a scalpel during a cesarean birth. They are most often found on the scalp or buttocks and may require an adhesive strip for closure. Parents would be overly concerned about a laceration on the cheek. A blood glucose level of 45 mg/dl and a heart rate of 160 beats per minute after crying are both normal findings that do not warrant a call to the physician. The passage of meconium from the rectum is an expected finding in the newborn.

DIF: Cognitive Level: Understand REF: IM: 570

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

4. What is the rationale for the administration of vitamin K to the healthy full-term newborn?

a. Most mothers have a diet deficient in vitamin K, which results in the infant being deficient.
b. Vitamin K prevents the synthesis of prothrombin in the liver and must be administered by injection.

c. Bacteria that synthesize vitamin K are not present in the newborns intestinal tract.
d. The supply of vitamin K in the healthy full-term newborn is inadequate for at least 3 to 4 months and must be supplemented.

ANS: C

Vitamin K is provided because the newborn does not have the intestinal flora to produce this vitamin for the first week. The maternal diet has no bearing on the amount of vitamin K found in the newborn. Vitamin K promotes the formation of clotting factors in the liver and is used for the prevention and treatment of hemorrhagic disease in the newborn. Vitamin K is not produced in the intestinal tract of the newborn until after microorganisms are introduced. By day 8, normal newborns are able to produce their own vitamin K.

DIF: Cognitive Level: Understand REF: pp. 568-569

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

5. The nurse is using the New Ballard Scale to determine the gestational age of a newborn. Which assessment finding is consistent with a gestational age of 40 weeks?

a. Flexed posture
b. Abundant lanugo
c. Smooth, pink skin with visible veins
d. Faint red marks on the soles of the feet

ANS: A

Term infants typically have a flexed posture. Abundant lanugo; smooth, pink skin with visible veins; and faint red marks are usually observed on preterm infants.

DIF: Cognitive Level: Understand REF: pp. 553, 554 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

6. A newborn is jaundiced and is receiving phototherapy via ultraviolet bank lights. What is the *most* appropriate nursing intervention when caring for an infant with hyperbilirubinemia and receiving phototherapy?

a. Applying an oil-based lotion to the newborns skin to prevent dying and cracking
b. Limiting the newborns intake of milk to prevent nausea, vomiting, and diarrhea
c. Placing eye shields over the newborns closed eyes
d. Changing the newborns position every 4 hours

ANS: C

The infants eyes must be protected by an opaque mask to prevent overexposure to the light. Eye shields should completely cover the eyes but not occlude the nares. Lotions and ointments should not be applied to the infant because they absorb heat and can cause burns. The lights increase insensible water loss, placing the infant at risk for fluid loss and dehydration. Therefore, adequate hydration is important for the infant. The infant should be turned every 2 hours to expose all body surfaces to the light.

DIF: Cognitive Level: Apply REF: IM: 572 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

7. Early this morning, an infant boy was circumcised using the PlastiBell method. Based on the nurses evaluation, when will the infant be ready for discharge?

a. When the bleeding completely stops
b. When yellow exudate forms over the glans
c. When the PlastiBell plastic rim (bell) falls off
d. When the infant voids

ANS: D

The infant should be observed for urination after the circumcision. Bleeding is a common complication after circumcision, and the nurse will check the penis for 12 hours after a

circumcision to assess and provide appropriate interventions for the prevention and treatment of bleeding. Yellow exudate covers the glans penis in 24 hours after the circumcision and is part of normal healing; yellow exudate is not an infective process. The PlastiBell plastic rim (bell) remains in place for approximately a week and falls off when healing has taken place.

DIF: Cognitive Level: Apply REF: IM: 582 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is preparing to administer a hepatitis B virus (HBV) vaccine to a newborn. Which intervention by the nurse is *correct*?

a. Obtaining a syringe with a 25-gauge, 5/8-inch needle for medication administration
b. Confirming that the newborns mother has been infected with the HBV
c. Assessing the dorsogluteal muscle as the preferred site for injection
d. Confirming that the newborn is at least 24 hours old

ANS: A

The HBV vaccine should be administered in the vastus lateralis muscle at childbirth with a 25-gauge, 5/8-inch needle and is recommended for all infants. If the infant is born to an infected mother who is a chronic HBV carrier, then the hepatitis vaccine and HBV immunoglobulin should be administered within 12 hours of childbirth.

DIF: Cognitive Level: Apply REF: IM: 579

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

9. The nurse is performing a gestational age and physical assessment on the newborn. The infant appears to have an excessive amount of saliva. This clinical finding may be indicative of what?

a. Excessive saliva is a normal finding in the newborn.
b. Excessive saliva in a neonate indicates that the infant is hungry.

c. It may indicate that the infant has a tracheoesophageal fistula or esophageal atresia.

d. Excessive saliva may indicate that the infant has a diaphragmatic hernia.

ANS: C

The presence of excessive saliva in a neonate should alert the nurse to the possibility of a tracheoesophageal fistula or esophageal atresia. Excessive salivation may not be a normal finding and should be further assessed for the possibility that the infant has an esophageal abnormality. The hungry infant reacts by making sucking motions, rooting, or making hand-to-mouth movements. The infant with a diaphragmatic hernia exhibits severe respiratory distress.

DIF: Cognitive Level: Analyze REF: IM: 561

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

10. A mother is changing the diaper of her newborn son and notices that his scrotum appears large and swollen. The client is concerned. What is the *best* response from the nurse?

a. A large scrotum and swelling indicate a hydrocele, which is a common finding in male newborns.

b. I dont know, but Im sure it is nothing.

c. Your baby might have testicular cancer.

d. Your babys urine is backing up into his scrotum.

ANS: A

Explaining what a hydrocele is and its characteristics is the most appropriate response by the nurse. The swelling usually decreases without intervention. Telling the mother that the condition is nothing important is inappropriate and does not address the mothers concern. Furthermore, if the nurse is unaware of any abnormal-appearing condition, then she should seek assistance from additional resources. Telling the mother that her newborn might have testicular cancer is inaccurate, inappropriate, and could cause the new mother undue worry. Urine will not back up into the scrotum if the infant has a hydrocele. Any nurse caring for the normal newborn should understand basic anatomy.

DIF: Cognitive Level: Apply REF: IM: 563 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

11. What is the primary rationale for nurses wearing gloves when handling the newborn?

a. To protect the baby from infection
b. As part of the Apgar protocol
c. To protect the nurse from contamination by the newborn
d. Because the nurse has the primary responsibility for the baby during the first 2 hours

ANS: C

With the possibility of transmission of viruses such as HBV and the human immunodeficiency virus (HIV) through maternal blood and amniotic fluid, the newborn must be considered a potential contamination source until proven otherwise. As part of Standard Precautions, nurses should wear gloves when handling the newborn until blood and amniotic fluid are removed by bathing. Proper hand hygiene is all that is necessary to protect the infant from infection. Wearing gloves is not necessary to complete the Apgar score assessment. The nurse assigned to the mother-baby couplet has primary responsibility for the newborn, regardless of whether or not she wears gloves.

DIF: Cognitive Level: Understand REF: IM: 549

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

12. At 1 minute after birth a nurse assesses an infant and notes a heart rate of 80 beats per minute, some flexion of extremities, a weak cry, grimacing, and a pink body but blue extremities. Which Apgar score does the nurse calculate based upon these observations and signs?

a. 4
b. 5

c. 6

d. 7

ANS: B

Each of the five signs the nurse notes scores a 1 on the Apgar scale, for a total of 5. A score of 4 is too low for this infant. A score of 6 is too high for this infant. A score of 7 is too high for an infant with this presentation.

DIF: Cognitive Level: Apply REF: IM: 551

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

13. Which statement *accurately* describes an appropriate-for-gestational age (AGA) weight assessment?

a. AGA weight assessment falls between the 25th and 75th percentiles for the infants age.

b. AGA weight assessment depends on the infants length and the size of the newborns head.

c. AGA weight assessment falls between the 10th and 90th percentiles for the infants age.

d. AGA weight assessment is modified to consider intrauterine growth restriction (IUGR).

ANS: C

An AGA weight falls between the 10th and 90th percentiles for the infants age. The AGA range is larger than the 25th and 75th percentiles. The infants length and head size are measured, but these measurements do not affect the normal weight designation. IUGR applies to the fetus, not to the newborns weight.

DIF: Cognitive Level: Understand REF: IM: 553 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

14. The nurse is completing a physical examination of the newborn 24 hours after birth. Which component of the evaluation is *correct*?

a. The parents are excused to reduce their normal anxiety.
b. The nurse can gauge the neonates maturity level by assessing his or her general appearance.
c. Once often neglected, blood pressure is now routinely checked.
d. When the nurse listens to the neonates heart, the S_1 and S_2 sounds can be heard; the S_1sound is somewhat higher in pitch and sharper than the S_2 sound.

ANS: B

The nurse is looking at skin color, alertness, cry, head size, and other features. The parents presence actively involves them in child care and gives the nurse the chance to observe their interactions. Blood pressure is not usually taken unless cardiac problems are suspected. The S_2 sound is higher and sharper than the S_1 sound.

DIF: Cognitive Level: Apply REF: IM: 551

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

15. The nurse is teaching new parents about metabolic screening for the newborn. Which statement is *most* helpful to these clients?

a. All states test for phenylketonuria (PKU), hypothyroidism, cystic fibrosis, and sickle cell diseases.
b. Federal law prohibits newborn genetic testing without parental consent.
c. If genetic screening is performed before the infant is 24 hours old, then it should be repeated at age 1 to 2 weeks.
d. Hearing screening is now mandated by federal law.

ANS: C

If testing is performed before the infant is 24 hours old, then genetic screening should be repeated when the infant is 1 to 2 weeks old. All states test for PKU and hypothyroidism but not for other genetic defects. Federal law mandates newborn genetic screening; however, parents can

decline the testing. A waiver should be signed, and a notation made in the infants medical record. Federal law does not mandate screening for hearing problems; however, the majority of states have enacted legislation mandating newborn hearing screening. In the United States, the majority (95%) of infants are screened for hearing loss before discharge from the hospital.

DIF: Cognitive Level: Apply REF: IM: 575 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

16. Which explanation will assist the parents in their decision on whether they should circumcise their son?

a. The circumcision procedure has pros and cons during the prenatal period.
b. American Academy of Pediatrics (AAP) recommends that all male newborns be routinely circumcised.
c. Circumcision is rarely painful, and any discomfort can be managed without medication.
d. The infant will likely be alert and hungry shortly after the procedure.

ANS: A

Parents need to make an informed choice regarding newborn circumcision, based on the most current evidence and recommendations. Health care providers and nurses who care for childbearing families should provide factual, unbiased information regarding circumcision and give parents opportunities to discuss the risks and benefits of the procedure. The AAP and other professional organizations note the benefits but stop short of recommending routine circumcision. Circumcision is painful and must be managed with environmental, nonpharmacologic, and pharmacologic measures. After the procedure, the infant may be fussy for several hours, or he may be sleepy and difficult to awaken for feeding.

DIF: Cognitive Level: Understand REF: IM: 580 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

17. The most serious complication of an infant heelstick is necrotizing osteochondritis resulting from lancet penetration of the bone. What approach should the nurse take when performing the test to prevent this complication?

a. Lancet should penetrate at the outer aspect of the heel.
b. Lancet should penetrate the walking surface of the heel.
c. Lancet should penetrate the ball of the foot.
d. Lancet should penetrate the area just below the fifth toe.

ANS: A

The stick should be made at the outer aspect of the heel and should penetrate no deeper than 2.4 mm. Repeated trauma to the walking surface of the heel can cause fibrosis and scarring that can lead to problems with walking later in life. The ball of the foot and the area below the fifth toe are inappropriate sites for a heelstick.

DIF: Cognitive Level: Apply REF: IM: 576

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

18. If the newborn has excess secretions, the mouth and nasal passages can be easily cleared with a bulb syringe. How should the nurse instruct the parents on the use of this instrument?

a. Avoid suctioning the nares.
b. Insert the compressed bulb into the center of the mouth.
c. Suction the mouth first.
d. Remove the bulb syringe from the crib when finished.

ANS: C

The mouth should always be suctioned first to prevent the infant from inhaling pharyngeal secretions by gasping as the nares are suctioned. After compressing the bulb, the syringe should be inserted into one side of the mouth. If it is inserted into the center of the mouth, then the gag reflex is likely to be initiated. When the infants cry no longer sounds as though it is through

mucus or a bubble, suctioning can be stopped. The nasal passages should be suctioned one nostril at a time. The bulb syringe should remain in the crib so that it is easily accessible if needed again.

DIF: Cognitive Level: Apply REF: IM: 567

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

19. As part of the infant discharge instructions, the nurse is reviewing the use of the infant car safety seat. Which information is the highest priority for the nurse to share?

a. Infant carriers are okay to use until an infant car safety seat can be purchased.
b. For traveling on airplanes, buses, and trains, infant carriers are satisfactory.
c. Infant car safety seats are used for infants only from birth to 15 pounds.
d. Infant car seats should be rear facing and placed in the back seat of the car.

ANS: D

An infant placed in the front seat could be severely injured by an air bag that deploys during an automobile accident. Infants should travel only in federally approved, rear-facing safety seats secured in the rear seat and only in federally approved safety seats even when traveling on a commercial vehicle. Infants should use a rear-facing car seat from birth to 20 pounds and to age 1 year.

DIF: Cognitive Level: Apply REF: IM: 589 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

20. A nurse is responsible for teaching new parents regarding the hygienic care of their newborn. Which instruction should the nurse provide regarding bathing?

a. Avoid washing the head for at least 1 week to prevent heat loss.
b. Sponge bathe the newborn for the first month of life.
c. Cleanse the ears and nose with cotton-tipped swabs, such as Q-tips.
d. Create a draft-free environment of at least 24 C (75 F) when bathing the infant.

ANS: D

The temperature of the room should be 24 C (75 F), and the bathing area should be free of drafts. To prevent heat loss, the infants head should be bathed before unwrapping and undressing. Tub baths may be initiated from birth. Ensure that the infant is fully immersed. Q-tips should not be used; they may cause injury. A corner of a moistened washcloth should be twisted into shape so that it can be used to cleanse the ears and nose.

DIF: Cognitive Level: Apply REF: IM: 595 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

21. A 3.8-kg infant was vaginally delivered at 39 weeks of gestation after a 30-minute second stage. A nuchal cord occurred. After the birth, the infant is noted to have petechiae over the face and upper back. Based on the nurses knowledge, which information regarding petechiae should be shared with the parents?

a. Petechiae (pinpoint hemorrhagic areas) are benign if they disappear within 48 hours of childbirth.
b. These hemorrhagic areas may result from increased blood volume.
c. Petechiae should always be further investigated.
d. Petechiae usually occur with a forceps delivery.

ANS: A

Petechiae that are acquired during birth may extend over the upper portion of the trunk and face. These lesions are benign if they disappear within 2 days of birth and no new lesions appear. Petechiae may result from decreased platelet formation. In this infant, the presence of petechiae is more likely a soft-tissue injury resulting from the nuchal cord at birth. Unless the lesions do not dissipate in 2 days, no reason exists to alarm the family. Petechiae usually occur with a breech presentation vaginal birth.

DIF: Cognitive Level: Apply REF: IM: 570

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

22. A mother expresses fear about changing her infants diaper after he is circumcised. What does the client need to be taught to care for her newborn son?

a. Cleanse the penis with prepackaged diaper wipes every 3 to 4 hours.
b. Apply constant, firm pressure by squeezing the penis with the fingers for at least 5 minutes if bleeding occurs.
c. Gently cleanse the penis with water and apply petroleum jelly around the glans after each diaper change.
d. Wash off the yellow exudate that forms on the glans at least once every day to prevent infection.

ANS: C

Gently cleansing the penis with water and applying petroleum jelly around the glans after each diaper change are appropriate techniques when caring for an infant who has had a circumcision. With each diaper change, the penis should be washed with warm water to remove any urine or feces. If bleeding occurs, then the mother should apply gentle pressure to the site of the bleeding with a sterile gauze square. Yellow exudates are part of normal healing and cover the glans penis 24 hours after the circumcision; yellow exudates are not an infective process and should not be removed.

DIF: Cognitive Level: Apply REF: IM: 582 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

23. What is the nurses initial action while caring for an infant with a slightly decreased temperature?

a. Immediately notify the physician.
b. Place a cap on the infants head, and have the mother perform kangaroo care.
c. Tell the mother that the infant must be kept in the nursery and observed for the next 4 hours.
d. Change the formula; a decreased body temperature is a sign of formula intolerance.

ANS: B

Keeping the head well covered with a cap prevents further heat loss from the head, and placing the infant skin-to-skin against the mother should increase the infants temperature. Nursing actions are needed first to correct the problem. If the problem persists after the interventions, physician notification may then be necessary. A slightly decreased temperature can be treated in the mothers room, offering an excellent time for parent teaching on the prevention of cold stress. Mild temperature instability is an expected deviation from normal during the first days after childbirth as the infant adapts to external life.

DIF: Cognitive Level: Apply REF: IM: 568

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

24. How should the nurse interpret an Apgar score of 10 at 1 minute after birth?

a. The infant is having no difficulty adjusting to extrauterine life and needs no further testing.
b. The infant is in severe distress and needs resuscitation.
c. The nurse predicts a future free of neurologic problems.
d. The infant is having no difficulty adjusting to extrauterine life but should be assessed again at 5 minutes after birth.

ANS: D

An initial Apgar score of 10 is a good sign of healthy adaptation; however, the test must be repeated at the 5-minute mark.

DIF: Cognitive Level: Understand REF: IM: 550 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

25. The nurse should be cognizant of which important statement regarding care of the umbilical cord?

a. The stump can become easily infected.
b. If bleeding occurs from the vessels of the cord, then the nurse should immediately call for assistance.

c. The cord clamp is removed at cord separation.
d. The average cord separation time is 5 to 7 days.

ANS: A

The cord stump is an excellent medium for bacterial growth. The nurse should first check the clamp (or tie) and apply a second one. If bleeding occurs and does not stop, then the nurse should call for assistance. The cord clamp is removed after 24 hours when it is dry. The average cord separation time is 10 to 14 days.

DIF: Cognitive Level: Understand REF: IM: 593 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

26. As part of their teaching function at discharge, nurses should educate parents regarding safe sleep. Based on the most recent evidence, which information is *incorrect* and should be discussed with parents?

a. Prevent exposure to people with upper respiratory tract infections.
b. Keep the infant away from secondhand smoke.
c. Avoid loose bedding, water beds, and beanbag chairs.
d. Place the infant on his or her abdomen to sleep.

ANS: D

The infant should be laid down to sleep on his or her back for better breathing and to prevent sudden infant death syndrome (SIDS). Grandmothers may encourage the new parents to place the infant on the abdomen; however, evidence shows back to sleep reduces SIDS. Infants are vulnerable to respiratory infections; therefore, infected people must be kept away. Secondhand smoke can damage lungs. Infants can suffocate in loose bedding and in furniture that can trap them. Per AAP guidelines, infants should always be placed back to sleep and allowed tummy time to play to prevent plagiocephaly.

DIF: Cognitive Level: Apply REF: IM: 589 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

27. Which intervention by the nurse would reduce the risk of abduction of the newborn from the hospital?

a. Instructing the mother not to give her infant to anyone except the one nurse assigned to her that day
b. Applying an electronic and identification bracelet to the mother and the infant
c. Carrying the infant when transporting him or her in the halls
d. Restricting the amount of time infants are out of the nursery

ANS: B

A measure taken by many facilities is to band both the mother and the baby with matching identification bracelets and band the infant with an electronic device that will sound an alarm if the infant is removed from the maternity unit. It is impossible for one nurse to be on call for one mother and baby for the entire shift; therefore, parents need to be able to identify the nurses who are working on the unit. Infants should always be transported in their bassinette for both safety and security reasons. All maternity unit nursing staff should have unique identification bracelets in comparison with the rest of the hospital. Infants should remain with their parents and spend as little time in the nursery as possible.

DIF: Cognitive Level: Apply REF: IM: 578

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

28. Nursing follow-up care often includes home visits for the new mother and her infant. Which information related to home visits is *correct*?

a. Ideally, the visit is scheduled within 72 hours after discharge.
b. Home visits are available in all areas.
c. Visits are completed within a 30-minute time frame.
d. Blood draws are not a part of the home visit.

ANS: A

The home visit is ideally scheduled within 72 hours after discharge. This timing allows early assessment and intervention for problems with feedings, jaundice, newborn adaptation, and maternal-infant interaction. Because of geographic distances, home visits are not available in all locales. Visits are usually 60 to 90 minutes in length to allow enough time for assessment and teaching. When jaundice is found, the nurse can discuss the implications and check the transcutaneous bilirubin level or draw blood for testing.

DIF: Cognitive Level: Apply REF: IM: 594 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

29. Screening for critical congenital heart disease (CCHD) was added to the uniform screening panel in 2011. The nurse has explained this testing to the new mother. Which action by the nurse related to this test is *correct*?

a. Screening is performed when the infant is 12 hours of age.
b. Testing is performed with an electrocardiogram.
c. Oxygen (O_2) is measured in both hands and in the right foot.
d. A passing result is an O_2 saturation of 95%.

ANS: D

Screening is performed when the infant is between 24 and 48 hours of age. The test is performed using pulse oximetry technology. O_2 is measured in the right hand and one foot. A passing result is an O_2 saturation of 95% with a 3% absolute difference between upper and lower extremity readings.

DIF: Cognitive Level: Analyze REF: IM: 576

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Pain should be regularly assessed in all newborns. If the infant is displaying physiologic or behavioral cues that indicate pain, then measures should be taken to manage the pain. Which interventions are examples of nonpharmacologic pain management techniques? *(Select all that apply.)*

a. Swaddling
b. Nonnutritive sucking
c. Skin-to-skin contact with the mother
d. Sucrose
e. Acetaminophen

ANS: A, B, C, D

Swaddling, nonnutritive sucking, skin-to-skin contact with the mother, and sucrose are all appropriate nonpharmacologic techniques used to manage pain in neonates. Acetaminophen is a pharmacologic method of treating pain.

DIF: Cognitive Level: Understand REF: pp. 584-585

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. As recently as 2005, the AAP revised safe sleep practices to assist in the prevention of SIDS. The nurse should model these practices in the hospital and incorporate this information into the teaching plan for new parents. Which practices are ideal for role modeling? *(Select all that apply.)*

a. Fully supine position for all sleep
b. Side-sleeping position as an acceptable alternative
c. Tummy time for play
d. Infant sleep sacks or buntings
e. Soft mattress

ANS: A, C, D

The back to sleep position is now recommended as the only position for every sleep period. To prevent positional plagiocephaly (flattening of the head) the infant should spend time on his or her abdomen while awake and for play. Loose sheets and blankets may be dangerous because they could easily cover the babys head. The parents should be instructed to tuck any bedding securely around the mattress or use sleep sacks or bunting bags instead. The side-sleeping position is no longer an acceptable alternative position, according to the AAP. Infants should always sleep on a firm surface, ideally a firm crib mattress covered by a sheet only. Quilts and sheepskins, among other bedding, should not be placed under the infant.

DIF: Cognitive Level: Apply REF: IM: 590

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

3. The Period of Purple Crying is a program developed to educate new parents about infant crying and the dangers of shaking a baby. Each letter in the acronym PURPLE represents a key concept of this program. Which concepts are accurate? *(Select all that apply.)*

a. P: peak of crying and painful expression
b. U: unexpected
c. R: baby is resting at last
d. L: extremely loud
e. E: evening

ANS: A, B, E

P: peak of crying; U: unexpectedcomes and goes; R: resists soothing; P: painline face; L: longlasting up to 5 hours a day; and E: evening or late afternoon. Many hospitals now provide parents with an educational DVD and provide education before discharge.

DIF: Cognitive Level: Analyze REF: IM: 596

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

4. Hearing loss is one of the genetic disorders included in the universal screening program. Auditory screening of all newborns within the first month of life is recommended by the AAP. What is the rationale for having this testing performed? *(Select all that apply.)*

a. Prevents or reduces developmental delays
b. Reassures concerned new parents
c. Provides early identification and treatment
d. Helps the child communicate better
e. Is recommended by the Joint Committee on Infant Hearing

ANS: A, C, D, E

New parents are often anxious regarding auditory screening and its impending results; however, parental anxiety is not the reason for performing the screening test. Auditory screening is usually performed before hospital discharge. Importantly, the nurse ensures the parents that the infant is receiving appropriate testing and fully explains the test to the parents. For infants who are referred for further testing and follow-up, providing further explanation and emotional support to the parents is an important responsibility for the nurse. All other responses are appropriate reasons for auditory screening of the newborn. Infants who do not pass the screening test should have it repeated. If the infant still does not pass the test, then he or she should have a full audiologic and medical evaluation by 3 months of age. If necessary, the infant should be enrolled in an early intervention program by 6 months of age.

Chapter 25: Newborn Nutrition and Feeding

MULTIPLE CHOICE

1. A new mother recalls from prenatal class that she should try to feed her newborn daughter when she exhibits feeding readiness cues rather than waiting until the baby is frantically crying. Which feeding cue would indicate that the baby is ready to eat?

a. Waves her arms in the air
b. Makes sucking motions

c. Has the hiccups

d. Stretches out her legs straight

ANS: B

Sucking motions, rooting, mouthing, and hand-to-mouth motions are examples of feeding readiness cues. Waving her arms in the air, having the hiccups, and stretching out her extremities are not typical feeding readiness cues.

DIF: Cognitive Level: Understand REF: IM: 609 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. A pregnant woman wants to breastfeed her infant; however, her husband is not convinced that there are any scientific reasons to do so. The nurse can give the couple printed information comparing breastfeeding and bottle feeding. Which statement regarding bottle feeding using commercially prepared infant formulas might influence their choice?

a. Bottle feeding using a commercially prepared formula increases the risk that the infant will develop allergies.

b. Bottle feeding helps the infant sleep through the night.

c. Commercially prepared formula ensures that the infant is getting iron in a form that is easily absorbed.

d. Bottle feeding requires that multivitamin supplements be given to the infant.

ANS: A

Exposure to cows milk poses a risk of developing allergies, eczema, and asthma. Newborns should be fed during the night, regardless of the feeding method. Iron is better absorbed from breast milk than from formula. Commercial formulas are designed to meet the nutritional needs of the infant and to resemble breast milk. No supplements are necessary.

DIF: Cognitive Level: Apply REF: IM: 602 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity, Basic Care and Comfort

3. A postpartum woman telephones the provider regarding her 5-day-old infant. The client is not scheduled for another weight check until the infant is 14 days old. The new mother is worried about whether breastfeeding is going well. Which statement indicates that breastfeeding is effective for meeting the infants nutritional needs?

a. Sleeps for 6 hours at a time between feedings
b. Has at least one breast milk stool every 24 hours
c. Gains 1 to 2 ounces per week
d. Has at least six to eight wet diapers per day

ANS: D

After day 4, when the mothers milk comes in, the infant should have six to eight wet diapers every 24 hours. Typically, infants sleep 2 to 4 hours between feedings, depending on whether they are being fed on a 2- to 3-hour schedule or cluster-fed. The infants sleep pattern is not an indication whether the infant is breastfeeding well. The infant should have a minimum of three bowel movements in a 24-hour period. Breastfed infants typically gain 15 to 30 g/day.

DIF: Cognitive Level: Understand REF: pp. 613-614 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

4. A primiparous woman is delighted with her newborn son and wants to begin breastfeeding as soon as possible. How should the client be instructed to position the infant to facilitate correct latch-on?

a. The infant should be positioned with his or her arms folded together over the chest.
b. The infant should be curled up in a fetal position.
c. The woman should cup the infants head in her hand.
d. The infants head and body should be in alignment with the mother.

ANS: D

The infants head and body should be in correct alignment with the mother and the breast during latch-on and feeding. The infant should be facing the mother with his arms hugging the breast. The babys body should be held in correct alignment (i.e., ears, shoulder, and hips in a straight line) during feedings. The mother should support the babys neck and shoulders with her hand and not push on the occiput.

DIF: Cognitive Level: Apply REF: IM: 610

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

5. A breastfeeding woman develops engorged breasts at 3 days postpartum. What action will help this client achieve her goal of reducing the engorgement?

a. Skip feedings to enable her sore breasts to rest.
b. Avoid using a breast pump.
c. Breastfeed her infant every 2 hours.
d. Reduce her fluid intake for 24 hours.

ANS: C

The mother should be instructed to attempt feeding her infant every 2 hours while massaging the breasts as the infant is feeding. Skipping feedings may cause further swelling and discomfort. If the infant does not adequately feed and empty the breast, then the mother may pump to extract the milk and relieve some of the discomfort. Dehydration further irritates swollen breast tissue.

DIF: Cognitive Level: Understand REF: IM: 623

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

6. At a 2-month well-baby examination, it was discovered that an exclusively breastfed infant had only gained 10 ounces in the past 4 weeks. The mother and the nurse develop a feeding plan for the infant to increase his weight gain. Which change in dietary management will assist the client in meeting this goal?

a. Begin solid foods.

b. Have a bottle of formula after every feeding.
c. Have one extra breastfeeding session every 24 hours.
d. Start iron supplements.

ANS: C

Usually the solution to slow weight gain is to improve the feeding technique. Position and the latch-on technique are evaluated, and adjustments are made. Adding a feeding or two within a 24-hour period might help. Solid foods should not be introduced to an infant for at least 4 to 6 months. Bottle feeding may cause nipple confusion and may limit the supply of milk. Iron supplements have no bearing on weight gain.

DIF: Cognitive Level: Apply REF: IM: 615

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

7. Parents have been asked by the neonatologist to provide breast milk for their newborn son, who was born prematurely at 32 weeks of gestation. The nurse who instructs them regarding pumping, storing, and transporting the milk needs to assess their knowledge of lactation. Which statement is valid?

a. Premature infants more easily digest breast milk than formula.
b. A glass of wine just before pumping will help reduce stress and anxiety.
c. The mother should only pump as much milk as the infant can drink.
d. The mother should pump every 2 to 3 hours, including during the night.

ANS: A

Human milk is the ideal food for preterm infants, with benefits that are unique, in addition to those benefits received by full-term, healthy infants. Greater physiologic stability occurs with breastfeeding, compared with formula feeding. Consumption of alcohol during lactation is approached with caution. Excessive amounts can have serious effects on the infant and can adversely affect the mothers milk ejection reflex. To establish an optimal milk supply, the most

appropriate instruction for the mother should be to pump 8 to 10 times a day for 10 to 15 minutes on each breast.

DIF: Cognitive Level: Analyze REF: IM: 616 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

8. A new mother wants to be sure that she is meeting her daughters needs while feeding the baby commercially prepared infant formula. The nurse should evaluate the mothers knowledge about appropriate infant feeding techniques. Which statement by the client reassures the nurse that correct learning has taken place?

a. Since reaching 2 weeks of age, I add rice cereal to my daughters formula to ensure adequate nutrition.
b. I warm the bottle in my microwave oven.
c. I burp my daughter during and after the feeding as needed.
d. I refrigerate any leftover formula for the next feeding.

ANS: C

Most infants swallow air when fed from a bottle and should be given a chance to burp several times during and after the feeding. Solid food should not be introduced to the infant for at least 4 to 6 months after birth. A microwave should never be used to warm any food to be given to an infant. The heat is not distributed evenly, which may pose a risk of burning the infant. Any formula left in the bottle after the feeding should be discarded because the infants saliva has mixed with it.

DIF: Cognitive Level: Understand REF: IM: 626 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

9. A nurse is discussing the storage of breast milk with a mother whose infant is preterm and in the special care nursery. Which statement indicates that the mother requires additional teaching?

a. I can store my breast milk in the refrigerator for 3 months.

b. I can store my breast milk in the freezer for 3 months.
c. I can store my breast milk at room temperature for 4 hours.
d. I can store my breast milk in the refrigerator for 3 to 5 days.

ANS: A

Breast milk for the hospitalized infant can be stored in the refrigerator for only 8 days, not for 3 months. Breast milk can be stored in the freezer for 3 months, in a deep freezer for 6 months, or at room temperature for 4 hours. Human milk for the healthy or preterm hospitalized infant can be kept in the refrigerator for up to 8 days or in the freezer for up to 3 months, but only for 4 hours or less at room temperature.

DIF: Cognitive Level: Analyze REF: IM: 618 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

10. A new mother asks the nurse what the experts say about the best way to feed her infant. Which recommendation of the American Academy of Pediatrics (AAP) regarding infant nutrition should be shared with this client?

a. Infants should be given only human milk for the first 6 months of life.
b. Infants fed on formula should be started on solid food sooner than breastfed infants.
c. If infants are weaned from breast milk before 12 months, then they should receive cows milk, not formula.
d. After 6 months, mothers should shift from breast milk to cows milk.

ANS: A

Breastfeeding and human milk should also be the sole source of milk for the first 12 months, not for only the first 6 months. Infants should be started on solids when they are ready, usually at 6 months, whether they start on formula or breast milk. If infants are weaned from breast milk before 12 months, then they should receive iron-fortified formula, not cows milk.

DIF: Cognitive Level: Apply REF: IM: 601 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

11. Which statement is the *best* rationale for recommending formula over breastfeeding?

a. Mother has a medical condition or is taking drugs that could be passed along to the infant via breast milk.
b. Mother lacks confidence in her ability to breastfeed.
c. Other family members or care providers also need to feed the baby.
d. Mother sees bottle feeding as more convenient.

ANS: A

Breastfeeding is contraindicated when mothers have certain viruses, tuberculosis, are undergoing chemotherapy, or are using or abusing drugs. Some women lack confidence in their ability to produce breast milk of adequate quantity or quality. The key to encouraging these mothers to breastfeed is anticipatory guidance beginning as early as possible during the pregnancy. A major barrier for many women is the influence of family and friends. She may view formula feeding as a way to ensure that the father and other family members can participate. Each encounter with the family is an opportunity for the nurse to educate, dispel myths, and clarify information regarding the benefits of breastfeeding. Many women see bottle feeding as more convenient and less embarrassing than breastfeeding. They may also see breastfeeding as incompatible with an active social life. Although modesty issues related to feeding the infant in public may exist, these concerns are not legitimate reasons to formula-feed an infant. Often, the decision to formula feed rather than breastfeed is made without complete information regarding the benefits of breastfeeding.

DIF: Cognitive Level: Understand REF: IM: 603 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

12. Which statement regarding the nutrient needs of breastfed infants is *correct*?

a. Breastfed infants need extra water in hot climates.
b. During the first 3 months, breastfed infants consume more energy than formula-fed infants.

c. Breastfeeding infants should receive oral vitamin D drops daily during at least the first 2 months.
d. Vitamin K injections at birth are not necessary for breastfed infants.

ANS: C

Human milk contains only small amounts of vitamin D. All infants who are breastfed should receive 400 International Units of vitamin D each day. Neither breastfed nor formula-fed infants need to be fed water, not even in very hot climates. During the first 3 months, formula-fed infants consume more energy than breastfed infants and therefore tend to grow more rapidly. Vitamin K shots are required for all infants because the bacteria that produce it are absent from the babys stomach at birth.

DIF: Cognitive Level: Understand REF: IM: 605 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

13. The nurse should be cognizant of which statement regarding the unique qualities of human breast milk?

a. Frequent feedings during predictable growth spurts stimulate increased milk production.
b. Milk of preterm mothers is the same as the milk of mothers who gave birth at term.
c. Milk at the beginning of the feeding is the same as the milk at the end of the feeding.
d. Colostrum is an early, less concentrated, less rich version of mature milk.

ANS: A

Growth spurts (at 10 days, 3 weeks, 6 weeks, and 3 months) usually last 24 to 48 hours, after which the infants resume normal feeding. The milk of mothers of preterm infants is different from that of mothers of full-term infants to meet the needs of these newborns. Milk changes composition during feeding. The fat content of the milk increases as the infant feeds. Colostrum precedes mature milk and is more concentrated and richer in proteins and minerals (but not fat).

DIF: Cognitive Level: Understand REF: IM: 607 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

14. A nurse providing couplet care should understand the issue of nipple confusion. In which situation might this condition occur?

a. Breastfeeding babies receive supplementary bottle feedings.
b. Baby is too abruptly weaned.
c. Pacifiers are used before breastfeeding is established.
d. Twins are breastfed together.

ANS: A

Nipple confusion can result when babies go back and forth between bottles and breasts, especially before breastfeeding is established in 3 to 4 weeks; bottle feeding and breastfeeding require different skills. Abrupt weaning can be distressing to the mother and/or baby but should not lead to nipple confusion. Pacifiers used before breastfeeding is established can be disruptive but do not lead to nipple confusion. Breastfeeding twins require some logistical adaptations but should not lead to nipple confusion.

DIF: Cognitive Level: Understand REF: IM: 614 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

15. Which information should the nurse provide to a breastfeeding mother regarding optimal self-care?

a. She will need an extra 1000 calories a day to maintain energy and produce milk.
b. She can return to prepregnancy consumption patterns of any drinks as long as she gets enough calcium.
c. She should avoid trying to lose large amounts of weight.
d. She must avoid exercising because it is too fatiguing.

ANS: C

Large weight loss releases fat-stored contaminants into her breast milk, and it also involves eating too little and/or exercising too much. A breastfeeding mother needs to add only 200 to 500 extra calories to her diet to provide the extra nutrients for her infant. However, this is true only if she does not drink alcohol, limits coffee to no more than two cups (including caffeine in chocolate, tea, and some sodas, too), and carefully reads the herbal tea ingredients. Although she needs her rest, moderate exercise is healthy.

DIF: Cognitive Level: Understand REF: IM: 620 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

16. A newly delivered mother who intends to breastfeed tells her nurse, I am so relieved that this pregnancy is over so that I can start smoking again. The nurse encourages the client to refrain from smoking. However, this new mother is insistent that she will resume smoking. How will the nurse adapt her health teaching with this new information?

a. Smoking has little-to-no effect on milk production.
b. No relationship exists between smoking and the time of feedings.
c. The effects of secondhand smoke on infants are less significant than for adults.
d. The mother should always smoke in another room.

ANS: D

The new mother should be encouraged not to smoke. If she continues to smoke, she should be encouraged to always smoke in another room, removed from the baby. Smoking may impair milk production. When the products of tobacco are broken down, they cross over into the breast milk. Tobacco also results in a reduction of the antiinfective properties of breast milk. Research supports the conclusion that mothers should not smoke within 2 hours before a feeding (AAP Committee on Drugs, 2001). The effects of secondhand smoke on infants include excessive crying, colic, upper respiratory infections, and an increased risk of sudden infant death syndrome (SIDS).

DIF: Cognitive Level: Apply REF: IM: 622 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

17. A new father is ready to take his wife and newborn son home. He proudly tells the nurse who is discharging them that within the next week he plans to start feeding the infant cereal between breastfeeding sessions. Which information should the nurse provide regarding this feeding plan?

a. Feeding solid foods before your son is 4 to 6 months old may decrease your sons intake of sufficient calories.
b. Feeding solid foods between breastfeeding sessions before your son is 4 to 6 months old will lead to an early cessation of breastfeeding.
c. Your feeding plan will help your son sleep through the night.
d. Feeding solid foods before your son is 4 to 6 months old will limit his growth.

ANS: B

The introduction of solid foods before the infant is 4 to 6 months of age may result in overfeeding and decreased intake of breast milk. The belief that feeding solid foods helps infants sleep through the night is untrue. The proper balance of carbohydrate, protein, and fat for an infant to grow properly is in the breast milk or formula.

DIF: Cognitive Level: Apply REF: IM: 629 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

18. According to demographic research, which woman is *least* likely to breastfeed and therefore *most* likely to need education regarding the benefits and proper techniques of breastfeeding?

a. Between 30 and 35 years of age, Caucasian, and employed part time outside the home
b. Younger than 25 years of age, Hispanic, and unemployed
c. Younger than 25 years of age, African-American, and employed full time outside the home
d. 35 years of age or older, Caucasian, and employed full time at home

ANS: C

Women least likely to breastfeed are typically younger than 25 years of age, have a lower income, are less educated, are employed full time outside the home, and are African-American.

DIF: Cognitive Level: Understand REF: IM: 603

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. The nurse is explaining the benefits associated with breastfeeding to a new mother. Which statement by the nurse would provide conflicting information to the client?

a. Women who breastfeed have a decreased risk of breast cancer.
b. Breastfeeding is an effective method of birth control.
c. Breastfeeding increases bone density.
d. Breastfeeding may enhance postpartum weight loss.

ANS: B

Although breastfeeding delays the return of fertility, it is not an effective birth control method. Women who breastfeed have a decreased risk of breast cancer, an increase in bone density, and a possibility of faster postpartum weight loss.

DIF: Cognitive Level: Understand REF: IM: 621 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

20. While discussing the societal impacts of breastfeeding, the nurse should be cognizant of the benefits and educate the client accordingly. Which statement as part of this discussion would be *incorrect*?

a. Breastfeeding requires fewer supplies and less cumbersome equipment.
b. Breastfeeding saves families money.
c. Breastfeeding costs employers in terms of time lost from work.
d. Breastfeeding benefits the environment.

ANS: C

Actually, less time is lost to work by breastfeeding mothers, in part because infants are healthier. Breastfeeding is convenient because it does not require cleaning or transporting bottles and other

equipment. It saves families money because the cost of formula far exceeds the cost of extra food for the lactating mother. Breastfeeding uses a renewable resource; it does not need fossil fuels, advertising, shipping, or disposal.

DIF: Cognitive Level: Understand REF: IM: 602 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

21. In assisting the breastfeeding mother to position the baby, which information regarding positioning is important for the nurse to keep in mind?

a. The cradle position is usually preferred by mothers who had a cesarean birth.
b. Women with perineal pain and swelling prefer the modified cradle position.
c. Whatever the position used, the infant is belly to belly with the mother.
d. While supporting the head, the mother should push gently on the occiput.

ANS: C

The infant naturally faces the mother, belly to belly. The football position is usually preferred after a cesarean birth. Women with perineal pain and swelling prefer the side-lying position because they can rest while breastfeeding. The mother should never push on the back of the head. It may cause the baby to bite, hyperextend the neck, or develop an aversion to being brought near the breast.

DIF: Cognitive Level: Apply REF: IM: 610

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

22. Nurses should be able to teach breastfeeding mothers the signs that the infant has correctly latched on. Which client statement indicates a poor latch?

a. I feel a firm tugging sensation on my nipples but not pinching or pain.
b. My baby sucks with cheeks rounded, not dimpled.
c. My babys jaw glides smoothly with sucking.
d. I hear a clicking or smacking sound.

ANS: D

The clicking or smacking sound may indicate that the baby is having difficulty keeping the tongue out over the lower gum ridge. The mother should hope to hear the sound of swallowing. The tugging sensation without pinching is a good sign. Rounded cheeks are a positive indicator of a good latch. A smoothly gliding jaw also is a good sign.

DIF: Cognitive Level: Understand REF: IM: 611 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

23. The breastfeeding mother should be taught a safe method to remove the breast from the babys mouth. Which suggestion by the nurse is *most* appropriate?

a. Slowly remove the breast from the babys mouth when the infant has fallen asleep and the jaws are relaxed.
b. Break the suction by inserting your finger into the corner of the infants mouth.
c. A popping sound occurs when the breast is correctly removed from the infants mouth.
d. Elicit the Moro reflex to wake the baby and remove the breast when the baby cries.

ANS: B

Inserting a finger into the corner of the babys mouth between the gums to break the suction avoids trauma to the breast. The infant who is sleeping may lose grasp on the nipple and areola, resulting in *chewing* on the nipple that makes it sore. A popping sound indicates improper removal of the breast from the babys mouth and may cause cracks or fissures in the breast. Most mothers prefer the infant to continue to sleep after the feeding. Gentle wake-up techniques are recommended.

DIF: Cognitive Level: Apply REF: IM: 611

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

24. Which type of formula is not diluted with water, before being administered to an infant?

a. Powdered
b. Concentrated
c. Ready-to-use
d. Modified cows milk

ANS: C

Ready-to-use formula can be poured directly from the can into the babys bottle and is good (but expensive) when a proper water supply is not available. Formula should be well mixed to dissolve the powder and make it uniform in consistency. Improper dilution of concentrated formula may cause malnutrition or sodium imbalances. Cows milk is more difficult for the infant to digest and is not recommended, even if it is diluted.

DIF: Cognitive Level: Understand REF: IM: 629

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

25. How many kilocalories per kilogram (kcal/kg) of body weight does a breastfed term infant require each day?

a. 50 to 65
b. 75 to 90
c. 95 to 110
d. 150 to 200

ANS: C

For the first 3 months, the infant needs 110 kcal/kg/day. At ages 3 to 6 months, the requirement is 100 kcal/kg/day. This level decreases slightly to 95 kcal/kg/day from 6 to 9 months and increases again to 100 kcal/kg/day until the baby reaches 12 months.

DIF: Cognitive Level: Remember REF: IM: 604

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

26. Which action by the mother will initiate the milk ejection reflex (MER)?

a. Wearing a firm-fitting bra
b. Drinking plenty of fluids
c. Placing the infant to the breast
d. Applying cool packs to her breast

ANS: C

Oxytocin, which causes the MER reflex, increases in response to nipple stimulation. A firm bra is important to support the breast; however, it will not initiate the MER reflex. Drinking plenty of fluids is necessary for adequate milk production, but adequate intake of water alone will not initiate the MER reflex. Cool packs to the breast will decrease the MER reflex.

DIF: Cognitive Level: Understand REF: IM: 607

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

27. As the nurse assists a new mother with breastfeeding, the client asks, If formula is prepared to meet the nutritional needs of the newborn, what is in breast milk that makes it better? What is the nurses *best* response?

a. More calories
b. Essential amino acids
c. Important immunoglobulins
d. More calcium

ANS: C

Breast milk contains immunoglobulins that protect the newborn against infection. The calorie count of formula and breast milk is approximately the same. All the essential amino acids are in both formula and breast milk; however, the concentrations may differ. Calcium levels are higher in formula than in breast milk, which can cause an excessively high renal solute load if the formula is not properly diluted.

DIF: Cognitive Level: Apply REF: IM: 607

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

28. Which instruction should the nurse provide to reduce the risk of nipple trauma?

a. Limit the feeding time to less than 5 minutes.
b. Position the infant so the nipple is far back in the mouth.
c. Assess the nipples before each feeding.
d. Wash the nipples daily with mild soap and water.

ANS: B

If the infants mouth does not cover as much of the areola as possible, the pressure during sucking will be applied to the nipple, thus causing trauma to the area. Stimulating the breast for less than 5 minutes will not produce the extra milk the infant may need and will also limit access to the higher-fat *hindmilk*. Assessing the nipples for trauma is important; however, this action alone will not prevent sore nipples. Soap can be drying to the nipples and should be avoided during breastfeeding.

DIF: Cognitive Level: Apply REF: IM: 624

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

29. A new mother asks whether she should feed her newborn colostrum, because it is not real milk. What is the nurses *most* appropriate answer?

a. Colostrum is high in antibodies, protein, vitamins, and minerals.
b. Colostrum is lower in calories than milk and should be supplemented by formula.
c. Giving colostrum is important in helping the mother learn how to breastfeed before she goes home.
d. Colostrum is unnecessary for newborns.

ANS: A

Colostrum is important because it has high levels of the nutrients needed by the neonate and helps protect against infection. Supplementation is not necessary and will decrease stimulation to the breast and decrease the production of milk. It is important for the mother to feel comfortable in this role before discharge; however, the importance of the colostrum to the infant is the top priority. Colostrum provides immunities and enzymes necessary to cleanse the gastrointestinal system, among other things.

DIF: Cognitive Level: Remember REF: IM: 607

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which actions are examples of appropriate techniques to wake a sleepy infant for breastfeeding? *(Select all that apply.)*

a. Unwrapping the infant
b. Changing the diaper
c. Talking to the infant
d. Slapping the infants hands and feet
e. Applying a cold towel to the infants abdomen

ANS: A, B, C

Unwrapping the infant, changing the diaper, and talking to the infant are appropriate techniques to use when trying to wake a sleepy infant. The parent can *rub, never slap,* the infants hands or feet to wake the infant. Applying a cold towel to the infants abdomen may lead to cold stress in the infant. The parent may want to apply a cool cloth to the infants face to wake the infant.

DIF: Cognitive Level: Apply REF: IM: 615

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

2. A nurse is discussing the signs and symptoms of mastitis with a mother who is breastfeeding. Which findings should the nurse include in the discussion? *(Select all that apply.)*

a. Breast tenderness
b. Warmth in the breast
c. Area of redness on the breast often resembling the shape of a pie wedge
d. Small white blister on the tip of the nipple
e. Fever and flulike symptoms

ANS: A, B, C, E

Breast tenderness, warmth in the breast, redness on the breast, and fever and flulike symptoms are commonly associated with mastitis and should be included in the nurses discussion of mastitis. A small white blister on the tip of the nipple generally is not associated with mastitis but is commonly seen in women who have a plugged milk duct.

DIF: Cognitive Level: Analyze REF: IM: 625 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

3. The Baby Friendly Hospital Initiative endorsed by the World Health Organization (WHO) and the United Nations Childrens Fund (UNICEF) was founded to encourage institutions to offer optimal levels of care for lactating mothers. Which actions are included in the Ten Steps to Successful Breastfeeding for Hospitals? *(Select all that apply.)*

a. Give newborns no food or drink other than breast milk.
b. Have a written breastfeeding policy that is communicated to all staff members.
c. Help mothers initiate breastfeeding within hour of childbirth.
d. Give artificial teats or pacifiers as necessary.
e. Return infants to the nursery at night.

ANS: A, B, C

No artificial teats or pacifiers (also called *dummies* or *soothers*) should be given to breastfeeding infants. Although pacifiers have been linked to a reduction in SIDs, they should not be introduced until the infant is 3 to 4 weeks old and breastfeeding is well established. No other food or drink should be given to the newborn unless medically indicated. The breastfeeding

policy should be routinely communicated to all health care staff members. All staff should be trained in the skills necessary to maintain this policy. Breastfeeding should be initiated within hour of childbirth, and all mothers need to be shown how to maintain lactation even if separated from their babies. The facility should practice rooming in and keep mothers and babies together 24 hours a day.

DIF: Cognitive Level: Apply REF: IM: 608

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

4. Which statements concerning the benefits or limitations of breastfeeding are *accurate*? *(Select all that apply.)*

a. Breast milk changes over time to meet the changing needs as infants grow.
b. Breastfeeding increases the risk of childhood obesity.
c. Breast milk and breastfeeding may enhance cognitive development.
d. Long-term studies have shown that the benefits of breast milk continue after the infant is weaned.
e. Benefits to the infant include a reduced incidence of SIDS.

ANS: A, C, D, E

Breastfeeding actually decreases the risk of childhood obesity. Human milk is the perfect food for human infants. Breast milk changes over time to meet the demands of the growing infant. Scientific evidence is clear that human milk provides the best nutrients for infants with continued benefits long after weaning. Fatty acids in breast milk promote brain growth and development and may lead to enhanced cognition. Infants who are breastfed experience a reduced incidence of SIDS.

DIF: Cognitive Level: Understand REF: IM: 602 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

5. The AAP recommends pasteurized donor milk for preterm infants if the mothers own milk in not available. Which statements regarding donor milk and milk banking are important for the nurse to understand and communicate to her client? *(Select all that apply.)*

a. All milk bank donors are screened for communicable diseases.
b. Internet milk sharing is an acceptable source for donor milk.
c. Donor milk may be given to transplant clients.
d. Donor milk is used in neonatal intensive care units (NICUs) for severely low-birth-weight infants only.
e. Donor milk may be used for children with immunoglobulin A (IgA) deficiencies.

ANS: A, C, E

Because of the antiinfective and growth promotion properties for donor milk, donor milk is highly recommended for preterm and sick infants, as well as for term newborns. Human donor milk has also been used for older children with short gut syndrome, immunodeficiencies, metabolic disorders, or congenital anomalies. Human donor milk has also been used in the adult populationposttransplant clients and for those with colitis, ulcers, or cirrhosis of the liver. Some mothers acquire milk through Internet-based or community-based milk sharing. The U.S. Food and Drug Administration (FDA) has issued a warning regarding this practice. Samples of milk from these sources are higher in contaminants and infectious disease. A milk bank that belongs to the Human Milk Banking Association of North America should always be used for donor milk. All donors are scrupulously screened, and the milk is tested to determine its safety for use.

Chapter 26: Assessment of High Risk Pregnancy

MULTIPLE CHOICE

1. A woman arrives at the clinic seeking confirmation that she is pregnant. The following information is obtained: She is 24 years old with a body mass index (BMI) of 17.5. She admits to having used cocaine several times during the past year and occasionally drinks alcohol. Her blood pressure is 108/70 mm Hg. The family history is positive for diabetes mellitus and cancer.

Her sister recently gave birth to an infant with a neural tube defect (NTD). Which characteristics places this client in a high-risk category?

a. Blood pressure, age, BMI
b. Drug and alcohol use, age, family history
c. Family history, blood pressure (BP), BMI
d. Family history, BMI, drug and alcohol abuse

ANS: D

The womans family history of an NTD, her low BMI, and her drug and alcohol use abuse are high risk factors of pregnancy. The womans BP is normal, and her age does not put her at risk. Her BMI is low and may indicate poor nutritional status, which is a high risk.

DIF: Cognitive Level: Analyze REF: IM: 633

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. A 39-year-old primigravida woman believes that she is approximately 8 weeks pregnant, although she has had irregular menstrual periods all her life. She has a history of smoking approximately one pack of cigarettes a day; however, she tells the nurse that she is trying to cut down. Her laboratory data are within normal limits. What diagnostic technique would be useful at this time?

a. Ultrasound examination
b. Maternal serum alpha-fetoprotein (MSAFP) screening
c. Amniocentesis
d. Nonstress test (NST)

ANS: A

An ultrasound examination could be performed to confirm the pregnancy and to determine the gestational age of the fetus. An MSAFP screening is performed at 16 to 18 weeks of gestation; therefore, it is too early in the womans pregnancy to perform this diagnostic test. An

amniocentesis is performed if the MSAFP levels are abnormal or if fetal or maternal anomalies are detected. An NST is performed to assess fetal well-being in the third trimester.

DIF: Cognitive Level: Understand REF: IM: 635

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. The nurse sees a woman for the first time when she is 30 weeks pregnant. The client has smoked throughout the pregnancy, and fundal height measurements now are suggestive of intrauterine growth restriction (IUGR) in the fetus. In addition to ultrasound to measure fetal size, what is another tool useful in confirming the diagnosis?

a. Doppler blood flow analysis
b. Contraction stress test (CST)
c. Amniocentesis
d. Daily fetal movement counts

ANS: A

Doppler blood flow analysis allows the examiner to study the blood flow noninvasively in the fetus and the placenta. It is a helpful tool in the management of high-risk pregnancies because of IUGR, diabetes mellitus, multiple fetuses, or preterm labor. Because of the potential risk of inducing labor and causing fetal distress, a CST is not performed on a woman whose fetus is preterm. Indications for an amniocentesis include diagnosis of genetic disorders or congenital anomalies, assessment of pulmonary maturity, and the diagnosis of fetal hemolytic disease, not IUGR. Fetal kick count monitoring is performed to monitor the fetus in pregnancies complicated by conditions that may affect fetal oxygenation. Although this may be a useful tool at some point later in this womans pregnancy, it is not used to diagnose IUGR.

DIF: Cognitive Level: Analyze REF: IM: 639

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

4. A 41-week pregnant multigravida arrives at the labor and delivery unit after a NST indicated that her fetus could be experiencing some difficulties in utero. Which diagnostic tool yields more detailed information about the condition of the fetus?

a. Ultrasound for fetal anomalies
b. Biophysical profile (BPP)
c. MSAFP screening
d. Percutaneous umbilical blood sampling (PUBS)

ANS: B

Real-time ultrasound permits a detailed assessment of the physical and physiologic characteristics of the developing fetus and a cataloging of normal and abnormal biophysical responses to stimuli. The BPP is a noninvasive, dynamic assessment of a fetus that is based on acute and chronic markers of fetal disease. An ultrasound for fetal anomalies would most likely have occurred earlier in the pregnancy. It is too late in the pregnancy to perform an MSAFP. Furthermore, it does not provide information related to fetal well-being. Indications for PUBS include prenatal diagnosis or inherited blood disorders, karyotyping of malformed fetuses, detection of fetal infection, determination of the acid-base status of the fetus with IUGR, and assessment and treatment of isoimmunization and thrombocytopenia in the fetus.

DIF: Cognitive Level: Understand REF: IM: 640

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

5. At 35 weeks of pregnancy, a woman experiences preterm labor. Although tocolytic medications are administered and she is placed on bed rest, she continues to experience regular uterine contractions and her cervix is beginning to dilate and efface. What is an important test for fetal well-being at this time?

a. PUBS
b. Ultrasound for fetal size

c. Amniocentesis for fetal lung maturity
d. NST

ANS: C

Amniocentesis is performed to assess fetal lung maturity in the event of a preterm birth. The fluid is examined to determine the lecithin to sphingomyelin (L/S) ratio. Indications for PUBS include prenatal diagnosis or inherited blood disorders, karyotyping of malformed fetuses, detection of fetal infection, determination of the acid-base status of the fetus with IUGR, and assessment and treatment of isoimmunization and thrombocytopenia in the fetus. Determination of fetal size by ultrasound is typically performed during the second trimester and is not indicated in this scenario. An NST measures the fetal response to fetal movement in a noncontracting mother.

DIF: Cognitive Level: Understand REF: IM: 642 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

6. A 30-year-old gravida 3, para 2-0-0-2 is at 18 weeks of gestation. Which screening test should the nurse recommend be ordered for this client?

a. BPP
b. Chorionic villi sampling
c. MSAFP screening
d. Screening for diabetes mellitus

ANS: C

The biochemical assessment MSAFP test is performed from week 15 to week 20 of gestation (weeks 16 to 18 are ideal). A BPP is a method of biophysical assessment of fetal well-being in the third trimester. Chorionic villi sampling is a biochemical assessment of the fetus that should be performed from the 10th to 12th weeks of gestation. Screening for diabetes mellitus begins with the first prenatal visit.

DIF: Cognitive Level: Apply REF: IM: 645 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

7. An MSAFP screening indicates an elevated level of alpha-fetoprotein. The test is repeated, and again the level is reported as higher than normal. What is the next step in the assessment sequence to determine the well-being of the fetus?

a. PUBS
b. Ultrasound for fetal anomalies
c. BPP for fetal well-being
d. Amniocentesis for genetic anomalies

ANS: B

If MSAFP findings are abnormal, then follow-up procedures include genetic counseling for families with a history of NTD, repeated MSAFP screenings, an ultrasound examination, and possibly amniocentesis. Indications for the use of PUBS include prenatal diagnosis of inherited blood disorders, karyotyping of malformed fetuses, detection of fetal infection, determination of the acid-base status of fetuses with IUGR, and assessment and treatment of isoimmunization and thrombocytopenia in the fetus. A BPP is a method of assessing fetal well-being in the third trimester. Before an amniocentesis, the client would have an ultrasound for direct visualization of the fetus.

DIF: Cognitive Level: Apply REF: IM: 645

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

8. A client asks her nurse, My doctor told me that he is concerned with the grade of my placenta because I am overdue. What does that mean? What is the nurses *best* response?

a. Your placenta changes as your pregnancy progresses, and it is given a score that indicates how well it is functioning.
b. Your placenta isnt working properly, and your baby is in danger.
c. We need to perform an amniocentesis to detect if you have any placental damage.
d. Dont worry about it. Everything is fine.

ANS: A

An explanation of what is meant by the grade of my placenta is the most appropriate response. If the client desires further information, the nurse can explain that calcium deposits are significant in postterm pregnancies, and ultrasonography can also be used to determine placental aging. Although stating that the clients placenta is not working properly and that the baby is in danger may be a valid response, it does not reflect therapeutic communication techniques and is likely to alarm the client. An ultrasound, not amniocentesis, is the method of assessment used to determine placental maturation. Telling the client not to worry is not appropriate and discredits her concerns.

DIF: Cognitive Level: Apply REF: IM: 639 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

9. A woman is undergoing a nipple-stimulated CST. She is having contractions that occur every 3 minutes. The fetal heart rate (FHR) has a baseline heart rate of approximately 120 beats per minute without any decelerations. What is the *correct* interpretation of this test?

a. Negative
b. Positive
c. Satisfactory
d. Unsatisfactory

ANS: A

Adequate uterine activity necessary for a CST consists of three contractions in a 10-minute time frame. If no decelerations are observed in the FHR pattern with the contractions, then the findings are considered to be negative. A positive CST indicates the presence of repetitive late FHR decelerations. The terms *satisfactory* or *unsatisfactory* are not applicable.

DIF: Cognitive Level: Analyze REF: IM: 650

TOP: Nursing Process: Assessment | Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

10. Of these psychosocial factors, which has the *least* negative effect on the health of the mother and/or fetus?

a. Moderate coffee consumption
b. Moderate alcohol consumption
c. Cigarette smoke
d. Emotional distress

ANS: A

Birth defects in humans have not been related to caffeine consumption. Pregnant women who consume more than 300 mg of caffeine daily may be at increased risk for miscarriage or IUGR. Although the exact effects of alcohol in pregnancy have not been quantified, it exerts adverse effects on the fetus including fetal alcohol syndrome, fetal alcohol effects, learning disabilities, and hyperactivity. A strong, consistent, causal relation has been established between maternal smoking and reduced birth weight. Childbearing triggers profound and complex physiologic and psychologic changes on the mother. Evidence suggests a relationship between emotional distress and birth complications.

DIF: Cognitive Level: Analyze REF: IM: 634

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. Which information should nurses provide to expectant mothers when teaching them how to evaluate daily fetal movement counts (DFMCs)?

a. Alcohol or cigarette smoke can irritate the fetus into greater activity.
b. Kick counts should be taken every hour and averaged every 6 hours, with every other 6-hour stretch off.
c. The fetal alarm signal should go off when fetal movements stop entirely for 12 hours.
d. A count of less than four fetal movements in 1 hour warrants future evaluation.

ANS: C

No movement in a 12-hour period is cause for investigation and possibly intervention. Alcohol and cigarette smoke temporarily reduce fetal movement. The mother should count fetal activity (kick counts) two or three times daily for 60 minutes each time. A count of less than 3 in 1 hour warrants further evaluation by a NST.

DIF: Cognitive Level: Understand REF: IM: 635 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. In comparing the abdominal and transvaginal methods of ultrasound examination, which information should the nurse provide to the client?

a. Both require the woman to have a full bladder.
b. The abdominal examination is more useful in the first trimester.
c. Initially, the transvaginal examination can be painful.
d. The transvaginal examination allows pelvic anatomy to be evaluated in greater detail.

ANS: D

The transvaginal examination allows pelvic anatomy to be evaluated in greater detail than the abdominal method and also allows intrauterine pregnancies to be diagnosed earlier. The abdominal examination requires a full bladder; the transvaginal examination requires an empty one. The transvaginal examination is more useful in the first trimester; the abdominal examination works better after the first trimester. Neither the abdominal nor the transvaginal method of ultrasound examination should be painful, although the woman will feel pressure as the probe is moved during the transvaginal examination.

DIF: Cognitive Level: Remember REF: IM: 636 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. Which clinical finding is a major use of ultrasonography in the first trimester?

a. Amniotic fluid volume
b. Presence of maternal abnormalities
c. Placental location and maturity
d. Cervical length

ANS: B

Ultrasonography can detect certain uterine abnormalities such as bicornuate uterus, fibroids, and ovarian cysts. Amniotic fluid volume, placental location and maturity, and cervical length are not available via ultrasonography until the second or third trimester.

DIF: Cognitive Level: Remember REF: IM: 637

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

14. Which information is the *highest* priority for the nurse to comprehend regarding the BPP?

a. BPP is an accurate indicator of impending fetal well-being.
b. BPP is a compilation of health risk factors of the mother during the later stages of pregnancy.
c. BPP consists of a Doppler blood flow analysis and an amniotic fluid index (AFI).
d. BPP involves an invasive form of an ultrasonic examination.

ANS: A

An abnormal BPP score is one indication that labor should be induced. The BPP evaluates the health of the fetus, requires many different measures, and is a noninvasive procedure.

DIF: Cognitive Level: Understand REF: IM: 640

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

15. A client in the third trimester has just undergone an amniocentesis to determine fetal lung maturity. Which statement regarding this testing is important for the nurse in formulating a care plan?

a. Because of new imaging techniques, an amniocentesis should have been performed in the first trimester.
b. Despite the use of ultrasonography, complications still occur in the mother or infant in 5% to 10% of cases.
c. Administration of Rh_o(D) immunoglobulin may be necessary.
d. The presence of meconium in the amniotic fluid is always a cause for concern.

ANS: C

As a result of the possibility of fetomaternal hemorrhage, administration of Rh_o(D) immunoglobulin is the standard of practice after amniocentesis for women who are Rh negative. Amniocentesis is possible after the 14th week of pregnancy when the uterus becomes an abdominal organ. Complications occur in less than 1% of cases; many have been minimized or eliminated through the use of ultrasonography. Meconium in the amniotic fluid before the beginning of labor is not usually a problem.

DIF: Cognitive Level: Apply REF: IM: 642 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

16. Which information is an important consideration when comparing the CST with the NST?

a. The NST has no known contraindications.
b. The CST has fewer false-positive results when compared with the NST.
c. The CST is more sensitive in detecting fetal compromise, as opposed to the NST.
d. The CST is slightly more expensive than the NST.

ANS: A

The CST has several contraindications. The NST has a high rate of false-positive results and is less sensitive than the CST but relatively inexpensive.

DIF: Cognitive Level: Understand REF: IM: 648

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

17. The nurse is planning the care for a laboring client with diabetes mellitus. This client is at greater risk for which clinical finding?

a. Oligohydramnios
b. Polyhydramnios
c. Postterm pregnancy
d. Chromosomal abnormalities

ANS: B

Polyhydramnios or amniotic fluid in excess of 2000 ml is 10 times more likely to occur in the client with diabetes mellitus rather than in nondiabetic pregnancies. This complication places the mother at risk for premature rupture of membranes, premature labor, and postpartum hemorrhage. Prolonged rupture of membranes, IUGR, intrauterine fetal death, and renal agenesis (Potter syndrome) place the client at risk for developing oligohydramnios. Anencephaly, placental insufficiency, and perinatal hypoxia contribute to the risk for postterm pregnancy. Maternal age older than 35 years and balanced translocation (maternal and paternal) are risk factors for chromosomal abnormalities.

DIF: Cognitive Level: Apply REF: IM: 635 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. Nurses should be aware of the strengths and limitations of various biochemical assessments during pregnancy. Which statement regarding monitoring techniques is the *most* accurate?

a. Chorionic villus sampling (CVS) is becoming more popular because it provides early diagnosis.
b. MSAFP screening is recommended only for women at risk for NTDs.
c. PUBS is one of the triple-marker tests for Down syndrome.
d. MSAFP is a screening tool only; it identifies candidates for more definitive diagnostic procedures.

ANS: D

MSAFP is a screening tool, not a diagnostic tool. CVS provides a rapid result, but it is declining in popularity because of advances in noninvasive screening techniques. An MSAFP screening is recommended for all pregnant women. MSAFP screening, not PUBS, is part of the triple-marker tests for Down syndrome.

DIF: Cognitive Level: Understand REF: IM: 645 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. In the past, factors to determine whether a woman was likely to develop a high-risk pregnancy were primarily evaluated from a medical point of view. A broader, more comprehensive approach to high-risk pregnancy has been adopted today. Four categories have now been established, based on the threats to the health of the woman and the outcome of pregnancy. Which category should *not* be included in this group?

a. Biophysical
b. Psychosocial
c. Geographic
d. Environmental

ANS: C

A geographic category is correctly referred to as *sociodemographic risk*. These factors stem from the mother and her family. Ethnicity may be one of the risks to pregnancy; however, it is not the only factor in this category. Low income, lack of prenatal care, age, parity, and marital status also are included. Biophysical is one of the broad categories used for determining risk. These include genetic considerations, nutritional status, and medical and obstetric disorders. Psychosocial risks include smoking, caffeine, drugs, alcohol, and psychologic status. All of these adverse lifestyles can have a negative effect on the health of the mother or fetus. Environmental risks are risks that can affect both fertility and fetal development. These include infections, chemicals, radiation, pesticides, illicit drugs, and industrial pollutants.

DIF: Cognitive Level: Understand REF: IM: 634 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

20. A pregnant womans BPP score is 8. She asks the nurse to explain the results. How should the nurse respond at this time?

a. The test results are within normal limits.
b. Immediate delivery by cesarean birth is being considered.
c. Further testing will be performed to determine the meaning of this score.
d. An obstetric specialist will evaluate the results of this profile and, within the next week, will inform you of your options regarding delivery.

ANS: A

The normal biophysical score ranges from 8 to 10 points if the amniotic fluid volume is adequate. A normal score allows conservative treatment of high-risk clients. Delivery can be delayed if fetal well-being is indicated. Scores less than 4 should be investigated, and delivery could be initiated sooner than planned. The results of the BPP are usually available immediately after the procedure is performed. Since this score is within normal range, no further testing is required at this time.

DIF: Cognitive Level: Apply REF: IM: 640

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

21. Which analysis of maternal serum may predict chromosomal abnormalities in the fetus?

a. Multiple-marker screening
b. L/S ratio
c. BPP
d. Blood type and crossmatch of maternal and fetal serum

ANS: A

Maternal serum can be analyzed for abnormal levels of alpha-fetoprotein, human chorionic gonadotropin, and estriol. The multiple-marker screening may predict chromosomal defects in the fetus. The L/S ratio is used to determine fetal lung maturity. A BPP is used for evaluating fetal status during the antepartum period. Five variables are used, but none is concerned with

chromosomal problems. The blood type and crossmatch would not predict chromosomal defects in the fetus.

DIF: Cognitive Level: Knowledge REF: IM: 645

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

22. While working with the pregnant client in her first trimester, what information does the nurse provide regarding when CVS can be performed (in weeks of gestation)?

a. 4
b. 8
c. 10
d. 14

ANS: C

CVS can be performed in the first or second trimester, ideally between 10 and 13 weeks of gestation. During this procedure, a small piece of tissue is removed from the fetal portion of the placenta. If performed after 9 completed weeks of gestation, then the risk of limb reduction is no greater than in the general population.

DIF: Cognitive Level: Remember REF: IM: 643

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

23. Which nursing intervention is necessary before a first-trimester transabdominal ultrasound?

a. Place the woman on nothing by mouth (*nil per os* [NPO]) for 12 hours.
b. Instruct the woman to drink 1 to 2 quarts of water.
c. Administer an enema.
d. Perform an abdominal preparation.

ANS: B

When the uterus is still in the pelvis, visualization may be difficult. Performing a first-trimester transabdominal ultrasound requires the woman to have a full bladder, which will elevate the uterus upward and provide a better visualization of the fetus; therefore, being NPO is not appropriate. Neither an enema nor an abdominal preparation is necessary for this procedure.

DIF: Cognitive Level: Apply REF: IM: 636

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

24. How does the nurse document a NST during which two or more FHR accelerations of 15 beats per minute or more occur with fetal movement in a 20-minute period?

a. Nonreactive
b. Positive
c. Negative
d. Reactive

ANS: D

The NST is *reactive* (normal) when two or more FHR accelerations of at least 15 beats per minute (each with a duration of at least 15 seconds) occur in a 20-minute period. A *nonreactive* result means that the heart rate did not accelerate during fetal movement. A *positive result* is not used with NST. CST uses *positive* as a result term. A *negative result* is not used with NST. CST uses *negative* as a result term.

DIF: Cognitive Level: Apply REF: IM: 649

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

25. The indirect Coombs test is a screening tool for Rh incompatibility. If the titer is greater than _____, amniocentesis may be a necessary next step.

a. 1:2
b. 1:4
c. 1:8

d. 1:12

ANS: C

If the maternal titer for Rh antibodies is greater 1:8, then an amniocentesis is indicated to determine the level of bilirubin in the amniotic fluid. This testing will determine the severity of fetal hemolytic anemia.

DIF: Cognitive Level: Remember REF: IM: 647

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. IUGR is associated with which pregnancy-related risk factors? *(Select all that apply.)*

a. Poor nutrition
b. Maternal collagen disease
c. Gestational hypertension
d. Premature rupture of membranes
e. Smoking

ANS: A, B, C, E

Poor nutrition, maternal collagen disease, gestational hypertension, and smoking are risk factors associated with the occurrence of IUGR. Premature rupture of membranes is associated with preterm labor, not IUGR.

DIF: Cognitive Level: Analyze REF: IM: 635 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

2. Which assessments are included in the fetal BPP? *(Select all that apply.)*

a. Fetal movement
b. Fetal tone

c. Fetal heart rate
d. AFI
e. Placental grade

ANS: A, B, C, D

Fetal movement, tone, heart rate, and AFI are all assessed in a BPP. The placental grade is determined by ultrasound and is not included in the criteria of assessment factors for a BPP.

DIF: Cognitive Level: Analyze REF: IM: 640

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. Transvaginal ultrasonography is often performed during the first trimester. While preparing a 6-week gestational client for this procedure, she expresses concerns over the necessity for this test. The nurse should explain that this diagnostic test may be indicated for which situations? *(Select all that apply.)*

a. Multifetal gestation
b. Obesity
c. Fetal abnormalities
d. Amniotic fluid volume
e. Ectopic pregnancy

ANS: A, B, C, E

Transvaginal ultrasound is useful in women who are obese whose thick abdominal layers cannot be penetrated with traditional abdominal ultrasound. This procedure is also used to identify multifetal gestation, ectopic pregnancy, estimating gestational age, confirming fetal viability, and identifying fetal abnormalities. Amniotic fluid volume is assessed during the second and third trimester; conventional ultrasound would be used.

DIF: Cognitive Level: Apply REF: IM: 637 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. Cell-free deoxyribonucleic acid (DNA) screening is a new method of noninvasive prenatal testing (NIPT) that has recently become available in the clinical setting. This technology can provide a definitive diagnosis of which findings? *(Select all that apply.)*

a. Fetal Rh status
b. Fetal gender
c. Maternally transmitted gene disorder
d. Paternally transmitted gene disorder
e. Trisomy 21

ANS: A, B, D, E

The NIPT cannot actually distinguish fetal from maternal DNA. It can determine fetal Rh status, gender, trisomies 13, 18, and 21, as well as paternally transmitted gene disorders. The test can be performed any time after 10 weeks of gestation and is recommended for women who have previously given birth to a child with chromosomal abnormalities.

Chapter 27: Hypertensive Disorders

MULTIPLE CHOICE

1. A primigravida is being monitored at the prenatal clinic for preeclampsia. Which finding is of *greatest* concern to the nurse?

a. Blood pressure (BP) increase to 138/86 mm Hg
b. Weight gain of 0.5 kg during the past 2 weeks
c. Dipstick value of 3+ for protein in her urine
d. Pitting pedal edema at the end of the day

ANS: C

Proteinuria is defined as a concentration of 1+ or greater via dipstick measurement. A dipstick value of 3+ alerts the nurse that additional testing or assessment should be performed. A 24-hour urine collection is preferred over dipstick testing attributable to accuracy. Generally, hypertension is defined as a BP of 140/90 mm Hg or an increase in systolic pressure of 30 mm Hg or diastolic pressure of 15 mm Hg. Preeclampsia may be demonstrated as a rapid weight gain of more than 2 kg in 1 week. Edema occurs in many normal pregnancies, as well as in women with preeclampsia. Therefore, the presence of edema is no longer considered diagnostic of preeclampsia.

DIF: Cognitive Level: Analyze REF: IM: 660 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

2. The labor of a pregnant woman with preeclampsia is going to be induced. Before initiating the oxytocin (Pitocin) infusion, the nurse reviews the womans latest laboratory test findings, which reveal a platelet count of 90,000 mm^3, an elevated aspartate aminotransaminase (AST) level, and a falling hematocrit. The laboratory results are indicative of which condition?

a. Eclampsia
b. Disseminated intravascular coagulation (DIC) syndrome
c. Hemolysis, elevated liver enzyme levels, and low platelet levels (HELLP) syndrome
d. Idiopathic thrombocytopenia

ANS: C

HELLP syndrome is a laboratory diagnosis for a variant of severe preeclampsia that involves hepatic dysfunction characterized by hemolysis (H), elevated liver (EL) enzymes, and low platelets (LP). Eclampsia is determined by the presence of seizures. DIC is a potential complication associated with HELLP syndrome. Idiopathic thrombocytopenia is the presence of low platelets of unknown cause and is not associated with preeclampsia.

DIF: Cognitive Level: Understand REF: IM: 657 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

3. A woman with preeclampsia has a seizure. What is the nurses *highest* priority during a seizure?

a. To insert an oral airway
b. To suction the mouth to prevent aspiration
c. To administer oxygen by mask
d. To stay with the client and call for help

ANS: D

If a client becomes eclamptic, then the nurse should stay with the client and call for help. Nursing actions during a convulsion are directed toward ensuring a patent airway and client safety. Insertion of an oral airway during seizure activity is no longer the standard of care. The nurse should attempt to keep the airway patent by turning the clients head to the side to prevent aspiration. Once the seizure has ended, it may be necessary to suction the clients mouth. Oxygen is administered after the convulsion has ended.

DIF: Cognitive Level: Apply REF: IM: 666

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

4. A pregnant woman has been receiving a magnesium sulfate infusion for treatment of severe preeclampsia for 24 hours. On assessment, the nurse finds the following vital signs: temperature 37.3 C, pulse rate 88 beats per minute, respiratory rate 10 breaths per minute, BP 148/90 mm Hg, absent deep tendon reflexes (DTRs), and no ankle clonus. The client complains, Im so thirsty and warm. What is the nurses *immediate* action?

a. To call for an immediate magnesium sulfate level
b. To administer oxygen
c. To discontinue the magnesium sulfate infusion
d. To prepare to administer hydralazine

ANS: C

Regardless of the magnesium level, the client is displaying the clinical signs and symptoms of magnesium toxicity. The first action by the nurse should be to discontinue the infusion of magnesium sulfate. In addition, calcium gluconate, the antidote for magnesium, may be administered. Hydralazine is an antihypertensive drug commonly used to treat hypertension in severe preeclampsia. Typically, hydralazine is administered for a systolic BP higher than 160 mm Hg or a diastolic BP higher than 110 mm Hg.

DIF: Cognitive Level: Apply REF: IM: 664

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

5. A woman at 39 weeks of gestation with a history of preeclampsia is admitted to the labor and birth unit. She suddenly experiences increased contraction frequency of every 1 to 2 minutes, dark red vaginal bleeding, and a tense, painful abdomen. Which clinical change does the nurse anticipate?

a. Eclamptic seizure
b. Rupture of the uterus
c. Placenta previa
d. Abruptio placentae

ANS: D

Uterine tenderness in the presence of increasing tone may be the earliest sign of abruptio placentae. Women with preeclampsia are at increased risk for an abruption attributable to decreased placental perfusion. Eclamptic seizures are evidenced by the presence of generalized tonic-clonic convulsions. Uterine rupture exhibits hypotonic uterine activity, signs of hypovolemia, and, in many cases, the absence of pain. Placenta previa exhibits bright red, painless vaginal bleeding.

DIF: Cognitive Level: Understand REF: IM: 662 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

6. A woman with worsening preeclampsia is admitted to the hospitals labor and birth unit. The physician explains the plan of care for severe preeclampsia, including the induction of labor, to the woman and her husband. Which statement by the husband leads the nurse to believe that the couple needs further information?

a. I will help my wife use the breathing techniques that we learned in our childbirth classes.
b. I will give my wife ice chips to eat during labor.
c. Since we will be here for a while, I will call my mother so she can bring the two boys2 years and 4 years of ageto visit their mother.
d. I will stay with my wife during her labor, just as we planned.

ANS: C

Arranging a visit with their two children indicates that the husband does not understand the importance of the quiet, subdued environment that is needed to prevent his wifes condition from worsening. Implementing breathing techniques is indicative of adequate knowledge related to pain management during labor. Administering ice chips indicates an understanding of nutritional needs during labor. Staying with his wife during labor demonstrates the husbands support for his wife and is appropriate.

DIF: Cognitive Level: Apply REF: IM: 662 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

7. The client has been on magnesium sulfate for 20 hours for the treatment of preeclampsia. She just delivered a viable infant girl 30 minutes ago. What uterine findings does the nurse expect to observe or assess in this client?

a. Absence of uterine bleeding in the postpartum period
b. Fundus firm below the level of the umbilicus
c. Scant lochia flow
d. Boggy uterus with heavy lochia flow

ANS: D

High serum levels of magnesium can cause a relaxation of smooth muscle such as the uterus. Because of this tocolytic effect, the client will most likely have a boggy uterus with increased amounts of bleeding. All women experience uterine bleeding in the postpartum period, especially those who have received magnesium therapy. Rather than scant lochial flow, however, this client will most likely have a heavy flow attributable to the relaxation of the uterine wall caused by magnesium administration.

DIF: Cognitive Level: Analyze REF: IM: 664

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

8. The client is being induced in response to worsening preeclampsia. She is also receiving magnesium sulfate. It appears that her labor has not become active, despite several hours of oxytocin administration. She asks the nurse, Why is this taking so long? What is the nurses *most* appropriate response?

a. The magnesium is relaxing your uterus and competing with the oxytocin. It may increase the duration of your labor.
b. I dont know why it is taking so long.
c. The length of labor varies for different women.
d. Your baby is just being stubborn.

ANS: A

Because magnesium sulfate is a tocolytic agent, its use may increase the duration of labor. The amount of oxytocin needed to stimulate labor may be more than that needed for the woman who is not receiving magnesium sulfate. The nurse should explain to the client the effects of magnesium sulfate on the duration of labor. Although the length of labor varies for different women, the most likely reason this womans labor is protracted is the tocolytic effects of magnesium sulfate. The behavior of the fetus has no bearing on the length of labor.

DIF: Cognitive Level: Apply REF: IM: 664 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

9. What nursing diagnosis is the *most* appropriate for a woman experiencing severe preeclampsia?

a. *Risk for injury* to mother and fetus, related to central nervous system (CNS) irritability
b. *Risk for altered gas exchange*
c. *Risk for deficient fluid volume,* related to increased sodium retention secondary to the administration of magnesium sulfate
d. *Risk for increased cardiac output,* related to the use of antihypertensive drugs

ANS: A

Risk for injury is the most appropriate nursing diagnosis for this client scenario. Gas exchange is more likely to become impaired, attributable to pulmonary edema. A risk for excess, not deficient, fluid volume, related to increased sodium retention, is increased, and a risk for decreased, not increased, cardiac output, related to the use of antihypertensive drugs, also is increased.

DIF: Cognitive Level: Apply REF: IM: 660 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

10. Which statement *best* describes chronic hypertension?

a. Chronic hypertension is defined as hypertension that begins during pregnancy and lasts for the duration of the pregnancy.
b. Chronic hypertension is considered severe when the systolic BP is higher than 140 mm Hg or the diastolic BP is higher than 90 mm Hg.
c. Chronic hypertension is general hypertension plus proteinuria.
d. Chronic hypertension can occur independently of or simultaneously with preeclampsia.

ANS: D

Women with chronic hypertension may develop superimposed preeclampsia, which increases the morbidity for both the mother and the fetus. Chronic hypertension is present before pregnancy or

diagnosed before the 20 weeks of gestation and persists longer than 6 weeks postpartum. Chronic hypertension becomes severe with a diastolic BP of 110 mm Hg or higher. Proteinuria is an excessive concentration of protein in the urine and is a complication of hypertension, not a defining characteristic.

DIF: Cognitive Level: Understand REF: IM: 667

TOP: Nursing Process: Diagnosis | Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

11. Which intervention is *most* important when planning care for a client with severe gestational hypertension?

a. Induction of labor is likely, as near term as possible.
b. If at home, the woman should be confined to her bed, even with mild gestational hypertension.
c. Special diet low in protein and salt should be initiated.
d. Vaginal birth is still an option, even in severe cases.

ANS: A

By 34 weeks of gestation, the risk of continuing the pregnancy may be considered greater than the risks of a preterm birth. Strict bed rest is controversial for mild cases; some women in the hospital are even allowed to move around. Diet and fluid recommendations are essentially the same as for healthy pregnant women, although some authorities have suggested a diet high in protein. Women with severe gestational hypertension should expect a cesarean delivery.

DIF: Cognitive Level: Apply REF: IM: 660 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. What is the primary purpose for magnesium sulfate administration for clients with preeclampsia and eclampsia?

a. To improve patellar reflexes and increase respiratory efficiency

b. To shorten the duration of labor
c. To prevent convulsions
d. To prevent a boggy uterus and lessen lochial flow

ANS: C

Magnesium sulfate is the drug of choice used to prevent convulsions, although it can generate other problems. Loss of patellar reflexes and respiratory depression are signs of magnesium toxicity. Magnesium sulfate can also increase the duration of labor. Women are at risk for a boggy uterus and heavy lochial flow as a result of magnesium sulfate therapy.

DIF: Cognitive Level: Understand REF: IM: 664

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

13. The American College of Obstetricians and Gynecologists (ACOG) has developed a comprehensive list of risk factors associated with the development of preeclampsia. Which client exhibits the greatest number of these risk factors?

a. 30-year-old obese Caucasian with her third pregnancy
b. 41-year-old Caucasian primigravida
c. 19-year-old African American who is pregnant with twins
d. 25-year-old Asian American whose pregnancy is the result of donor insemination

ANS: C

Three risk factors are present in the 19-year-old African-American client. She has African-American ethnicity, is at the young end of the age distribution, and has a multiple pregnancy. In planning care for this client, the nurse must frequently monitor her BP and teach her to recognize the early warning signs of preeclampsia. The 30-year-old obese Caucasian client has only has one known risk factor: obesity. Age distribution appears to be U-shaped, with women younger than 20 years of age and women older than 40 years of age being at greatest risk. Preeclampsia continues to be more frequently observed in primigravidas; this client is a multigravida woman. Two risk factors are present for the 41-year-old Caucasian primigravida client. Her age and

status as a primigravida place her at increased risk for preeclampsia. Caucasian women are at a lower risk than are African-American women. The 25-year-old Asian-American client exhibits only one risk factor. Pregnancies that result from donor insemination, oocyte donation, and embryo donation are at an increased risk of developing preeclampsia.

DIF: Cognitive Level: Analyze REF: IM: 655 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

14. Women with mild gestational hypertension and mild preeclampsia can be safely managed at home with frequent maternal and fetal evaluation. Complete or partial bed rest is still frequently ordered by some providers. Which complication is *rarely* the result of prolonged bed rest?

a. Thrombophlebitis
b. Psychologic stress
c. Fluid retention
d. Cardiovascular deconditioning

ANS: C

No evidence has been found that supports the practice of bed rest to improve pregnancy outcome. Fluid retention is not an adverse outcome of prolonged bed rest. The woman is more likely to experience diuresis with accompanying fluid and electrolyte imbalance and weight loss. Prolonged bed rest is known to increase the risk for thrombophlebitis. Psychologic stress is known to begin on the first day of bed rest and continue for the duration of the therapy. Therefore, restricted activity, rather than complete bed rest, is recommended. Cardiovascular deconditioning is a known complication of bed rest.

DIF: Cognitive Level: Understand REF: IM: 661 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

15. Which neonatal complications are associated with hypertension in the mother?

a. Intrauterine growth restriction (IUGR) and prematurity

b. Seizures and cerebral hemorrhage

c. Hepatic or renal dysfunction

d. Placental abruption and DIC

ANS: A

Neonatal complications are related to placental insufficiency and include IUGR, prematurity, and necrotizing enterocolitis. Seizures and cerebral hemorrhage are maternal complications. Hepatic and renal dysfunction are maternal complications of hypertensive disorders in pregnancy. Placental abruption and DIC are conditions related to maternal morbidity and mortality.

DIF: Cognitive Level: Understand REF: IM: 667

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

16. The nurse has evaluated a client with preeclampsia by assessing DTRs. The result is a grade of 3+. Which DTR response *most* accurately describes this score?

a. Sluggish or diminished

b. Brisk, hyperactive, with intermittent or transient clonus

c. Active or expected response

d. More brisk than expected, slightly hyperactive

ANS: D

DTRs reflect the balance between the cerebral cortex and the spinal cord. They are evaluated at baseline and to detect changes. A slightly hyperactive and brisk response indicates a grade 3+ response.

DIF: Cognitive Level: Apply REF: IM: 660

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

17. A woman with severe preeclampsia has been receiving magnesium sulfate by intravenous infusion for 8 hours. The nurse assesses the client and documents the following findings:

temperature of 37.1 C, pulse rate of 96 beats per minute, respiratory rate of 24 breaths per minute, BP of 155/112 mm Hg, 3+ DTRs, and no ankle clonus. The nurse calls the provider with an update. The nurse should anticipate an order for which medication?

a. Hydralazine
b. Magnesium sulfate bolus
c. Diazepam
d. Calcium gluconate

ANS: A

Hydralazine is an antihypertensive medication commonly used to treat hypertension in severe preeclampsia. Typically, it is administered for a systolic BP higher than 160 mm Hg or a diastolic BP higher than 110 mm Hg. An additional bolus of magnesium sulfate may be ordered for increasing signs of CNS irritability related to severe preeclampsia (e.g., clonus) or if eclampsia develops. Diazepam is sometimes used to stop or shorten eclamptic seizures. Calcium gluconate is used as the antidote for magnesium sulfate toxicity. The client is not currently displaying any signs or symptoms of magnesium toxicity.

DIF: Cognitive Level: Analyze REF: IM: 665 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. The client being cared for has severe preeclampsia and is receiving a magnesium sulfate infusion. Which new finding would give the nurse cause for concern?

a. Sleepy, sedated affect
b. Respiratory rate of 10 breaths per minute
c. DTRs of 2
d. Absent ankle clonus

ANS: B

A respiratory rate of 10 breaths per minute indicates the client is experiencing respiratory depression from magnesium toxicity. Because magnesium sulfate is a CNS depressant, the client will most likely become sedated when the infusion is initiated. DTRs of 2 and absent ankle clonus are normal findings.

DIF: Cognitive Level: Understand REF: IM: 664 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

19. What is the *most* common medical complication of pregnancy?

a. Hypertension
b. Hyperemesis gravidarum
c. Hemorrhagic complications
d. Infections

ANS: A

Preeclampsia and eclampsia are two noted deadly forms of hypertension. A large percentage of pregnant women will have nausea and vomiting, but a relatively few will have the severe form called *hyperemesis gravidarum*. Hemorrhagic complications are the second most common medical complication of pregnancy; hypertension is the most common. Infection is a risk factor for preeclampsia.

DIF: Cognitive Level: Remember REF: IM: 653

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

20. Which statement *most* accurately describes the HELLP syndrome?

a. Mild form of preeclampsia
b. Diagnosed by a nurse alert to its symptoms
c. Characterized by hemolysis, elevated liver enzymes, and low platelets
d. Associated with preterm labor but not perinatal mortality

ANS: C

The acronym HELLP stands for hemolysis (H), elevated liver (EL) enzymes, and low platelets (LP). The HELLP syndrome is a variant of severe preeclampsia and is difficult to identify because the symptoms are not often obvious. The HELLP syndrome must be diagnosed in the laboratory. Preterm labor is greatly increased; therefore, so is perinatal mortality.

DIF: Cognitive Level: Understand REF: IM: 657

TOP: Nursing Process: Diagnosis | Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which adverse prenatal outcomes are associated with the HELLP syndrome? *(Select all that apply.)*

a. Placental abruption
b. Placenta previa
c. Renal failure
d. Cirrhosis
e. Maternal and fetal death

ANS: A, C, E

The HELLP syndrome is associated with an increased risk for adverse perinatal outcomes, including placental abruption, acute renal failure, subcapsular hepatic hematoma, hepatic rupture, recurrent preeclampsia, preterm birth, and fetal and maternal death. The HELLP syndrome is associated with an increased risk for placental abruption, not placenta previa. It is also associated with an increased risk for hepatic hematoma, not cirrhosis.

DIF: Cognitive Level: Analyze REF: IM: 658

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. One of the most important components of the physical assessment of the pregnant client is the determination of BP. Consistency in measurement techniques must be maintained to ensure that the nuances in the variations of the BP readings are not the result of provider error. Which techniques are important in obtaining accurate BP readings? *(Select all that apply.)*

a. The client should be seated.
b. The clients arm should be placed at the level of the heart.
c. An electronic BP device should be used.
d. The cuff should cover a minimum of 60% of the upper arm.
e. The same arm should be used for every reading.

ANS: A, B, E

BP readings are easily affected by maternal position. Ideally, the client should be seated. An alternative position is left lateral recumbent with the arm at the level of the heart. The arm should always be held in a horizontal position at approximately the level of the heart. The same arm should be used at every visit. The manual sphygmomanometer is the most accurate device. If manual and electronic devices are used in the care setting, then the nurse must use caution when interpreting the readings. A proper size cuff should cover at least 80% of the upper arm or be approximately 1.5 times the length of the upper arm.

Chapter 28: Hemorrhagic Disorders

MULTIPLE CHOICE

1. A pregnant woman is being discharged from the hospital after the placement of a cervical cerclage because of a history of recurrent pregnancy loss, secondary to an incompetent cervix. Which information regarding postprocedural care should the nurse emphasize in the discharge teaching?

a. Any vaginal discharge should be immediately reported to her health care provider.
b. The presence of any contractions, rupture of membranes (ROM), or severe perineal pressure should be reported.
c. The client will need to make arrangements for care at home, because her activity level will be restricted.
d. The client will be scheduled for a cesarean birth.

ANS: B

Nursing care should stress the importance of monitoring for the signs and symptoms of preterm labor. Vaginal bleeding needs to be reported to her primary health care provider. Bed rest is an element of care. However, the woman may stand for periods of up to 90 minutes, which allows her the freedom to see her physician. Home uterine activity monitoring may be used to limit the womans need for visits and to monitor her status safely at home. The cerclage can be removed at 37 weeks of gestation (to prepare for a vaginal birth), or a cesarean birth can be planned.

DIF: Cognitive Level: Apply REF: IM: 675

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Health Promotion and Maintenance

2. A perinatal nurse is giving discharge instructions to a woman, status postsuction, and curettage secondary to a hydatidiform mole. The woman asks why she must take oral contraceptives for the next 12 months. What is the *best*response by the nurse?

a. If you get pregnant within 1 year, the chance of a successful pregnancy is very small. Therefore, if you desire a future pregnancy, it would be better for you to use the most reliable method of contraception available.
b. The major risk to you after a molar pregnancy is a type of cancer that can be diagnosed only by measuring the same hormone that your body produces during pregnancy. If you were to get pregnant, then it would make the diagnosis of this cancer more difficult.
c. If you can avoid a pregnancy for the next year, the chance of developing a second molar pregnancy is rare. Therefore, to improve your chance of a successful pregnancy, not getting pregnant at this time is best.

d. Oral contraceptives are the only form of birth control that will prevent a recurrence of a molar pregnancy.

ANS: B

Betahuman chorionic gonadotropin (beta-hCG) hormone levels are drawn for 1 year to ensure that the mole is completely gone. The chance of developing choriocarcinoma after the development of a hydatidiform mole is increased. Therefore, the goal is to achieve a zero human chorionic gonadotropin (hCG) level. If the woman were to become pregnant, then it may obscure the presence of the potentially carcinogenic cells. Women should be instructed to use birth control for 1 year after treatment for a hydatidiform mole. The rationale for avoiding pregnancy for 1 year is to ensure that carcinogenic cells are not present. Any contraceptive method except an intrauterine device (IUD) is acceptable.

DIF: Cognitive Level: Apply REF: IM: 679

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

3. The nurse is preparing to administer methotrexate to the client. This hazardous drug is *most* often used for which obstetric complication?

a. Complete hydatidiform mole
b. Missed abortion
c. Unruptured ectopic pregnancy
d. Abruptio placentae

ANS: C

Methotrexate is an effective nonsurgical treatment option for a hemodynamically stable woman whose ectopic pregnancy is unruptured and measures less than 4 cm in diameter. Methotrexate is not indicated or recommended as a treatment option for a complete hydatidiform mole, for a missed abortion, or for abruptio placentae.

DIF: Cognitive Level: Apply REF: IM: 677 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. A 26-year-old pregnant woman, gravida 2, para 1-0-0-1, is 28 weeks pregnant when she experiences bright red, painless vaginal bleeding. On her arrival at the hospital, which diagnostic procedure will the client *most* likely have performed?

a. Amniocentesis for fetal lung maturity
b. Transvaginal ultrasound for placental location
c. Contraction stress test (CST)
d. Internal fetal monitoring

ANS: B

The presence of painless bleeding should always alert the health care team to the possibility of placenta previa, which can be confirmed through ultrasonography. Amniocentesis is not performed on a woman who is experiencing bleeding. In the event of an imminent delivery, the fetus is presumed to have immature lungs at this gestational age, and the mother is given corticosteroids to aid in fetal lung maturity. A CST is not performed at a preterm gestational age. Furthermore, bleeding is a contraindication to a CST. Internal fetal monitoring is also contraindicated in the presence of bleeding.

DIF: Cognitive Level: Apply REF: IM: 680

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

5. A laboring woman with no known risk factors suddenly experiences spontaneous ROM. The fluid consists of bright red blood. Her contractions are consistent with her current stage of labor. No change in uterine resting tone has occurred. The fetal heart rate (FHR) begins to decline rapidly after the ROM. The nurse should suspect the possibility of what condition?

a. Placenta previa
b. Vasa previa
c. Severe abruptio placentae

d. Disseminated intravascular coagulation (DIC)

ANS: B

Vasa previa is the result of a velamentous insertion of the umbilical cord. The umbilical vessels are not surrounded by Wharton jelly and have no supportive tissue. The umbilical blood vessels thus are at risk for laceration at any time, but laceration occurs most frequently during ROM. The sudden appearance of bright red blood at the time of ROM and a sudden change in the FHR without other known risk factors should immediately alert the nurse to the possibility of vasa previa. The presence of placenta previa most likely would be ascertained before labor and is considered a risk factor for this pregnancy. In addition, if the woman had a placenta previa, it is unlikely that she would be allowed to pursue labor and a vaginal birth. With the presence of severe abruptio placentae, the uterine tonicity typically is tetanus (i.e., a boardlike uterus). DIC is a pathologic form of diffuse clotting that consumes large amounts of clotting factors, causing widespread external bleeding, internal bleeding, or both. DIC is always a secondary diagnosis, often associated with obstetric risk factors such as the hemolysis, elevated liver enzyme levels, and low platelet levels (HELLP) syndrome. This woman did not have any prior risk factors.

DIF: Cognitive Level: Analyze REF: IM: 684 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

6. A woman arrives for evaluation of signs and symptoms that include a missed period, adnexal fullness, tenderness, and dark red vaginal bleeding. On examination, the nurse notices an ecchymotic blueness around the womans umbilicus. What does this finding indicate?

a. Normal integumentary changes associated with pregnancy
b. Turner sign associated with appendicitis
c. Cullen sign associated with a ruptured ectopic pregnancy
d. Chadwick sign associated with early pregnancy

ANS: C

Cullen sign, the blue ecchymosis observed in the umbilical area, indicates hematoperitoneum associated with an undiagnosed ruptured intraabdominal ectopic pregnancy. Linea nigra on the

abdomen is the normal integumentary change associated with pregnancy and exhibits a brown pigmented, vertical line on the lower abdomen. Turner sign is ecchymosis in the flank area, often associated with pancreatitis. A Chadwick sign is a blue-purple cervix that may be seen during or around the eighth week of pregnancy.

DIF: Cognitive Level: Analyze REF: IM: 676

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

7. The nurse who elects to practice in the area of womens health must have a thorough understanding of miscarriage. Which statement regarding this condition is *most* accurate?

a. A miscarriage is a natural pregnancy loss before labor begins.
b. It occurs in fewer than 5% of all clinically recognized pregnancies.
c. Careless maternal behavior, such as poor nutrition or excessive exercise, can be a factor in causing a miscarriage.
d. If a miscarriage occurs before the 12th week of pregnancy, then it may be observed only as moderate discomfort and blood loss.

ANS: D

Before the sixth week, the only evidence might be a heavy menstrual flow. After the 12th week, more severe pain, similar to that of labor, is likely. Miscarriage is a natural pregnancy loss, but it occurs, by definition, before 20 weeks of gestation, before the fetus is viable. Miscarriages occur in approximately 10% to 15% of all clinically recognized pregnancies. Miscarriages can be caused by a number of disorders or illnesses outside the mothers control or knowledge.

DIF: Cognitive Level: Understand REF: IM: 670

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

8. A woman who is 30 weeks of gestation arrives at the hospital with bleeding. Which differential diagnosis would *not* be applicable for this client?

a. Placenta previa
b. Abruptio placentae

c. Spontaneous abortion

d. Cord insertion

ANS: C

Spontaneous abortion is another name for miscarriage; it occurs, by definition, early in pregnancy. Placenta previa is a well-known reason for bleeding late in pregnancy. The premature separation of the placenta (abruptio placentae) is a bleeding disorder that can occur late in pregnancy. Cord insertion may cause a bleeding disorder that can also occur late in pregnancy.

DIF: Cognitive Level: Understand REF: IM: 669

TOP: Nursing Process: Assessment

MSC: Client Needs: Physiologic Integrity, Physiologic Adaptation

9. With regard to hemorrhagic complications that may occur during pregnancy, what information is *most* accurate?

a. An incompetent cervix is usually not diagnosed until the woman has lost one or two pregnancies.

b. Incidences of ectopic pregnancy are declining as a result of improved diagnostic techniques.

c. One ectopic pregnancy does not affect a womans fertility or her likelihood of having a normal pregnancy the next time.

d. Gestational trophoblastic neoplasia (GTN) is one of the persistently incurable gynecologic malignancies.

ANS: A

Short labors and recurring losses of pregnancy at progressively earlier gestational ages are characteristics of reduced cervical competence. Because diagnostic technology is improving, more ectopic pregnancies are being diagnosed. One ectopic pregnancy places the woman at increased risk for another one. Ectopic pregnancy is a leading cause of infertility. Once invariably fatal, GTN now is the most curable gynecologic malignancy.

DIF: Cognitive Level: Understand REF: IM: 675

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. The management of the pregnant client who has experienced a pregnancy loss depends on the type of miscarriage and the signs and symptoms. While planning care for a client who desires outpatient management after a first-trimester loss, what would the nurse expect the plan to include?

a. Dilation and curettage (D&C)
b. Dilation and evacuation (D&E)
c. Misoprostol
d. Ergot products

ANS: C

Outpatient management of a first-trimester loss is safely accomplished by the intravaginal use of misoprostol for up to 2 days. If the bleeding is uncontrollable, vital signs are unstable, or signs of infection are present, then a surgical evacuation should be performed. D&C is a surgical procedure that requires dilation of the cervix and scraping of the uterine walls to remove the contents of pregnancy. This procedure is commonly performed to treat inevitable or incomplete abortion and should be performed in a hospital. D&E is usually performed after 16 weeks of pregnancy. The cervix is widely dilated, followed by removal of the contents of the uterus. Ergot products such as Methergine or Hemabate may be administered for excessive bleeding after miscarriage.

DIF: Cognitive Level: Apply REF: IM: 672 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

11. Which laboratory marker is indicative of DIC?

a. Bleeding time of 10 minutes
b. Presence of fibrin split products
c. Thrombocytopenia

d. Hypofibrinogenemia

ANS: B

Degradation of fibrin leads to the accumulation of multiple fibrin clots throughout the bodys vasculature. Bleeding time in DIC is normal. Low platelets may occur but are not indicative of DIC because they may be the result from other coagulopathies. Hypofibrinogenemia occurs with DIC.

DIF: Cognitive Level: Remember REF: IM: 684

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

12. When is a prophylactic cerclage for an incompetent cervix usually placed (in weeks of gestation)?

a. 12 to 14
b. 6 to 8
c. 23 to 24
d. After 24

ANS: A

A prophylactic cerclage is usually placed at 12 to 14 weeks of gestation. The cerclage is electively removed when the woman reaches 37 weeks of gestation or when her labor begins. Six to 8 weeks of gestation is too early to place the cerclage. Cerclage placement is offered if the cervical length falls to less than 20 to 25 mm before 23 to 24 weeks. Although no consensus has been reached, 24 weeks is used as the upper gestational age limit for cerclage placement.

DIF: Cognitive Level: Apply REF: IM: 674 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. In caring for an immediate postpartum client, the nurse notes petechiae and oozing from her intravenous (IV) site. The client would be closely monitored for which clotting disorder?

a. DIC
b. Amniotic fluid embolism (AFE)
c. Hemorrhage
d. HELLP syndrome

ANS: A

The diagnosis of DIC is made according to clinical findings and laboratory markers. A physical examination reveals unusual bleeding. Petechiae may appear around a blood pressure cuff on the womans arm. Excessive bleeding may occur from the site of slight trauma such as venipuncture sites. These symptoms are not associated with AFE, nor is AFE a bleeding disorder. Hemorrhage occurs for a variety of reasons in the postpartum client. These symptoms are associated with DIC. Hemorrhage would be a finding associated with DIC and is not a clotting disorder in and of itself. HELLP syndrome is not a clotting disorder, but it may contribute to the clotting disorder DIC.

DIF: Cognitive Level: Understand REF: IM: 685 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

14. In caring for the woman with DIC, which order should the nurse anticipate?

a. Administration of blood
b. Preparation of the client for invasive hemodynamic monitoring
c. Restriction of intravascular fluids
d. Administration of steroids

ANS: A

Primary medical management in all cases of DIC involves a correction of the underlying cause, volume replacement, blood component therapy, optimization of oxygenation and perfusion status, and continued reassessment of laboratory parameters. Central monitoring would not be initially ordered in a client with DIC because it could contribute to more areas of bleeding.

Management of DIC would include volume replacement, not volume restriction. Steroids are not indicated for the management of DIC.

DIF: Cognitive Level: Apply REF: pp. 685-686 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

15. A woman arrives at the emergency department with complaints of bleeding and cramping. The initial nursing history is significant for a last menstrual period 6 weeks ago. On sterile speculum examination, the primary care provider finds that the cervix is closed. The anticipated plan of care for this woman would be based on a probable diagnosis of which type of spontaneous abortion?

a. Incomplete
b. Inevitable
c. Threatened
d. Septic

ANS: C

A woman with a threatened abortion has spotting, mild cramps, and no cervical dilation. A woman with an incomplete abortion would have heavy bleeding, mild-to-severe cramping, and cervical dilation. An inevitable abortion demonstrates the same symptoms as an incomplete abortion: heavy bleeding, mild-to-severe cramping, and cervical dilation. A woman with a septic abortion has malodorous bleeding and typically a dilated cervix.

DIF: Cognitive Level: Understand REF: IM: 670 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

16. In contrast to placenta previa, what is the *most* prevalent clinical manifestation of abruptio placentae?

a. Bleeding
b. Intense abdominal pain

c. Uterine activity
d. Cramping

ANS: B

Pain is absent with placenta previa and may be agonizing with abruptio placentae. Bleeding may be present in varying degrees for both placental conditions. Uterine activity and cramping may be present with both placental conditions.

DIF: Cognitive Level: Understand REF: IM: 683 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

17. Which maternal condition always necessitates delivery by cesarean birth?

a. Marginal placenta previa
b. Complete placenta previa
c. Ectopic pregnancy
d. Eclampsia

ANS: B

In complete placenta previa, the placenta completely covers the cervical os. A cesarean birth is the acceptable method of delivery. The risk of fetal death occurring is due to preterm birth. If the previa is marginal (i.e., 2 cm or greater away from the cervical os), then labor can be attempted. A cesarean birth is not indicated for an ectopic pregnancy. Labor can be safely induced if the eclampsia is under control.

DIF: Cognitive Level: Understand REF: IM: 681

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

18. What is the *correct* definition of a spontaneous termination of a pregnancy (abortion)?

a. Pregnancy is less than 20 weeks.

b. Fetus weighs less than 1000 g.
c. Products of conception are passed intact.
d. No evidence exists of intrauterine infection.

ANS: A

An abortion is the termination of pregnancy before the age of viability (20 weeks). The weight of the fetus is not considered because some older fetuses may have a low birth weight. A spontaneous abortion may be complete or incomplete and may be caused by many problems, one being intrauterine infection.

DIF: Cognitive Level: Remember REF: IM: 669

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

19. What is the *correct* terminology for an abortion in which the fetus dies but is retained within the uterus?

a. Inevitable abortion
b. Missed abortion
c. Incomplete abortion
d. Threatened abortion

ANS: B

Missed abortion refers to the retention of a dead fetus in the uterus. An inevitable abortion means that the cervix is dilating with the contractions. An incomplete abortion means that not all of the products of conception were expelled. With a threatened abortion, the woman has cramping and bleeding but no cervical dilation.

DIF: Cognitive Level: Remember REF: IM: 670

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

20. What condition indicates concealed hemorrhage when the client experiences abruptio placentae?

a. Decrease in abdominal pain
b. Bradycardia
c. Hard, boardlike abdomen
d. Decrease in fundal height

ANS: C

Concealed hemorrhage occurs when the edges of the placenta do not separate. The formation of a hematoma behind the placenta and subsequent infiltration of the blood into the uterine muscle results in a very firm, boardlike abdomen. Abdominal pain may increase. The client will have shock symptoms that include tachycardia. As bleeding occurs, the fundal height increases.

DIF: Cognitive Level: Analyze REF: IM: 683

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

21. What is the *highest* priority nursing intervention when admitting a pregnant woman who has experienced a bleeding episode in late pregnancy?

a. Assessing FHR and maternal vital signs
b. Performing a venipuncture for hemoglobin and hematocrit levels
c. Placing clean disposable pads to collect any drainage
d. Monitoring uterine contractions

ANS: A

Assessment of the FHR and maternal vital signs will assist the nurse in determining the degree of the blood loss and its effect on the mother and fetus. The most important assessment is to check the well-being of both the mother and the fetus. The blood levels can be obtained later. Assessing future bleeding is important; however, the top priority remains mother/fetal well-being. Monitoring uterine contractions is important but not a top priority.

DIF: Cognitive Level: Apply REF: IM: 681

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

22. Which order should the nurse expect for a client admitted with a threatened abortion?

a. Bed rest
b. Administration of ritodrine IV
c. Nothing by mouth (*nil per os* [NPO])
d. Narcotic analgesia every 3 hours, as needed

ANS: A

Decreasing the womans activity level may alleviate the bleeding and allow the pregnancy to continue. Ritodrine is not the first drug of choice for tocolytic medications. Having the woman placed on NPO is unnecessary. At times, dehydration may produce contractions; therefore, hydration is important. Narcotic analgesia will not decrease the contractions and may mask the severity of the contractions.

DIF: Cognitive Level: Understand REF: pp. 671-672 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

23. Which finding on a prenatal visit at 10 weeks of gestation might suggest a hydatidiform mole?

a. Complaint of frequent mild nausea
b. Blood pressure of 120/80 mm Hg
c. Fundal height measurement of 18 cm
d. History of bright red spotting for 1 day, weeks ago

ANS: C

The uterus in a hydatidiform molar pregnancy is often larger than would be expected on the basis of the duration of the pregnancy. Nausea increases in a molar pregnancy because of the increased

production of hCG. A woman with a molar pregnancy may have early-onset pregnancy-induced hypertension. In the clients history, bleeding is normally described as brownish.

DIF: Cognitive Level: Analyze REF: IM: 678

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

24. A 32-year-old primigravida is admitted with a diagnosis of ectopic pregnancy. Which information assists the nurse in developing the plan of care?

a. Bed rest and analgesics are the recommended treatment.
b. She will be unable to conceive in the future.
c. A D&C will be performed to remove the products of conception.
d. Hemorrhage is the primary concern.

ANS: D

Severe bleeding occurs if the fallopian tube ruptures. The recommended treatment is to remove the pregnancy before rupture to prevent hemorrhaging. If the tube must be removed, then the womans fertility will decrease; however, she will not be infertile. A D&C is performed on the inside of the uterine cavity. The ectopic pregnancy is located within the tubes.

DIF: Cognitive Level: Apply REF: IM: 676 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A client who has undergone a D&C for early pregnancy loss is likely to be discharged the same day. The nurse must ensure that her vital signs are stable, that bleeding has been controlled, and that the woman has adequately recovered from the administration of anesthesia. To promote an optimal recovery, what information should discharge teaching include? *(Select all that apply.)*

a. Iron supplementation
b. Resumption of intercourse at 6 weeks postprocedure

c. Referral to a support group, if necessary
d. Expectation of heavy bleeding for at least 2 weeks
e. Emphasizing the need for rest

ANS: A, C, E

The woman should be advised to consume a diet high in iron and protein. For many women, iron supplementation also is necessary. The nurse should acknowledge that the client has experienced a loss, however early. She can be taught to expect mood swings and possibly depression. Referral to a support group, clergy, or professional counseling may be necessary. Discharge teaching should emphasize the need for rest. Nothing should be placed in the vagina for 2 weeks after the procedure, including tampons and vaginal intercourse. The purpose of this recommendation is to prevent infection. Should infection occur, antibiotics may be prescribed. The client should expect a scant, dark discharge for 1 to 2 weeks. Should heavy, profuse, or bright bleeding occur, she should be instructed to contact her health care provider.

DIF: Cognitive Level: Apply REF: IM: 672

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. Approximately 10% to 15% of all clinically recognized pregnancies end in miscarriage. What are possible causes of early miscarriage? *(Select all that apply.)*

a. Chromosomal abnormalities
b. Infections
c. Endocrine imbalance
d. Systemic disorders
e. Varicella

ANS: A, C, D, E

Infections are not a common cause of early miscarriage. At least 50% of pregnancy losses result from chromosomal abnormalities. Endocrine imbalances such as hypothyroidism or diabetes are also possible causes for early pregnancy loss. Other systemic disorders that may contribute to

pregnancy loss include lupus and genetic conditions. Although infections are not a common cause of early miscarriage, varicella infection in the first trimester has been associated with pregnancy loss.

DIF: Cognitive Level: Remember REF: IM: 669

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. The reported incidence of ectopic pregnancy has steadily risen over the past 2 decades. Causes include the increase in sexually transmitted infections (STIs) accompanied by tubal infection and damage. The popularity of contraceptive devices such as the IUD has also increased the risk for ectopic pregnancy. The nurse suspects that a client has early signs of ectopic pregnancy. The nurse should be observing the client for which signs or symptoms? *(Select all that apply.)*

a. Pelvic pain
b. Abdominal pain
c. Unanticipated heavy bleeding
d. Vaginal spotting or light bleeding
e. Missed period

ANS: A, B, D, E

A missed period or spotting can be easily mistaken by the client as an early sign of pregnancy. More subtle signs depend on exactly where the implantation occurs. The nurse must be thorough in her assessment because pain is not a normal symptom of early pregnancy. As the fallopian tube tears open and the embryo is expelled, the client often exhibits severe pain accompanied by intraabdominal hemorrhage, which may progress to hypovolemic shock with minimal or even no external bleeding. In approximately one half of women, shoulder and neck pain results from irritation of the diaphragm from the hemorrhage.

Chapter 29: Endocrine and Metabolic Disorders

MULTIPLE CHOICE

1. Preconception counseling is critical in the safe management of diabetic pregnancies. Which complication is commonly associated with poor glycemic control before and during early pregnancy?

a. Frequent episodes of maternal hypoglycemia
b. Congenital anomalies in the fetus
c. Hydramnios
d. Hyperemesis gravidarum

ANS: B

Preconception counseling is particularly important since strict metabolic control before conception and in the early weeks of gestation is instrumental in decreasing the risk of congenital anomalies. Frequent episodes of maternal hypoglycemia may occur during the first trimester (not before conception) as a result of hormonal changes and the effects on insulin production and use. Hydramnios occurs approximately 10 times more often in diabetic pregnancies than in nondiabetic pregnancies. Typically, it is observed in the third trimester of pregnancy. Hyperemesis gravidarum may exacerbate hypoglycemic events because the decreased food intake by the mother and glucose transfer to the fetus contribute to hypoglycemia.

DIF: Cognitive Level: Understand REF: IM: 687 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

2. During a prenatal visit, the nurse is explaining dietary management to a woman with pregestational diabetes. Which statement by the client reassures the nurse that teaching has been effective?

a. I will need to eat 600 more calories per day because I am pregnant.
b. I can continue with the same diet as before pregnancy as long as it is well balanced.
c. Diet and insulin needs change during pregnancy.
d. I will plan my diet based on the results of urine glucose testing.

ANS: C

Diet and insulin needs change during the pregnancy in direct correlation to hormonal changes and energy needs. In the third trimester, insulin needs may double or even quadruple. The diet is individualized to allow for increased fetal and metabolic requirements, with consideration of such factors as prepregnancy weight and dietary habits, overall health, ethnic background, lifestyle, stage of pregnancy, knowledge of nutrition, and insulin therapy. Energy needs are usually calculated on the basis of 30 to 35 calories per kilogram of ideal body weight. Dietary management during a diabetic pregnancy must be based on blood, not urine, glucose changes.

DIF: Cognitive Level: Analyze REF: IM: 689 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

3. Screening at 24 weeks of gestation reveals that a pregnant woman has gestational diabetes mellitus (GDM). In planning her care, the nurse and the client mutually agree that an expected outcome is to prevent injury to the fetus as a result of GDM. This fetus is at the greatest risk for which condition?

a. Macrosomia
b. Congenital anomalies of the central nervous system
c. Preterm birth
d. Low birth weight

ANS: A

Poor glycemic control later in pregnancy increases the rate of fetal macrosomia. Poor glycemic control during the preconception time frame and into the early weeks of the pregnancy is associated with congenital anomalies. Preterm labor or birth is more likely to occur with severe diabetes and is the greatest risk in women with pregestational diabetes. Increased weight, or macrosomia, is the greatest risk factor for this fetus.

DIF: Cognitive Level: Understand REF: IM: 690

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

4. A 26-year-old primigravida has come to the clinic for her regular prenatal visit at 12 weeks. She appears thin and somewhat nervous. She reports that she eats a well-balanced diet, although her weight is 5 pounds less than it was at her last visit. The results of laboratory studies confirm that she has a hyperthyroid condition. Based on the available data, the nurse formulates a plan of care. Which nursing diagnosis is *most* appropriate for the client at this time?

a. Deficient fluid volume
b. Imbalanced nutrition: less than body requirements
c. Imbalanced nutrition: more than body requirements
d. Disturbed sleep pattern

ANS: B

This clients clinical cues include weight loss, which supports a nursing diagnosis of Imbalanced nutrition: less than body requirements. No clinical signs or symptoms support a nursing diagnosis of deficient fluid volume. This client reports weight loss, not weight gain. Although the client reports nervousness, the most appropriate nursing diagnosis, based on the clients other clinical symptoms, is Imbalanced nutrition: less than body requirements.

DIF: Cognitive Level: Analyze REF: IM: 706 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

5. A client with maternal phenylketonuria (PKU) has come to the obstetrical clinic to begin prenatal care. Why would this preexisting condition result in the need for closer monitoring during pregnancy?

a. PKU is a recognized cause of preterm labor.
b. The fetus may develop neurologic problems.
c. A pregnant woman is more likely to die without strict dietary control.
d. Women with PKU are usually mentally handicapped and should not reproduce.

ANS: B

Children born to women with untreated PKU are more likely to be born with mental retardation, microcephaly, congenital heart disease, and low birth weight. Maternal PKU has no effect on labor. Women without dietary control of PKU are more likely to miscarry or bear a child with congenital anomalies. Screening for undiagnosed maternal PKU at the first prenatal visit may be warranted, especially in individuals with a family history of the disorder, with low intelligence of an uncertain cause, or who have given birth to microcephalic infants.

DIF: Cognitive Level: Understand REF: IM: 707

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. The nurse who is caring for a woman hospitalized for hyperemesis gravidarum would expect the initial treatment to involve what?

a. Corticosteroids to reduce inflammation
b. Intravenous (IV) therapy to correct fluid and electrolyte imbalances
c. Antiemetic medication, such as pyridoxine, to control nausea and vomiting
d. Enteral nutrition to correct nutritional deficits

ANS: B

Initially, the woman who is unable to down clear liquids by mouth requires IV therapy to correct fluid and electrolyte imbalances. Corticosteroids have been successfully used to treat refractory hyperemesis gravidarum, but they are not the expected initial treatment for this disorder. Pyridoxine is vitamin B_6, not an antiemetic medication. Promethazine, a common antiemetic, may be prescribed. In severe cases of hyperemesis gravidarum, enteral nutrition via a feeding tube may be necessary to correct maternal nutritional deprivation but is not the initial treatment for this client.

DIF: Cognitive Level: Apply REF: IM: 705

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

7. In terms of the incidence and classification of diabetes, which information should the nurse keep in mind when evaluating clients during their ongoing prenatal appointments?

a. Type 1 diabetes is most common.
b. Type 2 diabetes often goes undiagnosed.
c. GDM means that the woman will receive insulin treatment until 6 weeks after birth.
d. Type 1 diabetes may become type 2 during pregnancy.

ANS: B

Type 2 diabetes often goes undiagnosed because hyperglycemia gradually develops and is often not severe. Type 2, sometimes called *adult-onset diabetes*, is the most common type of diabetes. GDM refers to any degree of glucose intolerance first recognized during pregnancy; insulin may or may not be needed. People do not go back and forth between type 1 and type 2 diabetes.

DIF: Cognitive Level: Apply REF: IM: 688

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

8. A number of metabolic changes occur throughout pregnancy. Which physiologic adaptation of pregnancy will influence the nurses plan of care?

a. Insulin crosses the placenta to the fetus only in the first trimester, after which the fetus secretes its own.
b. Women with insulin-dependent diabetes are prone to hyperglycemia during the first trimester because they are consuming more sugar.
c. During the second and third trimesters, pregnancy exerts a diabetogenic effect that ensures an abundant supply of glucose for the fetus.
d. Maternal insulin requirements steadily decline during pregnancy.

ANS: C

Pregnant women develop increased insulin resistance during the second and third trimesters. Insulin never crosses the placenta; the fetus starts making its own around the 10th week. As a result of normal metabolic changes during pregnancy, insulin-dependent women are prone to

hypoglycemia (low levels). Maternal insulin requirements may double or quadruple by the end of pregnancy.

DIF: Cognitive Level: Understand REF: IM: 689 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

9. Which statement concerning the complication of maternal diabetes is the *most* accurate?

a. Diabetic ketoacidosis (DKA) can lead to fetal death at any time during pregnancy.
b. Hydramnios occurs approximately twice as often in diabetic pregnancies than in nondiabetic pregnancies.
c. Infections occur about as often and are considered about as serious in both diabetic and nondiabetic pregnancies.
d. Even mild-to-moderate hypoglycemic episodes can have significant effects on fetal well-being.

ANS: A

Prompt treatment of DKA is necessary to save the fetus and the mother. Hydramnios occurs 10 times more often in diabetic pregnancies. Infections are more common and more serious in pregnant women with diabetes. Mild-to-moderate hypoglycemic episodes do not appear to have significant effects on fetal well-being.

DIF: Cognitive Level: Understand REF: IM: 691 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

10. Which statement regarding the laboratory test for glycosylated hemoglobin A_{lc} is *correct*?

a. The laboratory test for glycosylated hemoglobin A_{lc} is performed for all pregnant women, not only those with or likely to have diabetes.
b. This laboratory test is a snapshot of glucose control at the moment.
c. This laboratory test measures the levels of hemoglobin A_{lc}, which should remain at less than 7%.

d. This laboratory test is performed on the womans urine, not her blood.

ANS: C

Hemoglobin A_{1c} levels greater than 7% indicate an elevated glucose level during the previous 4 to 6 weeks. This extra laboratory test is for diabetic women and defines glycemic control over the previous 4 to 6 weeks. Glycosylated hemoglobin level tests are performed on the blood.

DIF: Cognitive Level: Understand REF: IM: 692 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

11. A new mother with a thyroid disorder has come for a lactation follow-up appointment. Which thyroid disorder is a contraindication for breastfeeding?

a. Hyperthyroidism
b. PKU
c. Hypothyroidism
d. Thyroid storm

ANS: B

PKU is a cause of mental retardation in infants; mothers with PKU pass on phenylalanine and therefore should elect not to breastfeed. A woman with either hyperthyroidism or hypothyroidism would have no particular reason not to breastfeed. A thyroid storm is a complication of hyperthyroidism and is not a contraindication to breastfeeding.

DIF: Cognitive Level: Understand REF: IM: 708 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

12. An 18-year-old client who has reached 16 weeks of gestation was recently diagnosed with pregestational diabetes. She attends her centering appointment accompanied by one of her girlfriends. This young woman appears more concerned about how her pregnancy will affect her

social life than her recent diagnosis of diabetes. A number of nursing diagnoses are applicable to assist in planning adequate care. What is the *most* appropriate diagnosis at this time?

a. Risk for injury, to the fetus related to birth trauma
b. Deficient knowledge, related to diabetic pregnancy management
c. Deficient knowledge, related to insulin administration
d. Risk for injury, to the mother related to hypoglycemia or hyperglycemia

ANS: B

Before a treatment plan is developed or goals for the outcome of care are outlined, this client must come to an understanding of diabetes and the potential effects on her pregnancy. She appears more concerned about changes to her social life than adopting a new self-care regimen. Risk for injury to the fetus related to either placental insufficiency or birth trauma may come later in the pregnancy. At this time, the client is having difficulty acknowledging the adjustments that she needs to make to her lifestyle to care for herself during pregnancy. The client may not yet be on insulin. Insulin requirements increase with gestation. The importance of glycemic control must be part of health teaching for this client. However, she has not yet acknowledged that changes to her lifestyle need to be made and may not participate in the plan of care until understanding takes place.

DIF: Cognitive Level: Analyze REF: IM: 693 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

13. A woman with gestational diabetes has had little or no experience reading and interpreting glucose levels. The client shows the nurse her readings for the past few days. Which reading signals the nurse that the client may require an adjustment of insulin or carbohydrates?

a. 75 mg/dl before lunch. This is low; better eat now.
b. 115 mg/dl 1 hour after lunch. This is a little high; maybe eat a little less next time.
c. 115 mg/dl 2 hours after lunch. This is too high; it is time for insulin.
d. 50 mg/dl just after waking up from a nap. This is too low; maybe eat a snack before going to sleep.

ANS: D

50 mg/dl after waking from a nap is too low. During hours of sleep, glucose levels should not be less than 60 mg/dl. Snacks before sleeping can be helpful. The premeal acceptable range is 60 to 99 mg/dl. The readings 1 hour after a meal should be less than 129 mg/dl. Two hours after eating, the readings should be less than 120 mg/dl.

DIF: Cognitive Level: Apply REF: IM: 693 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

14. Which major neonatal complication is carefully monitored after the birth of the infant of a diabetic mother?

a. Hypoglycemia
b. Hypercalcemia
c. Hypobilirubinemia
d. Hypoinsulinemia

ANS: A

The neonate is at highest risk for hypoglycemia because fetal insulin production is accelerated during pregnancy to metabolize excessive glucose from the mother. At birth, the maternal glucose supply stops and the neonatal insulin exceeds the available glucose, thus leading to hypoglycemia. Hypocalcemia is associated with preterm birth, birth trauma, and asphyxia, all common problems of the infant of a diabetic mother. Excess erythrocytes are broken down after birth, and large amounts of bilirubin are released into the neonates circulation, with resulting hyperbilirubinemia. Because fetal insulin production is accelerated during pregnancy, hyperinsulinemia develops in the neonate.

DIF: Cognitive Level: Apply REF: IM: 698 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

15. Which preexisting factor is known to increase the risk of GDM?

a. Underweight before pregnancy
b. Maternal age younger than 25 years
c. Previous birth of large infant
d. Previous diagnosis of type 2 diabetes mellitus

ANS: C

A previous birth of a large infant suggests GDM. Obesity (body mass index [BMI] of 30 or greater) creates a higher risk for gestational diabetes. A woman younger than 25 years is not generally at risk for GDM. The person with type 2 diabetes mellitus already has diabetes and thus will continue to have it after pregnancy. Insulin may be required during pregnancy because oral hypoglycemia drugs are contraindicated during pregnancy.

DIF: Cognitive Level: Understand REF: IM: 699

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

16. Which physiologic alteration of pregnancy *most* significantly affects glucose metabolism?

a. Pancreatic function in the islets of Langerhans is affected by pregnancy.
b. Pregnant women use glucose at a more rapid rate than nonpregnant women.
c. Pregnant women significantly increase their dietary intake.
d. Placental hormones are antagonistic to insulin, thus resulting in insulin resistance.

ANS: D

Placental hormones, estrogen, progesterone, and human placental lactogen (HPL) create insulin resistance. Insulin is also broken down more quickly by the enzyme placental insulinase. Pancreatic functioning is not affected by pregnancy. The glucose requirements differ because of the growing fetus. The pregnant woman should increase her intake by 200 calories a day.

DIF: Cognitive Level: Understand REF: IM: 699

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

17. To manage her diabetes appropriately and to ensure a good fetal outcome, how would the pregnant woman with diabetes alter her diet?

a. Eat six small equal meals per day.
b. Reduce the carbohydrates in her diet.
c. Eat her meals and snacks on a fixed schedule.
d. Increase her consumption of protein.

ANS: C

Having a fixed meal schedule will provide the woman and the fetus with a steady blood sugar level, provide a good balance with insulin administration, and help prevent complications. Having a fixed meal schedule is more important than the equal division of food intake. Approximately 45% of the food eaten should be in the form of carbohydrates.

DIF: Cognitive Level: Understand REF: IM: 693 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. A serious but uncommon complication of undiagnosed or partially treated hyperthyroidism is a thyroid storm, which may occur in response to stress such as infection, birth, or surgery. What are the signs and symptoms of this emergency disorder? *(Select all that apply.)*

a. Fever
b. Hypothermia
c. Restlessness
d. Bradycardia
e. Hypertension

ANS: A, C

Fever, restlessness, tachycardia, vomiting, hypotension, and stupor are symptoms of a thyroid storm. Fever, not hypothermia; tachycardia, not bradycardia; and hypotension, not hypertension, are symptoms of thyroid storm.

DIF: Cognitive Level: Analyze REF: IM: 706

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. Hypothyroidism occurs in 2 to 3 pregnancies per 1000. Because severe hypothyroidism is associated with infertility and miscarriage, it is not often seen in pregnancy. Regardless of this fact, the nurse should be aware of the characteristic symptoms of hypothyroidism. Which do they include? *(Select all that apply.)*

a. Hot flashes
b. Weight loss
c. Lethargy
d. Decrease in exercise capacity
e. Cold intolerance

ANS: C, D, E

Symptoms include weight gain, lethargy, decrease in exercise capacity, and intolerance to cold. Other presentations might include constipation, hoarseness, hair loss, and dry skin. Thyroid supplements are used to treat hyperthyroidism in pregnancy.

DIF: Cognitive Level: Understand REF: IM: 707

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. Diabetes refers to a group of metabolic diseases characterized by hyperglycemia resulting from defects in insulin action, insulin secretion, or both. Over time, diabetes causes significant changes in the microvascular and macrovascular circulations. What do these complications include? *(Select all that apply.)*

a. Atherosclerosis

b. Retinopathy
c. Intrauterine fetal death (IUFD)
d. Nephropathy
e. Neuropathy
f. Autonomic neuropathy

ANS: A, B, D, E

These structural changes will most likely affect a variety of systems, including the heart, eyes, kidneys, and nerves. IUFD (stillbirth) remains a major complication of diabetes in pregnancy; however, this is a fetal complication.

DIF: Cognitive Level: Understand REF: IM: 688 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

COMPLETION

1. Achieving and maintaining euglycemia are the primary goals of medical therapy for the pregnant woman with diabetes. These goals are achieved through a combination of diet, insulin, exercise, and blood glucose monitoring. The target blood glucose levels 1 hour after a meal should be _____.

ANS:

110 to 129 mg/dl

Target levels of blood glucose during pregnancy are lower than nonpregnant values. Accepted fasting levels are between 60 and 99 mg/dl, and 1-hour postmeal levels should be between 110 to 129 mg/dl. Two-hour postmeal levels should be 120 mg/dl or less.

Chapter 30: Medical-Surgical Disorders

MULTIPLE CHOICE

1. When caring for a pregnant woman with cardiac problems, the nurse must be alert for the signs and symptoms of cardiac decompensation. Which critical findings would the nurse find on assessment of the client experiencing this condition?

a. Regular heart rate and hypertension
b. Increased urinary output, tachycardia, and dry cough
c. Shortness of breath, bradycardia, and hypertension
d. Dyspnea, crackles, and an irregular, weak pulse

ANS: D

Signs of cardiac decompensation include dyspnea; crackles; an irregular, weak, and rapid pulse; rapid respirations; a moist and frequent cough; generalized edema; increasing fatigue; and cyanosis of the lips and nailbeds. A regular heart rate and hypertension are not generally associated with cardiac decompensation. Of the symptoms of increased urinary output, tachycardia, and dry cough, only tachycardia is indicative of cardiac decompensation. Of the symptoms of shortness of breath, bradycardia, and hypertension, only dyspnea is indicative of cardiac decompensation.

DIF: Cognitive Level: Understand REF: IM: 716

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. Which condition would require prophylaxis to prevent subacute bacterial endocarditis (SBE) both antepartum and intrapartum?

a. Valvular heart disease
b. Congestive heart disease
c. Arrhythmias
d. Postmyocardial infarction

ANS: A

Prophylaxis for intrapartum endocarditis and pulmonary infection may be provided for women who have mitral valve prolapse. Prophylaxis for intrapartum endocarditis is not indicated for a client with congestive heart disease, underlying arrhythmias, or postmyocardial infarction.

DIF: Cognitive Level: Understand REF: IM: 712

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

3. Which information should the nurse take into consideration when planning care for a postpartum client with cardiac disease?

a. The plan of care for a postpartum client is the same as the plan for any pregnant woman.
b. The plan of care includes rest, stool softeners, and monitoring of the effect of activity.
c. The plan of care includes frequent ambulating, alternating with active range-of-motion exercises.
d. The plan of care includes limiting visits with the infant to once per day.

ANS: B

Bed rest may be ordered, with or without bathroom privileges. Bowel movements without stress or strain for the woman are promoted with stool softeners, diet, and fluids. Care of the woman with cardiac disease in the postpartum period is tailored to the womans functional capacity. The woman will be on bed rest to conserve energy and to reduce the strain on the heart. Although the woman may need help caring for the infant, breastfeeding and infant visits are not contraindicated.

DIF: Cognitive Level: Understand REF: pp. 718-719 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. A woman has experienced iron deficiency anemia during her pregnancy. She had been taking iron for 3 months before the birth. The client gave birth by cesarean 2 days earlier and has been having problems with constipation. After assisting her back to bed from the bathroom, the nurse notes that the womans stools are dark (greenish-black). What should the nurses initial action be?

a. Perform a guaiac test, and record the results.
b. Recognize the finding as abnormal, and report it to the primary health care provider.
c. Recognize the finding as a normal result of iron therapy.
d. Check the womans next stool to validate the observation.

ANS: C

The nurse should recognize that dark stools are a common side effect in clients who are taking iron replacement therapy. A guaiac test would be indicated if gastrointestinal (GI) bleeding was suspected. GI irritation, including dark stools, is also a common side effect of iron therapy. Observation of stool formation is a normal nursing activity.

DIF: Cognitive Level: Apply REF: IM: 716 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

5. A woman with asthma is experiencing a postpartum hemorrhage. Which drug should be avoided when treating postpartum bleeding to avoid exacerbating asthma?

a. Oxytocin (Pitocin)
b. Nonsteroidal antiinflammatory drugs (NSAIDs)
c. Hemabate
d. Fentanyl

ANS: C

Prostaglandin derivatives should not be used to treat women with asthma, because they may exacerbate symptoms. Oxytocin is the drug of choice to treat this womans bleeding; it will not exacerbate her asthma. NSAIDs are not used to treat bleeding. Fentanyl is used to treat pain, not bleeding.

DIF: Cognitive Level: Analyze REF: IM: 722 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

6. Which important component of nutritional counseling should the nurse include in health teaching for a pregnant woman who is experiencing cholecystitis?

a. Assess the womans dietary history for adequate calories and proteins.
b. Teach the woman that the bulk of calories should come from proteins.
c. Instruct the woman to eat a low-fat diet and to avoid fried foods.
d. Instruct the woman to eat a low-cholesterol, low-salt diet.

ANS: C

Eating a low-fat diet and avoiding fried foods is appropriate nutritional counseling for this client. Caloric and protein intake do not predispose a woman to the development of cholecystitis. The woman should be instructed to limit protein intake and choose foods that are high in carbohydrates. A low-cholesterol diet may be the result of limiting fats. However, a low-salt diet is not indicated.

DIF: Cognitive Level: Apply REF: IM: 728

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

7. Postoperative care of the pregnant woman who requires abdominal surgery for appendicitis includes which additional assessment?

a. Intake and output (I&O) and intravenous (IV) site
b. Signs and symptoms of infection
c. Vital signs and incision
d. Fetal heart rate (FHR) and uterine activity

ANS: D

Care of a pregnant woman undergoing surgery for appendicitis differs from that for a nonpregnant woman in one significant aspect: the presence of the fetus. Continuous fetal and uterine monitoring should take place. An assessment of I&O levels, along with an assessment of the IV site, are normal postoperative care procedures. Evaluating the client for signs and

symptoms of infection is also part of routine postoperative care. Routine vital signs and evaluation of the incision site are expected components of postoperative care.

DIF: Cognitive Level: Apply REF: IM: 730

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

8. Since the gene for cystic fibrosis was identified in 1989, data can be collected for the purposes of genetic counseling for couples regarding carrier status. According to the most recent statistics, how often does cystic fibrosis occur in Caucasian live births?

a. 1 in 100
b. 1 in 1000
c. 1 in 2000
d. 1 in 3200

ANS: D

Cystic fibrosis occurs in approximately 1 in 3200 Caucasian live births. 1 in 100, 1 in 1000, and 1 in 2000 occurrences of cystic fibrosis in live births are all too frequent rates.

DIF: Cognitive Level: Remember REF: IM: 722

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. Which information regarding the care of antepartum women with cardiac conditions is *most* important for the nurse to understand?

a. Stress on the heart is greatest in the first trimester and the last 2 weeks before labor.
b. Women with class II cardiac disease should avoid heavy exertion and any activity that causes even minor symptoms.
c. Women with class III cardiac disease should get 8 to 10 hours of sleep every day and limit housework, shopping, and exercise.
d. Women with class I cardiac disease need bed rest through most of the pregnancy and face the possibility of hospitalization near term.

ANS: B

Class II cardiac disease is symptomatic with ordinary activity. Women in this category need to avoid heavy exertion and limit regular activities as symptoms dictate. Stress is greatest between weeks 28 and 32 of gestation, when hemodynamic changes reach their maximum. Class III cardiac disease is symptomatic with less-than-ordinary activity. These women need bed rest most of the day and face the possibility of hospitalization near term. Class I cardiac disease is asymptomatic at normal levels of activity. These women can perform limited normal activities with discretion, although they still need a good amount of sleep.

DIF: Cognitive Level: Understand REF: IM: 711 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

10. A woman at 28 weeks of gestation experiences blunt abdominal trauma as the result of a fall. The nurse must closely observe the client for what?

a. Alteration in maternal vital signs, especially blood pressure
b. Complaints of abdominal pain
c. Placental absorption
d. Hemorrhage

ANS: C

Electronic fetal monitoring (EFM) tracings can help evaluate maternal status after trauma and can reflect fetal cardiac responses to hypoxia and hypoperfusion. Signs and symptoms of placental absorption include uterine irritability, contractions, vaginal bleeding, and changes in FHR characteristics. Hypoperfusion may be present in the pregnant woman before the onset of clinical signs of shock. EFM tracings show the first signs of maternal compromise, such as when the maternal heart rate, blood pressure, and color appear normal, yet the EFM printout shows signs of fetal hypoxia. Abdominal pain, in and of itself, is not the most important symptom. However, if it is accompanied by contractions, changes in the FHR, rupture of membranes, or vaginal bleeding, then the client should be evaluated for abruptio placentae. Clinical signs of hemorrhage do not appear until after a 30% loss of circulating volume occurs. Careful

monitoring of fetal status significantly assists in maternal assessment, because the fetal monitor tracing works as an oximeter of internal well-being.

DIF: Cognitive Level: Apply REF: IM: 732

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

11. Which neurologic condition would require preconception counseling, if at all possible?

a. Eclampsia
b. Bell palsy
c. Epilepsy
d. Multiple sclerosis

ANS: C

Women with epilepsy should receive preconception counseling, if at all possible. Achieving seizure control before becoming pregnant is a desirable state. Medication should also be carefully reviewed. Eclampsia may sometimes be confused with epilepsy, and Bell palsy is a form of facial paralysis; preconception counseling for either condition is not essential to care. Multiple sclerosis is a patchy demyelination of the spinal cord that does not affect the normal course of pregnancy or birth.

DIF: Cognitive Level: Understand REF: IM: 725 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

12. The client makes an appointment for preconception counseling. The woman has a known heart condition and is unsure if she should become pregnant. Which is the *only* cardiac condition that would cause concern?

a. Marfan syndrome
b. Eisenmenger syndrome
c. Heart transplant
d. Ventricular septal defect (VSD)

ANS: B

Pregnancy is contraindicated in clients with Eisenmenger syndrome. Women who have had heart transplants are successfully having babies. However, conception should be postponed for at least 1 year after transplantation. Management of the client with Marfan syndrome during pregnancy includes bed rest, beta-blockers, and surgery before conception. VSD is usually corrected early in life and is therefore not a contraindication to pregnancy.

DIF: Cognitive Level: Understand REF: IM: 714

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. What form of heart disease in women of childbearing years generally has a benign effect on pregnancy?

a. Cardiomyopathy
b. Rheumatic heart disease
c. Congenital heart disease
d. Mitral valve prolapse

ANS: D

Mitral valve prolapse is a benign condition that is usually asymptomatic. Cardiomyopathy produces congestive heart failure during pregnancy. Rheumatic heart disease can lead to heart failure during pregnancy. Some congenital heart diseases produce pulmonary hypertension or endocarditis during pregnancy.

DIF: Cognitive Level: Remember REF: IM: 713

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

14. A pregnant woman at 33 weeks of gestation is brought to the birthing unit after a minor automobile accident. The client is experiencing no pain and no vaginal bleeding, her vital signs are stable, and the FHR is 132 beats per minute with variability. What is the nurses *highest* priority?

a. Monitoring the woman for a ruptured spleen
b. Obtaining a physicians order to discharge her home
c. Monitoring her for 24 hours
d. Using continuous EFM for a minimum of 4 hours

ANS: D

Monitoring the external FHR and contractions is recommended after blunt trauma in a viable gestation for a minimum of 4 hours, regardless of injury severity. Fetal monitoring should be initiated as soon as the woman is stable. In this scenario, no clinical findings indicate the possibility of a ruptured spleen. If the maternal and fetal findings are normal, then EFM should continue for a minimum of 4 hours after a minor trauma or a minor automobile accident. Once the monitoring has been completed and the health care provider is reassured of fetal well-being, the client may be discharged home. Monitoring for 24 hours is unnecessary unless the ERM strip is abnormal or nonreassuring.

DIF: Cognitive Level: Apply REF: IM: 732 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

15. Bell palsy is an acute idiopathic facial paralysis, the cause for which remains unknown. Which statement regarding this condition is *correct*?

a. Bell palsy is the sudden development of bilateral facial weakness.
b. Women with Bell palsy have an increased risk for hypertension.
c. Pregnant women are affected twice as often as nonpregnant women.
d. Bell palsy occurs most frequently in the first trimester.

ANS: B

The clinical manifestations of Bell palsy include the development of unilateral facial weakness, pain surrounding the ears, difficulty closing the eye, and hyperacusis. The cause is unknown; however, Bell palsy may be related to a viral infection. Pregnant women are affected at a rate of three to five times that of nonpregnant women. The incidence rate peaks during the third

trimester and puerperium. Women who develop Bell palsy in pregnancy have an increased risk for hypertension.

DIF: Cognitive Level: Understand REF: IM: 726

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

16. A pregnant woman at term is transported to the emergency department (ED) after a severe vehicular accident. The obstetric nurse responds and rushes to the ED with a fetal monitor. Cardiopulmonary arrest occurs as the obstetric nurse arrives. What is the *highest* priority for the trauma team?

a. Obtaining IV access, and starting aggressive fluid resuscitation
b. Quickly applying the fetal monitor to determine whether the fetus viability
c. Starting cardiopulmonary resuscitation (CPR)
d. Transferring the woman to the surgical unit for an emergency cesarean delivery in case the fetus is still alive

ANS: C

In a situation of severe maternal trauma, the systematic evaluation begins with a primary survey and the initial ABCs (airway, breathing, and circulation) of resuscitation. CPR is initiated first, followed by intravenous (IV) replacement fluid. After immediate resuscitation and successful stabilization measures, a more detailed secondary survey of the mother and fetus should be accomplished. Attempts at maternal resuscitation are made, followed by a secondary survey of the fetus. In the presence of multisystem trauma, a cesarean delivery may be indicated to increase the chance for maternal survival.

DIF: Cognitive Level: Apply REF: IM: 734

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

17. Another common pregnancy-specific condition is pruritic urticarial papules and plaques of pregnancy (PUPPP). A client asks the nurse why she has developed this condition and what can be done. What is the nurses *best*response?

a. PUPPP is associated with decreased maternal weight gain.
b. The rate of hypertension decreases with PUPPP.
c. This common pregnancy-specific condition is associated with a poor fetal outcome.
d. The goal of therapy is to relieve discomfort.

ANS: D

PUPPP is associated with increased maternal weight gain, increased rate of twin gestation, and hypertension. It is not, however, associated with poor maternal or fetal outcomes. The goal of therapy is simply to relieve discomfort. Antipruritic topical medications, topical steroids, and antihistamines usually provide relief. PUPPP usually resolves before childbirth or shortly thereafter.

DIF: Cognitive Level: Apply REF: IM: 724 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

18. It is extremely rare for a woman to die in childbirth; however, it can happen. In the United States, the annual occurrence of maternal death is 12 per 100,000 cases of live birth. What are the leading causes of maternal death?

a. Embolism and preeclampsia
b. Trauma and motor vehicle accidents (MVAs)
c. Hemorrhage and infection
d. Underlying chronic conditions

ANS: B

Trauma is the leading cause of obstetric death in women of childbearing age. Most maternal injuries are the result of MVAs and falls. Although preeclampsia and embolism are significant contributors to perinatal morbidity, these are not the leading cause of maternal mortality. Maternal death caused by trauma may occur as the result of hemorrhagic shock or abruptio placentae. In these cases, the hemorrhage is the result of trauma, not childbirth. The wish to

become a parent is not eliminated by a chronic health problem, and many women each year risk their lives to have a baby. Because of advanced pediatric care, many women are surviving childhood illnesses and reaching adulthood with chronic health problems such as cystic fibrosis, diabetes, and pulmonary disorders.

DIF: Cognitive Level: Understand REF: IM: 731

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Which congenital anomalies can occur as a result of the use of antiepileptic drugs (AEDs) in pregnancy? *(Select all that apply.)*

a. Cleft lip
b. Congenital heart disease
c. Neural tube defects
d. Gastroschisis
e. Diaphragmatic hernia

ANS: A, B, C

Congenital anomalies that can occur with AEDs include cleft lip or palate, congenital heart disease, urogenital defects, and neural tube defects. Carbamazepine and valproate should be avoided if all possible; they may cause neural tube defects. Congenital anomalies of gastroschisis and diaphragmatic hernia are not associated with the use of AEDs.

DIF: Cognitive Level: Understand REF: IM: 725 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

2. A lupus flare-up during pregnancy or early postpartum occurs in 15% to 60% of women with this disorder. Which conditions associated with systemic lupus erythematosus (SLE) are maternal risks? *(Select all that apply.)*

a. Miscarriage
b. Intrauterine growth restriction (IUGR)
c. Nephritis
d. Preeclampsia
e. Cesarean birth

ANS: A, C, D, E

Maternal risks associated with SLE include miscarriage, nephritis, preeclampsia, and cesarean birth. IUGR is a fetal risk related to SLE. Other fetal risks include stillbirth and prematurity.

DIF: Cognitive Level: Understand REF: IM: 727

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. In caring for a pregnant woman with sickle cell anemia, the nurse must be aware of the signs and symptoms of a sickle cell crisis. What do these include? *(Select all that apply.)*

a. Fever
b. Endometritis
c. Abdominal pain
d. Joint pain
e. Urinary tract infection (UTI)

ANS: A, C, D

Women with sickle cell anemia have recurrent attacks (crises) of fever and pain, most often in the abdomen, joints, and extremities. These attacks are attributed to vascular occlusion when red blood cells (RBCs) assume the characteristic sickled shape. Crises are usually triggered by dehydration, hypoxia, or acidosis. Women with the sickle cell trait are usually at a greater risk for postpartum endometritis (uterine wall infection); however, this development is not likely to occur during the pregnancy and is not a sign for the disorder. Although women with sickle cell anemia are at an increased risk for UTIs, these infections are not an indication of a sickle cell crisis.

DIF: Cognitive Level: Understand REF: IM: 721

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

4. Autoimmune disorders often occur during pregnancy because a large percentage of women with an autoimmune disorder are of childbearing age. Which disorders fall into the category of collagen vascular disease? *(Select all that apply.)*

a. Multiple sclerosis
b. SLE
c. Antiphospholipid syndrome
d. Rheumatoid arthritis
e. Myasthenia gravis

ANS: B, C, D, E

Multiple sclerosis is not an autoimmune disorder. This patchy demyelination of the spinal cord may be a viral disorder. Autoimmune disorders (collagen vascular disease) make up a large group of conditions that disrupt the function of the immune system of the body. These disorders include those listed, as well as systemic sclerosis.

Chapter 31: Mental Health Disorders and Substance Abuse

MULTIPLE CHOICE

1. A client with a history of bipolar disorder is called by the postpartum support nurse for follow-up. Which symptoms would reassure the nurse that the client is not experiencing a manic episode?

a. Psychomotor agitation and lack of sleep
b. Increased appetite and lack of interest in activities
c. Hyperactivity and distractibility
d. Pressured speech and grandiosity

ANS: B

An increased appetite and a lack of interest would reassure the nurse that the client is not experiencing an episode of mania. Clinical manifestations of a manic episode include at least three of the following: grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, psychomotor agitation, and excessive involvement in pleasurable activities. The pregnant woman exhibiting symptoms of a manic episode will likely have a decreased interest in eating and an increased level of interest in pleasurable activities without regard for negative consequences. Psychomotor agitation and a lack of sleep, hyperactivity and distractibility, and pressured speech and grandiosity are all clinical manifestations of a manic episode.

DIF: Cognitive Level: Apply REF: IM: 746

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. When a woman is diagnosed with postpartum depression (PPD) *with* psychotic features, what is the nurses primary concern in planning the clients care?

a. Displaying outbursts of anger
b. Neglecting her hygiene
c. Harming her infant
d. Losing interest in her husband

ANS: C

Thoughts of harm to herself or to the infant are among the most serious symptoms of PPD and require immediate assessment and intervention. Although outbursts of anger and neglecting personal hygiene are symptoms attributable to PPD, the major concern remains the potential of harm to herself or her infant. Although this client is likely to lose interest in her spouse, it is not the nurses primary concern.

DIF: Cognitive Level: Understand REF: IM: 748 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. During an inpatient psychiatric hospitalization, what is the *most* important nursing intervention?

a. Contacting the clients significant other
b. Supervising and guiding visits with her infant
c. Allowing no contact with anyone who annoys her
d. Having the infant with the mother at all times

ANS: B

In the hospital setting, the reintroduction of the infant to the mother can and should occur at the mothers own pace. A schedule is set that increases the number of hours the mother cares for her infant over several days, culminating in the infant staying overnight in the mothers room. These supervised and guided visits allow the mother to experience meeting the infants needs and giving up sleep for the infant. Reintroducing the mother to her infant while in a supervised setting is essential. Another important task for a mother under psychiatric care is to reestablish positive interactions with others.

DIF: Cognitive Level: Understand REF: pp. 749-750 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

4. Despite warnings, prenatal exposure to alcohol continues to far exceed exposure to illicit drugs. Which condition is rarely associated with fetal alcohol syndrome (FAS)?

a. Respiratory conditions
b. Intellectual impairment
c. Neural development disorder
d. Alcohol-related birth defects (ARBDs)

ANS: A

Respiratory difficulties are not attributed to exposure to alcohol in utero. Other abnormalities related to FAS include mental retardation, neurodevelopment disorders, and ARBDs.

DIF: Cognitive Level: Understand REF: IM: 752

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

5. As a powerful central nervous system (CNS) stimulant, which of these substances can lead to miscarriage, preterm labor, placental separation (abruption), and stillbirth?

a. Heroin
b. Alcohol
c. Phencyclidine (1-phenylcyclohexylpiperidine; PCP)
d. Cocaine

ANS: D

Cocaine is a powerful CNS stimulant. Effects on pregnancy associated with cocaine use include abruptio placentae, preterm labor, precipitous birth, and stillbirth. Heroin is an opiate; its use in pregnancy is associated with preeclampsia, intrauterine growth restriction, miscarriage, premature rupture of membranes, infections, breech presentation, and preterm labor. The most serious effect of alcohol use in pregnancy is FAS. The major concern regarding PCP use in pregnant women is its association with polydrug abuse and its neurobehavioral effects on the neonate.

DIF: Cognitive Level: Understand REF: pp. 752-753

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

6. According to research, which risk factor for PPD is likely to have the greatest effect on the client postpartum?

a. Prenatal depression
b. Single-mother status
c. Low socioeconomic status
d. Unplanned or unwanted pregnancy

ANS: A

Prenatal depression has been found to be a major risk factor for PPD. Single-mother status and low socioeconomic status are both small-relationship predictors for PPD. Although an unwanted pregnancy may contribute to the risk for PPD, it does not pose as great an effect as prenatal depression.

DIF: Cognitive Level: Understand REF: IM: 744

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

7. Which is the most accurate description of PPD *without* psychotic features?

a. Postpartum baby blues requiring the woman to visit with a counselor or psychologist
b. Condition that is more common among older Caucasian women because they have higher expectations
c. Distinguishable by pervasive sadness along with mood swings
d. Condition that disappears without outside help

ANS: C

PPD is characterized by an intense pervasive sadness along with labile mood swings and is more persistent than postpartum baby blues. PPD, even without psychotic features, is more serious and persistent than postpartum baby blues. PPD is more common among younger mothers and African-American mothers. Most women need professional help to get through PPD, including pharmacologic intervention.

DIF: Cognitive Level: Understand REF: IM: 745

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

8. While providing care to the maternity client, the nurse should be aware that one of these anxiety disorders is likely to be triggered by the process of labor and birth. Which disorder fits this criterion?

a. Phobias
b. Panic disorder

c. Posttraumatic stress disorder (PTSD)
d. Obsessive-compulsive disorder (OCD)

ANS: C

PTSD can occur as the result of a past trauma such as rape. Symptoms of PTSD include re-experiencing the event, numbing, irritability, angry outbursts, and exaggerated startle reflex. With the increased bodily touch and vaginal examinations that occur during labor, the client may have memories of the original trauma. The process of giving birth may result in her feeling out of control. The nurse should verbalize an understanding and reassure the client as necessary. Phobias are irrational fears that may lead a person to avoid certain events or situations. Panic disorders may occur in as many as 3% to 5% of women in the *postpartum* period and are described as episodes of intense apprehension, fear, and terror. Symptoms of a panic disorder may include palpitations, chest pain, choking, or smothering. OCD symptoms include recurrent, persistent, and intrusive thoughts. The mother may repeatedly check and recheck her infant once he or she is born, although she realizes that this behavior is irrational. OCD is optimally treated with medications.

DIF: Cognitive Level: Understand REF: IM: 742

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

9. Which substance used during pregnancy causes vasoconstriction and decreased placental perfusion, resulting in maternal and neonatal complications?

a. Alcohol
b. Caffeine
c. Tobacco
d. Chocolate

ANS: C

Smoking in pregnancy is known to cause a decrease in placental perfusion and is the cause of low-birth-weight infants. Prenatal alcohol exposure is the single greatest preventable cause of

mental retardation. Alcohol use during pregnancy can cause high blood pressure, miscarriage, premature birth, stillbirth, and anemia. Caffeine may interfere with certain medications and worsen arrhythmias. Chocolate, particularly dark chocolate, contains caffeine that may interfere with certain medications.

DIF: Cognitive Level: Remember REF: IM: 752

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

10. As part of the discharge teaching, the nurse can prepare the mother for her upcoming adjustment to her new role by instructing her regarding self-care activities to help prevent PPD. Which statement regarding this condition is*most* helpful for the client?

a. Stay home, and avoid outside activities to ensure adequate rest.
b. Be certain that you are the only caregiver for your baby to facilitate infant attachment.
c. Keep your feelings of sadness and adjustment to your new role to yourself.
d. Realize that PPD is a common occurrence that affects many women.

ANS: D

Should the new mother experience symptoms of the baby blues, it is important that she be aware that these symptoms are nothing to be ashamed of. As many as 10% to 15% of new mothers experience similar symptoms. Although obtaining enough rest is important for the mother, she should not distance herself from her family and friends. Her spouse or partner can communicate the best visiting times to enable the new mother to obtain adequate rest. It is also important that she not isolate herself at home by herself during this time of role adjustment. Even if breastfeeding, other family members can participate in the infants care. If depression occurs, then the symptoms will often interfere with mothering functions; therefore, family support is essential. The new mother should share her feelings with someone else and avoid overcommitting herself or feel as though she has to be*superwoman*. A telephone call to the hospital warm line may provide reassurance with lactation issues and other infant care questions. Should symptoms continue, a referral to a professional therapist may be necessary.

DIF: Cognitive Level: Apply REF: IM: 748

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

11. A woman at 24 weeks of gestation states that she has a glass of wine with dinner every evening. Why would the nurse counsel the client to eliminate all alcohol?

a. Daily consumption of alcohol indicates a risk for alcoholism.
b. She will be at risk for abusing other substances as well.
c. The fetus is placed at risk for altered brain growth.
d. The fetus is at risk for multiple organ anomalies.

ANS: C

No period exists when consuming alcohol during pregnancy is safe. The documented effects of alcohol consumption during pregnancy include mental retardation, learning disabilities, high activity level, and short attention span. The brain grows most rapidly in the third trimester and is vulnerable to alcohol exposure during this time. Abuse of other substances has not been linked to alcohol use.

DIF: Cognitive Level: Apply REF: IM: 752

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

12. A pregnant woman who abuses cocaine admits to exchanging sex to finance her drug habit. This behavior places the client at the greatest risk for what?

a. Depression of the CNS
b. Hypotension and vasodilation
c. Sexually transmitted infections (STIs)
d. Postmature birth

ANS: C

Exchanging sex acts for drugs places the woman at increased risk for STIs because of multiple partners and the lack of protection. Cocaine is a CNS stimulant that causes hypertension and

vasoconstriction. Premature delivery of the infant is one of the more common problems associated with cocaine use during pregnancy.

DIF: Cognitive Level: Understand REF: IM: 754

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

13. What is the most dangerous effect on the fetus of a mother who smokes cigarettes while pregnant?

a. Genetic changes and anomalies
b. Extensive CNS damage
c. Fetal addiction to the substance inhaled
d. Intrauterine growth restriction

ANS: D

The major consequences of smoking tobacco during pregnancy are low-birth-weight infants, prematurity, and increased perinatal loss. Cigarettes will not normally cause genetic changes or extensive CNS damage. Addiction to tobacco is not a usual concern related to the neonate.

DIF: Cognitive Level: Understand REF: IM: 752

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

14. The use of methamphetamine (meth) has been described as a significant drug problem in the United States. The nurse who provides care to this client population should be cognizant of what regarding methamphetamine use?

a. Methamphetamines are similar to opiates.
b. Methamphetamines are stimulants with vasoconstrictive characteristics.
c. Methamphetamines should not be discontinued during pregnancy.
d. Methamphetamines are associated with a low rate of relapse.

ANS: B

Methamphetamines are stimulants with vasoconstrictive characteristics similar to cocaine and are similarly used. As is the case with cocaine users, methamphetamine users are urged to immediately stop all use during pregnancy. Unfortunately, because methamphetamine users are extremely psychologically addicted, the rate of relapse is extremely high.

DIF: Cognitive Level: Understand REF: IM: 753

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

15. With one exception, the safest pregnancy is one during which the woman is drug and alcohol free. What is the *optimal* treatment for women addicted to opioids?

a. Methadone maintenance treatment (MMT)
b. Detoxification
c. Smoking cessation
d. *4 Ps Plus*

ANS: A

MMT is currently considered the standard of care for pregnant women who are dependent on heroin or other narcotics. Buprenorphine is another medication approved for the treatment of opioid addiction that is increasingly being used during pregnancy. Opioid replacement therapy has been shown to decrease opioid and other drug use, reduce criminal activity, improve individual functioning, and decrease the rates of infections such as hepatitis B and C, human immunodeficiency virus (HIV), and other STIs. Detoxification is the treatment used for alcohol addiction. Pregnant women requiring withdrawal from alcohol should be admitted for inpatient management. Women are more likely to stop smoking during pregnancy than at any other time in their lives. A smoking cessation program can assist in achieving this goal. The *4 Ps Plus* is a screening tool specifically designed to identify pregnant women who need in-depth assessment related to substance abuse.

DIF: Cognitive Level: Apply REF: IM: 755 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

MULTIPLE RESPONSE

1. Reports have linked third trimester use of selective serotonin uptake inhibitors (SSRIs) with a constellation of neonatal signs. The nurse is about to perform an assessment on the infant of a mother with a history of a mood disorder. Which signs and symptoms in the neonate may be the result of maternal SSRI use? *(Select all that apply.)*

a. Hypotonia
b. Hyperglycemia
c. Shivering
d. Fever
e. Irritability

ANS: C, D, E

Neonatal signs of maternal SSRI use include continuous crying, irritability, jitteriness, shivering, fever, hypertonia, respiratory distress, feeding difficulty, hypoglycemia, and seizures. The onset of signs and symptoms ranges from several hours to several days after birth, but the signs generally resolve within 2 weeks.

DIF: Cognitive Level: Apply REF: IM: 742

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. Screening questions for alcohol and drug abuse should be included in the overall assessment during the first prenatal visit for all women. The *4 Ps Plus* is a screening tool specifically designed to identify the need for a more in-depth assessment. Which are the correct components of the *4 Ps Plus*? *(Select all that apply.)*

a. Parents
b. Partner
c. Present
d. Past
e. Pregnancy

ANS: A, B, D, E

The nurse who is screening the client using the *4 Ps Plus* would use the following format: Parents: Did either of your parents have a problem with alcohol or drugs? Partner: Does your partner have a problem with alcohol or drugs? Past: Have you ever had any beer, wine, or liquor? Pregnancy: In the month before you knew you were pregnant, how many cigarettes did you smoke? How much beer, wine, or liquor did you drink? Present: Is not a component of the *4 Ps Plus*.

Chapter 32: Labor and Birth Complications

MULTIPLE CHOICE

1. In planning for home care of a woman with preterm labor, which concern should the nurse need to address?

a. Nursing assessments are different from those performed in the hospital setting.
b. Restricted activity and medications are necessary to prevent a recurrence of preterm labor.
c. Prolonged bed rest may cause negative physiologic effects.
d. Home health care providers are necessary.

ANS: C

Prolonged bed rest may cause adverse effects such as weight loss, loss of appetite, muscle wasting, weakness, bone demineralization, decreased cardiac output, risk for thrombophlebitis, alteration in bowel functions, sleep disturbance, and prolonged postpartum recovery. Nursing assessments differ somewhat from those performed in the acute care setting, but this concern does not need to be addressed. Restricted activity and medications may prevent preterm labor but not in all women. In addition, the plan of care is individualized to meet the needs of each client. Many women receive home health nurse visits, but care is individualized for each woman.

DIF: Cognitive Level: Analyze REF: IM: 777 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

2. Which nursing intervention is paramount when providing care to a client with preterm labor who has received terbutaline?

a. Assess deep tendon reflexes (DTRs).
b. Assess for dyspnea and crackles.
c. Assess for bradycardia.
d. Assess for hypoglycemia.

ANS: B

Terbutaline is a beta$_2$-adrenergic agonist that affects the mothers cardiopulmonary and metabolic systems. Signs of cardiopulmonary decompensation include adventitious breath sounds and dyspnea. An assessment for dyspnea and crackles is important for the nurse to perform if the woman is taking magnesium sulfate. Assessing DTRs does not address the possible respiratory side effects of using terbutaline. Since terbutaline is a beta$_2$-adrenergic agonist, it can lead to hyperglycemia, not hypoglycemia. Beta$_2$-adrenergic agonist drugs cause tachycardia, not bradycardia.

DIF: Cognitive Level: Analyze REF: pp. 767-768

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

3. In evaluating the effectiveness of magnesium sulfate for the treatment of preterm labor, which finding alerts the nurse to possible side effects?

a. Urine output of 160 ml in 4 hours
b. DTRs 2+ and no clonus
c. Respiratory rate (RR) of 16 breaths per minute
d. Serum magnesium level of 10 mg/dl

ANS: D

The therapeutic range for magnesium sulfate management is 4 to 7.5 mg/dl. A serum magnesium level of 10 mg/dl could lead to signs and symptoms of magnesium toxicity, including oliguria and respiratory distress. Urine output of 160 ml in 4 hours, DTRs of 2+, and a RR of 16 breaths per minute are all normal findings.

DIF: Cognitive Level: Apply REF: IM: 767 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

4. A woman in preterm labor at 30 weeks of gestation receives two 12-mg intramuscular (IM) doses of betamethasone. What is the purpose of this pharmacologic intervention?

a. To stimulate fetal surfactant production
b. To reduce maternal and fetal tachycardia associated with ritodrine administration
c. To suppress uterine contractions
d. To maintain adequate maternal respiratory effort and ventilation during magnesium sulfate therapy

ANS: A

Antenatal glucocorticoids administered as IM injections to the mother accelerate fetal lung maturity. Propranolol (Inderal) is given to reduce the effects of ritodrine administration. Betamethasone has no effect on uterine contractions. Calcium gluconate is given to reverse the respiratory depressive effects of magnesium sulfate therapy.

DIF: Cognitive Level: Understand REF: IM: 769 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. A primigravida at 40 weeks of gestation is having uterine contractions every to 2 minutes and states that they are very painful. Her cervix is dilated 2 cm and has not changed in 3 hours. The woman is crying and wants an epidural. What is the *likely* status of this womans labor?

a. She is exhibiting hypotonic uterine dysfunction.
b. She is experiencing a normal latent stage.

c. She is exhibiting hypertonic uterine dysfunction.
d. She is experiencing precipitous labor.

ANS: C

The contraction pattern observed in this woman signifies hypertonic uterine activity. Typically, uterine activity in this phase occurs at 4- to 5-minute intervals lasting 30 to 45 seconds. Women who experience hypertonic uterine dysfunction, or primary dysfunctional labor, are often anxious first-time mothers who are having painful and frequent contractions that are ineffective at causing cervical dilation or effacement to progress. With hypotonic uterine dysfunction, the woman initially makes normal progress into the active stage of labor; then the contractions become weak and inefficient or stop altogether. Precipitous labor is one that lasts less than 3 hours from the onset of contractions until time of birth.

DIF: Cognitive Level: Apply REF: IM: 773 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

6. A woman is having her first child. She has been in labor for 15 hours. A vaginal examination performed 2 hours earlier revealed the cervix to be dilated to 5 cm and 100% effaced, and the presenting part of the fetus was at station 0; however, another vaginal examination performed 5 minutes ago indicated no changes. What abnormal labor pattern is associated with this description?

a. Prolonged latent phase
b. Protracted active phase
c. Secondary arrest
d. Protracted descent

ANS: C

With a secondary arrest of the active phase, the progress of labor has stopped. This client has not had any anticipated cervical change, indicating an arrest of labor. In the nulliparous woman, a prolonged latent phase typically lasts longer than 20 hours. A protracted active phase, the first or

second stage of labor, is prolonged (slow dilation). With a protracted descent, the fetus fails to descend at an anticipated rate during the deceleration phase and second stage of labor.

DIF: Cognitive Level: Analyze REF: IM: 774

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

7. Prostaglandin gel has been ordered for a pregnant woman at 43 weeks of gestation. What is the primary purpose of prostaglandin administration?

a. To enhance uteroplacental perfusion in an aging placenta
b. To increase amniotic fluid volume
c. To ripen the cervix in preparation for labor induction
d. To stimulate the amniotic membranes to rupture

ANS: C

Preparations of prostaglandin E_1 and E_2 are effective when used before labor induction to ripen (i.e., soften and thin) the cervix. Uteroplacental perfusion is not altered by the use of prostaglandins. The insertion of prostaglandin gel has no effect on the level of amniotic fluid. In some cases, women will spontaneously begin laboring after the administration of prostaglandins, thereby eliminating the need for oxytocin. It is not common for a womans membranes to rupture as a result of prostaglandin use.

DIF: Cognitive Level: Apply REF: IM: 779 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

8. A pregnant woman at 29 weeks of gestation has been diagnosed with preterm labor. Her labor is being controlled with tocolytic medications. She asks when she might be able to go home. Which response by the nurse is *most*accurate?

a. After the baby is born.
b. When we can stabilize your preterm labor and arrange home health visits.
c. Whenever your physician says that it is okay.

d. It depends on what kind of insurance coverage you have.

ANS: B

This clients preterm labor is being controlled with tocolytics. Once she is stable, home care may be a viable option for this type of client. Care of a client with preterm labor is multidisciplinary and multifactorial; the goal is to prevent delivery. In many cases, this goal may be achieved at home. Managed care may dictate an earlier hospital discharge or a shift from hospital to home care. Insurance coverage may be one factor in client care, but ultimately, client safety remains the most important factor.

DIF: Cognitive Level: Apply REF: IM: 765 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

9. The obstetric provider has informed the nurse that she will be performing an amniotomy on the client to induce labor. What is the nurses *highest* priority intervention after the amniotomy is performed?

a. Applying clean linens under the woman
b. Taking the clients vital signs
c. Performing a vaginal examination
d. Assessing the fetal heart rate (FHR)

ANS: D

The FHR is assessed before and immediately after the amniotomy to detect any changes that might indicate cord compression or prolapse. Providing comfort measures, such as clean linens, for the client is important but not the priority immediately after an amniotomy. The womans temperature should be checked every 2 hours after the rupture of membranes but not the priority immediately after an amniotomy. The woman would have had a vaginal examination during the procedure. Unless cord prolapse is suspected, another vaginal examination is not warranted. Additionally, FHR assessment provides clinical cues to a prolapsed cord.

DIF: Cognitive Level: Analyze REF: IM: 783

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

10. The nurse who elects to work in the specialty of obstetric care must have the ability to distinguish between preterm birth, preterm labor, and low birth weight. Which statement regarding this terminology is *correct*?

a. Terms *preterm birth* and *low birth weight* can be used interchangeably.
b. *Preterm labor* is defined as cervical changes and uterine contractions occurring between 20 and 37 weeks of gestation.
c. *Low birth weight* is a newborn who weighs below 3.7 pounds.
d. *Preterm birth* rate in the United States continues to increase.

ANS: B

Before 20 weeks of gestation, the fetus is not viable (miscarriage); after 37 weeks, the fetus can be considered term. Although these terms are used interchangeably, they have different meanings: preterm birth describes the length of gestation (before 37 weeks), regardless of the newborns weight; low birth weight describes only the infants weight at the time of birth (2500 g or less), whenever it occurs. Low birth weight is anything below 2500 g or approximately pounds. In 2011, the preterm birth rate in the United States was 11.7 %; it has dropped every year since 2008.

DIF: Cognitive Level: Understand REF: IM: 759

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

11. The nurse is performing an assessment on a client who thinks she may be experiencing preterm labor. Which information is the *most* important for the nurse to understand and share with the client?

a. Because all women must be considered at risk for preterm labor and prediction is so variable, teaching pregnant women the symptoms of preterm labor probably causes more harm through false alarms.
b. Braxton Hicks contractions often signal the onset of preterm labor.

c. Because preterm labor is likely to be the start of an extended labor, a woman with symptoms can wait several hours before contacting the primary caregiver.

d. Diagnosis of preterm labor is based on gestational age, uterine activity, and progressive cervical change.

ANS: D

Gestational age of 20 to 37 weeks, uterine contractions, and a cervix that is 80% effaced or dilated 2 cm indicates preterm labor. It is essential that nurses teach women how to detect the early symptoms of preterm labor. Braxton Hicks contractions resemble preterm labor contractions, but they are not true labor. Waiting too long to see a health care provider could result in essential medications failing to be administered. Preterm labor is not necessarily long-term labor.

DIF: Cognitive Level: Understand REF: IM: 759 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

12. Which statement related to cephalopelvic disproportion (CPD) is the *least* accurate?

a. CPD can be related to either fetal size or fetal position.

b. The fetus cannot be born vaginally.

c. CPD can be accurately predicted.

d. Causes of CPD may have maternal or fetal origins.

ANS: C

Unfortunately, accurately predicting CPD is not possible. Although CPD is often related to excessive fetal size (macrosomia), malposition of the fetal presenting part is the problem in many cases, not true CPD. When CPD is present, the fetus cannot fit through the maternal pelvis to be born vaginally. CPD may be related to either fetal origins such as macrosomia or malposition or maternal origins such as a too small or malformed pelvis.

DIF: Cognitive Level: Understand REF: IM: 775 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. Which statement related to the induction of labor is *most* accurate?

a. Can be achieved by external and internal version techniques
b. Is also known as a *trial of labor (TOL)*
c. Is almost always performed for medical reasons
d. Is rated for viability by a Bishop score

ANS: D

Induction of labor is likely to be more successful with a Bishop score of 9 or higher for first-time mothers or 5 or higher for veterans. *Version* is the turning of the fetus to a better position by a physician for an easier or safer birth. A TOL is the observance of a woman and her fetus for several hours of active labor to assess the safety of vaginal birth. Two thirds of cases of induced labor are elective and not done for medical reasons.

DIF: Cognitive Level: Understand REF: IM: 780 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Safe and Effective Care Environment

14. A number of methods can be used for inducing labor. Which cervical ripening method falls under the category of mechanical or physical?

a. Prostaglandins are used to soften and thin the cervix.
b. Labor can sometimes be induced with balloon catheters or laminaria tents.
c. Oxytocin is less expensive and more effective than prostaglandins but creates greater health risks.
d. Amniotomy can be used to make the cervix more favorable for labor.

ANS: B

Balloon catheters or laminaria tents are mechanical means of ripening the cervix. Ripening the cervix, making it softer and thinner, increases the success rate of induced labor. Prostaglandin E_1 is less expensive and more effective than oxytocin but carries a greater risk. Amniotomy is the artificial rupture of membranes, which is used to induce labor only when the cervix is already ripe.

DIF: Cognitive Level: Apply REF: IM: 781 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

15. Which description *most* accurately describes the augmentation of labor?

a. Is part of the active management of labor that is instituted when the labor process is unsatisfactory
b. Relies on more invasive methods when oxytocin and amniotomy have failed
c. Is a modern management term to cover up the negative connotations of forceps-assisted birth
d. Uses vacuum cups

ANS: A

Augmentation is part of the active management of labor that stimulates uterine contractions after labor has started but is not progressing satisfactorily. Augmentation uses amniotomy and oxytocin infusion, as well as some more gentle, noninvasive methods. Forceps-assisted births are less common than in the past and not considered a method of augmentation. A vacuum-assisted delivery occurs during childbirth if the mother is too exhausted to push. Vacuum extraction is not considered an augmentation methodology.

DIF: Cognitive Level: Understand REF: pp. 785-786 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

16. The exact cause of preterm labor is unknown but believed to be multifactorial. Infection is thought to be a major factor in many preterm labors. Which type of infection has *not* been linked to preterm birth?

a. Viral
b. Periodontal
c. Cervical
d. Urinary tract

ANS: A

Infections that increase the risk of preterm labor and birth are bacterial and include cervical, urinary tract, periodontal, and other bacterial infections. Therefore, early, continual, and comprehensive participation by the client in her prenatal care is important. Recent evidence has shown a link between periodontal infections and preterm labor. Researchers recommend regular dental care before and during pregnancy, oral assessment as a routine part of prenatal care, and scrupulous oral hygiene to prevent periodontal infections.

DIF: Cognitive Level: Remember REF: IM: 760

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

17. The nurse is teaching a client with preterm premature rupture of membranes (PPROM) regarding self-care activities. Which activities should the nurse include in her teaching?

a. Report a temperature higher than 40 C.
b. Tampons are safe to use to absorb the leaking amniotic fluid.
c. Do not engage in sexual activity.
d. Taking frequent tub baths is safe.

ANS: C

Sexual activity should be avoided because it may induce preterm labor. A temperature higher than 38 C should be reported. To prevent the risk of infection, tub baths should be avoided and nothing should be inserted into the vagina. Further, foul-smelling vaginal fluid, which may be a sign of infection, should be reported.

DIF: Cognitive Level: Apply REF: IM: 762

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

18. A woman at 26 weeks of gestation is being assessed to determine whether she is experiencing preterm labor. Which finding indicates that preterm labor is occurring?

a. Estriol is not found in maternal saliva.
b. Irregular, mild uterine contractions are occurring every 12 to 15 minutes.
c. Fetal fibronectin is present in vaginal secretions.
d. The cervix is effacing and dilated to 2 cm.

ANS: D

Cervical changes such as shortened endocervical length, effacement, and dilation are predictors of imminent preterm labor. Changes in the cervix accompanied by regular contractions indicate labor at any gestation. Estriol is a form of estrogen produced by the fetus that is present in plasma at 9 weeks of gestation. Levels of salivary estriol have been shown to increase before preterm birth. Irregular, mild contractions that do not cause cervical change are not considered a threat. The presence of fetal fibronectin in vaginal secretions between 24 and 36 weeks of gestation could predict preterm labor, but it has only a 20% to 40% positive predictive value. Of more importance are other physiologic clues of preterm labor such as cervical changes.

DIF: Cognitive Level: Apply REF: IM: 759

TOP: Nursing Process: Assessment | Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

19. Which assessment is *least* likely to be associated with a breech presentation?

a. Meconium-stained amniotic fluid
b. Fetal heart tones heard at or above the maternal umbilicus
c. Preterm labor and birth
d. Postterm gestation

ANS: D

Postterm gestation is not likely to occur with a breech presentation. The presence of meconium in a breech presentation may be a result of pressure on the fetal wall as it traverses the birth canal. Fetal heart tones heard at the level of the umbilical level of the mother are a typical

finding in a breech presentation because the fetal back would be located in the upper abdominal area. Breech presentations often occur in preterm births.

DIF: Cognitive Level: Analyze REF: pp. 775-776

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

20. A pregnant womans amniotic membranes have ruptured. A prolapsed umbilical cord is suspected. What intervention would be the nurses *highest* priority?

a. Placing the woman in the knee-chest position
b. Covering the cord in sterile gauze soaked in saline
c. Preparing the woman for a cesarean birth
d. Starting oxygen by face mask

ANS: A

The woman is assisted into a modified Sims position, Trendelenburg position, or the knee-chest position in which gravity keeps the pressure of the presenting part off the cord. Although covering the cord in sterile gauze soaked saline, preparing the woman for a cesarean, and starting oxygen by face mark are appropriate nursing interventions in the event of a prolapsed cord, the intervention of top priority would be positioning the mother to relieve cord compression.

DIF: Cognitive Level: Apply REF: IM: 797

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

21. What is the primary purpose for the use of tocolytic therapy to suppress uterine activity?

a. Drugs can be efficaciously administered up to the designated beginning of term at 37 weeks gestation.
b. Tocolytic therapy has no important maternal (as opposed to fetal) contraindications.
c. The most important function of tocolytic therapy is to provide the opportunity to administer antenatal glucocorticoids.

d. If the client develops pulmonary edema while receiving tocolytic therapy, then intravenous (IV) fluids should be given.

ANS: C

Buying time for antenatal glucocorticoids to accelerate fetal lung development may be the best reason to use tocolytic therapy. Once the pregnancy has reached 34 weeks, however, the risks of tocolytic therapy outweigh the benefits. Important maternal contraindications to tocolytic therapy exist. Tocolytic-induced edema can be caused by IV fluids.

DIF: Cognitive Level: Comprehend REF: IM: 766 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

22. When would an internal version be indicated to manipulate the fetus into a vertex position?

a. Fetus from a breech to a cephalic presentation before labor begins
b. Fetus from a transverse lie to a longitudinal lie before a cesarean birth
c. Second twin from an oblique lie to a transverse lie before labor begins
d. Second twin from a transverse lie to a breech presentation during a vaginal birth

ANS: D

Internal version is used only during a vaginal birth to manipulate the second twin into a presentation that allows it to be vaginally born. For internal version to occur, the cervix needs to be completely dilated.

DIF: Cognitive Level: Remember REF: IM: 779

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

23. A client at 39 weeks of gestation has been admitted for an external version. Which intervention would the nurse anticipate the provider to order?

a. Tocolytic drug
b. Contraction stress test (CST)

c. Local anesthetic
d. Foley catheter

ANS: A

A tocolytic drug will relax the uterus before and during the version, thus making manipulation easier. CST is used to determine the fetal response to stress. A local anesthetic is not used with external version. Although the bladder should be emptied, catheterization is not necessary.

DIF: Cognitive Level: Apply REF: IM: 779 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

24. What is a maternal indication for the use of vacuum-assisted birth?

a. Wide pelvic outlet
b. Maternal exhaustion
c. History of rapid deliveries
d. Failure to progress past station 0

ANS: B

A mother who is exhausted may be unable to assist with the expulsion of the fetus. The client with a wide pelvic outlet will likely not require vacuum extraction. With a rapid delivery, vacuum extraction is not necessary. A station of 0 is too high for a vacuum-assisted birth.

DIF: Cognitive Level: Understand REF: IM: 786

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

25. Which nursing intervention should be immediately performed after the forceps-assisted birth of an infant?

a. Assessing the infant for signs of trauma
b. Administering prophylactic antibiotic agents to the infant

c. Applying a cold pack to the infants scalp
d. Measuring the circumference of the infants head

ANS: A

The infant should be assessed for bruising or abrasions at the site of application, facial palsy, and subdural hematoma. Prophylactic antibiotics are not necessary with a forceps delivery. A cold pack would place the infant at risk for cold stress and is contraindicated. Measuring the circumference of the head is part of the initial nursing assessment.

DIF: Cognitive Level: Apply REF: IM: 788

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. The nurse recognizes that uterine hyperstimulation with oxytocin requires emergency interventions. What clinical cues alert the nurse that the woman is experiencing uterine hyperstimulation? *(Select all that apply.)*

a. Uterine contractions lasting <90 seconds and occurring >2 minutes in frequency
b. Uterine contractions lasting >90 seconds and occurring <2 minutes in frequency
c. Uterine tone <20 mm Hg
d. Uterine tone >20 mm Hg
e. Increased uterine activity accompanied by a nonreassuring FHR and pattern

ANS: B, D, E

Uterine contractions that occur less frequently than 2 minutes apart and last longer than 90 seconds, a uterine tone over 20 mm Hg, and a nonreassuring FHR and pattern are indications of uterine hyperstimulation with oxytocin administration. Uterine contractions that occur more frequently than 2 minutes apart and last less than 90 seconds are the expected goal of oxytocin induction. A uterine tone less than 20 mm Hg is normal.

DIF: Cognitive Level: Analyze REF: IM: 785

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. What are the complications and risks associated with cesarean births? *(Select all that apply.)*

a. Pulmonary edema
b. Wound dehiscence
c. Hemorrhage
d. Urinary tract infections
e. Fetal injuries

ANS: A, B, C, D, E

Pulmonary edema, wound dehiscence, hemorrhage, urinary tract infections, and fetal injuries are possible complications and risks associated with cesarean births.

DIF: Cognitive Level: Understand REF: IM: 790 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

3. Women who are obese are at risk for several complications during pregnancy and birth. Which of these would the nurse anticipate with an obese client? *(Select all that apply.)*

a. Thromboembolism
b. Cesarean birth
c. Wound infection
d. Breech presentation
e. Hypertension

ANS: A, B, C, E

A breech presentation is not a complication of pregnancy or birth for the client who is obese. Venous thromboembolism is a known risk for obese women. Therefore, the use of thromboembolism-deterrent (TED) hose and sequential compression devices may help decrease the chance for clot formation. Women should also be encouraged to ambulate as soon as

possible. In addition to having an increased risk for complications with a cesarean birth, in general, obese women are also more likely to require an emergency cesarean birth. Many obese women have a pannus (i.e., large roll of abdominal fat) that overlies a lower transverse incision made just above the pubic area. The pannus causes the area to remain moist, which encourages the development of infection. Obese women are more likely to begin pregnancy with comorbidities such as hypertension and type 2 diabetes.

DIF: Cognitive Level: Analyze REF: IM: 778

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

4. The induction of labor is considered an acceptable obstetric procedure if it is in the best interest to deliver the fetus. The charge nurse on the labor and delivery unit is often asked to schedule clients for this procedure and therefore must be cognizant of the specific conditions appropriate for labor induction. What are appropriate indications for induction? *(Select all that apply?)*

a. Rupture of membranes at or near term
b. Convenience of the woman or her physician
c. Chorioamnionitis (inflammation of the amniotic sac)
d. Postterm pregnancy
e. Fetal death

ANS: A, C, D, E

The conditions listed are all acceptable indications for induction. Other conditions include intrauterine growth restriction (IUGR), maternal-fetal blood incompatibility, hypertension, and placental abruption. Elective inductions for the convenience of the woman or her provider are not recommended; however, they have become commonplace. Factors such as rapid labors and living a long distance from a health care facility may be valid reasons in such a circumstance. Elective delivery should not occur before 39 weeks of completed gestation.

DIF: Cognitive Level: Apply REF: IM: 790 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. Indications for a primary cesarean birth are often nonrecurring. Therefore, a woman who has had a cesarean birth with a low transverse scar may be a candidate for vaginal birth after cesarean (VBAC). Which clients would be*less* likely to have a successful VBAC? *(Select all that apply.)*

a. Lengthy interpregnancy interval
b. African-American race
c. Delivery at a rural hospital
d. Estimated fetal weight <4000 g
e. Maternal obesity (BMI >30)

ANS: B, C, E

Indications for a low success rate for a VBAC delivery include a short interpregnancy interval, non-Caucasian race, gestational age longer than 40 weeks, maternal obesity, preeclampsia, fetal weight greater than 4000 g, and delivery at a rural or private hospital.

Chapter 33: Postpartum Complications

MULTIPLE CHOICE

1. A perinatal nurse is caring for a woman in the immediate postbirth period. Assessment reveals that the client is experiencing profuse bleeding. What is the *most* likely cause for this bleeding?

a. Uterine atony
b. Uterine inversion
c. Vaginal hematoma
d. Vaginal laceration

ANS: A

Uterine atony is significant hypotonia of the uterus and is the leading cause of postpartum hemorrhage. Uterine inversion may lead to hemorrhage; however, it is not the most likely source

of this clients bleeding. Further, if the woman were experiencing a uterine inversion, it would be evidenced by the presence of a large, red, rounded mass protruding from the introitus. A vaginal hematoma may be associated with hemorrhage. However, the most likely clinical finding for vaginal hematoma is pain, not the presence of profuse bleeding. A vaginal laceration should be suspected if vaginal bleeding continues in the presence of a firm, contracted uterine fundus.

DIF: Cognitive Level: Understand REF: IM: 803 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

2. What is the *primary* nursing responsibility when caring for a client who is experiencing an obstetric hemorrhage associated with uterine atony?

a. Establishing venous access
b. Performing fundal massage
c. Preparing the woman for surgical intervention
d. Catheterizing the bladder

ANS: B

The initial management of excessive postpartum bleeding is a firm massage of the uterine fundus. Although establishing venous access may be a necessary intervention, fundal massage is the initial intervention. The woman may need surgical intervention to treat her postpartum hemorrhage, but the initial nursing intervention is to assess the uterus. After uterine massage, the nurse may want to catheterize the client to eliminate any bladder distention that may be preventing the uterus from properly contracting.

DIF: Cognitive Level: Apply REF: IM: 805

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

3. What is the *most* common reason for late postpartum hemorrhage (PPH)?

a. Subinvolution of the uterus
b. Defective vascularity of the decidua

c. Cervical lacerations
d. Coagulation disorders

ANS: A

Late PPH may be the result of subinvolution of the uterus. Recognized causes of subinvolution include retained placental fragments and pelvic infection. Although defective vascularity, cervical lacerations, and coagulation disorders of the decidua may also cause PPH, late PPH typically results from subinvolution of the uterus, pelvic infection, or retained placental fragments.

DIF: Cognitive Level: Understand REF: IM: 805 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. Which client is at *greatest* risk for early PPH?

a. Primiparous woman (G 2, P 1-0-0-1) being prepared for an emergency cesarean birth for fetal distress
b. Woman with severe preeclampsia on magnesium sulfate whose labor is being induced
c. Multiparous woman (G 3, P 2-0-0-2) with an 8-hour labor
d. Primigravida in spontaneous labor with preterm twins

ANS: B

Magnesium sulfate administration during labor poses a risk for PPH. Magnesium acts as a smooth muscle relaxant, thereby contributing to uterine relaxation and atony. A primiparous woman being prepared for an emergency cesarean birth for fetal distress, a multiparous woman with an 8-hour labor, and a primigravida in spontaneous labor with preterm twins do not indicate risk factors or causes of early PPH.

DIF: Cognitive Level: Analyze REF: IM: 803 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. The nurse suspects that her postpartum client is experiencing hemorrhagic shock. Which observation indicates or would confirm this diagnosis?

a. Absence of cyanosis in the buccal mucosa
b. Cool, dry skin
c. Calm mental status
d. Urinary output of at least 30 ml/hr

ANS: D

Hemorrhage may result in hemorrhagic shock. Shock is an emergency situation during which the perfusion of body organs may become severely compromised, and death may occur. The presence of adequate urinary output indicates adequate tissue perfusion. The assessment of the buccal mucosa for cyanosis can be subjective. The presence of cool, pale, clammy skin is associated with hemorrhagic shock. Hemorrhagic shock is associated with lethargy, not restlessness.

DIF: Cognitive Level: Analyze REF: IM: 809

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. The most effective and least expensive treatment of puerperal infection is prevention. What is the *most* important strategy for the nurse to adopt?

a. Large doses of vitamin C during pregnancy
b. Prophylactic antibiotics
c. Strict aseptic technique, including hand washing, by all health care personnel
d. Limited protein and fat intake

ANS: C

Strict adherence by all health care personnel to aseptic techniques during childbirth and the postpartum period is extremely important and the least expensive measure to prevent infection. Good nutrition to control anemia is a preventive measure. Increased iron intake assists in

preventing anemia. Antibiotics may be administered to manage infections; they are not a cost-effective measure to prevent postpartum infection. Limiting protein and fat intake does not help prevent anemia or prevent infection.

DIF: Cognitive Level: Apply REF: IM: 814 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

7. What is one of the initial signs and symptoms of puerperal infection in the postpartum client?

a. Fatigue continuing for longer than 1 week
b. Pain with voiding
c. Profuse vaginal lochia with ambulation
d. Temperature of 38 C (100.4 F) or higher on 2 successive days

ANS: D

Postpartum or puerperal infection is any clinical infection of the genital canal that occurs within 28 days after miscarriage, induced abortion, or childbirth. The definition used in the United States continues to be the presence of a fever of 38 C (100.4 F) or higher on 2 successive days of the first 10 postpartum days, starting 24 hours after birth. Fatigue is a late finding associated with infection. Pain with voiding may indicate a urinary tract infection (UTI), but it is not typically one of the earlier symptoms of infection. Profuse lochia may be associated with endometritis, but it is not the first symptom associated with infection.

DIF: Cognitive Level: Understand REF: IM: 812

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

8. Nurses need to understand the basic definitions and incidence data regarding PPH. Which statement regarding this condition is *most* accurate?

a. PPH is easy to recognize early; after all, the woman is bleeding.
b. Traditionally, it takes more than 1000 ml of blood after vaginal birth and 2500 ml after cesarean birth to define the condition as PPH.

c. If anything, nurses and physicians tend to overestimate the amount of blood loss.
d. Traditionally, PPH has been classified as early PPH or late PPH with respect to birth.

ANS: D

Early PPH is also known as *primary*, or *acute*, PPH; late PPH is known as *secondary* PPH. Unfortunately, PPH can occur with little warning and is often recognized only after the mother has profound symptoms. Traditionally, a 500-ml blood loss after a vaginal birth and a 1000-ml blood loss after a cesarean birth constitute PPH. Medical personnel tend to underestimate blood loss by as much as 50% in their subjective observations.

DIF: Cognitive Level: Remember REF: IM: 802 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

9. A woman who has recently given birth complains of pain and tenderness in her leg. On physical examination, the nurse notices warmth and redness over an enlarged, hardened area. Which condition should the nurse suspect, and how will it be confirmed?

a. Disseminated intravascular coagulation (DIC); asking for laboratory tests
b. von Willebrand disease (vWD); noting whether bleeding times have been extended
c. Thrombophlebitis; using real-time and color Doppler ultrasound
d. Idiopathic or immune thrombocytopenic purpura (ITP); drawing blood for laboratory analysis

ANS: C

Pain and tenderness in the extremities, which show warmth, redness, and hardness, is likely thrombophlebitis. A Doppler ultrasound examination is a common noninvasive way to confirm the diagnosis. A diagnosis of DIC is made according to clinical findings and laboratory markers. With DIC, a physical examination will reveal symptoms that may include unusual bleeding, petechiae around a blood pressure cuff on the womans arm, and/or excessive bleeding from the site of a slight trauma such as a venipuncture site. Symptoms of vWD, a type of hemophilia,

include recurrent bleeding episodes, prolonged bleeding time, and factor VIII deficiency. A risk for PPH exists with vWD but does not exhibit a warm or reddened area in an extremity. ITP is an autoimmune disorder in which the life span of antiplatelet antibodies is decreased. Increased bleeding time is a diagnostic finding, and the risk of postpartum uterine bleeding is increased.

DIF: Cognitive Level: Analyze REF: IM: 811

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

10. Which classification of placental separation is *not* recognized as an abnormal adherence pattern?

a. Placenta accreta
b. Placenta increta
c. Placenta percreta
d. Placenta abruptio

ANS: D

Placenta abruptio is premature separation of the placenta as opposed to partial or complete adherence. This classification occurs between the 20th week of gestation and delivery in the area of the decidua basalis. Symptoms include localized pain and bleeding. *Placenta accreta* is a recognized degree of attachment. With placenta accreta, the trophoblast slightly penetrates into the myometrium. *Placenta increta* is a recognized degree of attachment that results in deep penetration of the myometrium. *Placenta percreta* is the most severe degree of placental penetration that results in deep penetration of the myometrium. Bleeding with complete placental attachment occurs only when separation of the placenta is attempted after delivery. Treatment includes blood component therapy and, in extreme cases, hysterectomy may be necessary.

DIF: Cognitive Level: Understand REF: IM: 804 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

11. Which condition is considered a medical emergency that requires immediate treatment?

a. Inversion of the uterus
b. Hypotonic uterus
c. ITP
d. Uterine atony

ANS: A

Inversion of the uterus is likely to lead to hypovolemic shock and therefore is considered a medical emergency. Although hypotonic uterus, ITP, and uterine atony are serious conditions, they are not necessarily medical emergencies that require immediate treatment.

DIF: Cognitive Level: Understand REF: IM: 805

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

12. Which is the initial treatment for the client with vWD who experiences a PPH?

a. Cryoprecipitate
b. Factor VIII and von Willebrand factor (vWf)
c. Desmopressin
d. Hemabate

ANS: C

Desmopressin is the primary treatment of choice for vWD and can be administered orally, nasally, and intravenously. This medication promotes the release of factor VIII and vWf from storage. Cryoprecipitate may be used; however, because of the risk of possible donor viruses, other modalities are considered safer. Treatment with plasma products such as factor VIII and vWf is an acceptable option for this client. Because of the repeated exposure to donor blood products and possible viruses, this modality is not the initial treatment of choice. Although the administration of the prostaglandin, Hemabate, is known to promote contraction of the uterus during PPH, it is not effective for the client who has a bleeding disorder.

DIF: Cognitive Level: Apply REF: IM: 811

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

13. What would a steady trickle of bright red blood from the vagina in the presence of a firm fundus suggest to the nurse?

a. Uterine atony
b. Lacerations of the genital tract
c. Perineal hematoma
d. Infection of the uterus

ANS: B

Undetected lacerations will bleed slowly and continuously. Bleeding from lacerations is uncontrolled by uterine contraction. The fundus is not firm in the presence of uterine atony. A hematoma would develop internally. Swelling and discoloration would be noticeable; however, bright bleeding would not be. With an infection of the uterus, an odor to the lochia and systemic symptoms such as fever and malaise would be present.

DIF: Cognitive Level: Understand REF: IM: 804

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

14. If nonsurgical treatment for late PPH is ineffective, which surgical procedure would be appropriate to correct the cause of this condition?

a. Hysterectomy
b. Laparoscopy
c. Laparotomy
d. Dilation and curettage (D&C)

ANS: D

D&C allows the examination of the uterine contents and the removal of any retained placental fragments or blood clots. Hysterectomy is the removal of the uterus and is not the appropriate treatment for late PPH. A laparoscopy is the insertion of an endoscope through the abdominal

wall to examine the peritoneal cavity, but it, too, is not the appropriate treatment for this condition. A laparotomy is the surgical incision into the peritoneal cavity to explore it but is also not the appropriate treatment for late PPH.

DIF: Cognitive Level: Apply REF: IM: 805

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. Which medications are used to manage PPH? *(Select all that apply.)*

a. Oxytocin
b. Methergine
c. Terbutaline
d. Hemabate
e. Magnesium sulfate

ANS: A, B, D

Oxytocin, Methergine, and Hemabate are medications used to manage PPH. Terbutaline and magnesium sulfate are tocolytic medications that are used to relax the uterus, which would cause or worsen PPH.

DIF: Cognitive Level: Apply REF: IM: 807

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. Lacerations of the cervix, vagina, or perineum are also causes of PPH. Which factors influence the causes and incidence of obstetric lacerations of the lower genital tract? *(Select all that apply.)*

a. Operative and precipitate births
b. Adherent retained placenta
c. Abnormal presentation of the fetus
d. Congenital abnormalities of the maternal soft tissue

e. Previous scarring from infection

ANS: A, C, D, E

Abnormal adherence of the placenta occurs for unknown reasons. Attempts to remove the placenta in the usual manner can be unsuccessful, and lacerations or a perforation of the uterine wall may result. However, attempts to remove the placenta do not influence lower genital tract lacerations. Lacerations of the perineum are the most common of all lower genital tract injuries and often occur with both precipitate and operative births and are classified as first-, second-, third-, and fourth-degree lacerations. An abnormal presentation or position of the fetus, the relative size of the presenting part, and the birth canal may contribute to lacerations of the lower genital tract. Congenital abnormalities, previous scarring from infection or injury, and a contracted pelvis may also influence injury to the lower genital tract, followed by hemorrhage.

Chapter 34: Nursing Care of the High Risk Newborn

MULTIPLE CHOICE

1. An infant at 36 weeks of gestation has increasing respirations (80 to 100 breaths per minute with significant substernal retractions). The infant is given oxygen by continuous nasal positive airway pressure (CPAP). What level of partial pressure of arterial oxygen (PaO_2) indicates hypoxia?

a. 67 mm Hg
b. 89 mm Hg
c. 45 mm Hg
d. 73 mm Hg

ANS: C

The laboratory value of PaO_2 of 45 mm Hg is below the range for a normal neonate and indicates hypoxia in this infant. The normal range for PaO_2 is 60 to 80 mm Hg; therefore, PaO_2 levels of 67 and 73 mm Hg fall within the normal range, and a PaO_2 of 89 mm Hg is higher than the normal range.

DIF: Cognitive Level: Understand REF: IM: 837

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. On day 3 of life, a newborn continues to require 100% oxygen by nasal cannula. The parents ask if they may hold their infant during his next gavage feeding. Considering that this newborn is physiologically stable, what response should the nurse provide?

a. Parents are not allowed to hold their infants who are dependent on oxygen.
b. You may only hold your babys hand during the feeding.
c. Feedings cause more physiologic stress; therefore, the baby must be closely monitored. I dont think you should hold the baby.
d. You may hold your baby during the feeding.

ANS: D

Physical contact with the infant is important to establish early bonding. The nurse as the support person and teacher is responsible for shaping the environment and making the caregiving responsive to the needs of both the parents and the infant. Allowing the parents to hold their baby is the most appropriate response by the nurse. Parental interaction by holding should be encouraged during gavage feedings; nasal cannula oxygen therapy allows for easy feedings and psychosocial interactions. The parent can swaddle the infant or provide kangaroo care while gavage feeding their infant. Both swaddling and kangaroo care during feedings provide positive interactions for the infant and help the infant associate feedings with positive interactions.

DIF: Cognitive Level: Apply REF: IM: 834 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. A premature infant with respiratory distress syndrome (RDS) receives artificial surfactant. How does the nurse explain surfactant therapy to the parents?

a. Surfactant improves the ability of your babys lungs to exchange oxygen and carbon dioxide.
b. The drug keeps your baby from requiring too much sedation.

c. Surfactant is used to reduce episodes of periodic apnea.
d. Your baby needs this medication to fight a possible respiratory tract infection.

ANS: A

Surfactant can be administered as an adjunct to oxygen and ventilation therapy. With the administration of an artificial surfactant, respiratory compliance is improved until the infant can generate enough surfactant on his or her own. Surfactant has no bearing on the sedation needs of the infant. Surfactant is used to improve respiratory compliance, including the exchange of oxygen and carbon dioxide. The goal of surfactant therapy in an infant with RDS is to stimulate the production of surfactant in the type 2 cells of the alveoli. The clinical presentation of RDS and neonatal pneumonia may be similar. The infant may be started on broad-spectrum antibiotics to treat infection.

DIF: Cognitive Level: Apply REF: IM: 826 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

4. An infant is to receive gastrostomy feedings. Which intervention should the nurse institute to prevent bloating, gastrointestinal reflux into the esophagus, vomiting, and respiratory compromise?

a. Rapid bolusing of the entire amount in 15 minutes
b. Warm cloths to the abdomen for the first 10 minutes
c. Slow, small, warm bolus feedings over 30 minutes
d. Cold, medium bolus feedings over 20 minutes

ANS: C

Feedings by gravity are slowly accomplished over 20- to 30-minute periods to prevent adverse reactions. Rapid bolusing would most likely lead to the adverse reactions listed. Temperature stability in the newborn is critical. Applying warm cloths to the abdomen would not be appropriate because the environment is not thermoregulated. In addition, abdominal warming is

not indicated with feedings of any kind. Small feedings at room temperature are recommended to prevent adverse reactions.

DIF: Cognitive Level: Apply REF: IM: 830

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

5. A premature infant never seems to sleep longer than an hour at a time. Each time a light is turned on, an incubator closes, or people talk near her crib, she wakes up and inconsolably cries until held. What is the *correct* nursing diagnosis beginning with ineffective coping, related to?

a. Severe immaturity
b. Environmental stress
c. Physiologic distress
d. Behavioral responses

ANS: B

Ineffective coping, related to environmental stress is the most appropriate nursing diagnosis for this infant. Light and sound are known adverse stimuli that add to an already stressed premature infant. The nurse must closely monitor the environment for sources of overstimulation. Although the infant may be severely immature in this case, she is responding to environmental stress. Physiologic distress is the response to environmental stress. The result is stress cues such as increased metabolic rate, increased oxygen and caloric use, and depression of the immune system. The infants behavioral response to the environmental stress is crying. The appropriate nursing diagnosis reflects the *cause* of this response.

DIF: Cognitive Level: Apply REF: pp. 831-832 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Safe and Effective Care Environment

6. Which clinical findings would alert the nurse that the neonate is expressing pain?

a. Low-pitched crying; tachycardia; eyelids open wide
b. Cry face; flaccid limbs; closed mouth

c. High-pitched, shrill cry; withdrawal; change in heart rate

d. Cry face; eyes squeezed; increase in blood pressure

ANS: D

Crying and an increased heart rate are manifestations indicative of pain in the neonate. Typically, infants tightly close their eyes when in pain, not open them wide. In addition, infants may display a rigid posture with the mouth open and may also withdraw limbs and become tachycardic with pain. A high-pitched, shrill cry is associated with genetic or neurologic anomalies.

DIF: Cognitive Level: Understand REF: IM: 840

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

7. A newborn was admitted to the neonatal intensive care unit (NICU) after being delivered at 29 weeks of gestation to a 28-year-old multiparous, married, Caucasian woman whose pregnancy was uncomplicated until the premature rupture of membranes and preterm birth. The newborns parents arrive for their first visit after the birth. The parents walk toward the bedside but remain approximately 5 feet away from the bed. What is the nurses *most* appropriate action?

a. Wait quietly at the newborns bedside until the parents come closer.

b. Go to the parents, introduce him or herself, and gently encourage them to meet their infant. Explain the equipment first, and then focus on the newborn.

c. Leave the parents at the bedside while they are visiting so that they have some privacy.

d. Tell the parents only about the newborns physical condition and caution them to avoid touching their baby.

ANS: B

The nurse is instrumental in the initial interactions with the infant. The nurse can help the parents *see* the infant rather than focus on the equipment. The importance and purpose of the apparatus that surrounds their infant also should be explained to them. Parents often need encouragement and recognition from the nurse to acknowledge the reality of the infants condition. Parents need

to see and touch their infant as soon as possible to acknowledge the reality of the birth and the infants appearance and condition. Encouragement from the nurse is instrumental in this process. Telling the parents to avoid touching their baby is inappropriate and unhelpful.

DIF: Cognitive Level: Apply REF: IM: 834

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

8. An infant is being discharged from the NICU after 70 days of hospitalization. The infant was born at 30 weeks of gestation with several conditions associated with prematurity, including RDS, mild bronchopulmonary dysplasia (BPD), and retinopathy of prematurity (ROP), requiring surgical treatment. During discharge teaching, the infants mother asks the nurse if her baby will meet developmental milestones on time, as did her son who was born at term. What is the nurses *most* appropriate response?

a. Your baby will develop exactly like your first child.
b. Your baby does not appear to have any problems at this time.
c. Your baby will need to be corrected for prematurity.
d. Your baby will need to be followed very closely.

ANS: C

The age of a preterm newborn is corrected by adding the gestational age and the postnatal age. The infants responses are accordingly evaluated against the norm expected for the corrected age of the infant. The baby is currently 40 weeks of postconceptional age and can be expected to be doing what a 40-week-old infant would be doing. Although predicting with complete accuracy the growth and development potential of each preterm infant is impossible, certain measurable factors predict normal growth and development. The preterm infant experiences catch-up body growth during the first 2 to 3 years of life. Development needs to be evaluated over time. The growth and developmental milestones are corrected for gestational age until the child is approximately years old.

DIF: Cognitive Level: Apply REF: pp. 819-820 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

9. A pregnant woman was admitted for induction of labor at 43 weeks of gestation with sure dates. A nonstress test (NST) in the obstetricians office revealed a nonreactive tracing. On artificial rupture of membranes, thick meconium-stained fluid was noted. What should the nurse caring for the infant after birth anticipate?

a. Meconium aspiration, hypoglycemia, and dry, cracked skin
b. Excessive vernix caseosa covering the skin, lethargy, and RDS
c. Golden yellow to green-stained skin and nails, absence of scalp hair, and an increased amount of subcutaneous fat
d. Hyperglycemia, hyperthermia, and an alert, wide-eyed appearance

ANS: A

Meconium aspiration, hypoglycemia, and dry, cracked skin are consistent with a postmature infant. Excessive vernix caseosa, lethargy, and RDS are consistent with a very premature infant. The skin may be meconium stained, but the infant will most likely have long hair and decreased amounts of subcutaneous fat. Postmaturity with a nonreactive NST is indicative of hypoxia. Signs and symptoms associated with fetal hypoxia are hypoglycemia, temperature instability, and lethargy.

DIF: Cognitive Level: Analyze REF: IM: 843 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

10. During the assessment of a preterm infant, the nurse notices continued respiratory distress even though oxygen and ventilation have been provided. In this situation, which condition should the nurse suspect?

a. Hypovolemia and/or shock
b. Excessively cool environment
c. Central nervous system (CNS) injury
d. Pending renal failure

ANS: A

Other symptoms might include hypotension, prolonged capillary refill, and tachycardia, followed by bradycardia. Intervention is necessary. Preterm infants are susceptible to temperature instability. The goal of thermoregulation is to provide a *neutral thermal environment*. Hypoglycemia is likely to occur if the infant is attempting to conserve heat. CNS injury is manifested by hyperirritability, seizures, and abnormal movements of the extremities. Urine output and testing of specific gravity are appropriate interventions for the infant with suspected renal failure. This neonate is unlikely to be delivered with respiratory distress.

DIF: Cognitive Level: Apply REF: IM: 818 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

11. In appraising the growth and development potential of a preterm infant, the nurse should be cognizant of the information that is best described in which statement?

a. Tell the parents that their child will not catch up until approximately age 10 years (for girls) to age 12 years (for boys).
b. Correct for milestones, such as motor competencies and vocalizations, until the child is approximately 2 years of age.
c. Know that the greatest catch-up period is between 9 and 15 months postconceptual age.
d. Know that the length and breadth of the trunk is the first part of the infant to experience catch-up growth.

ANS: B

Corrections are made with a formula that adds gestational age and postnatal age. Whether a girl or boy, the infant experiences catch-up body growth during the first 2 to 3 years of life. Maximum catch-up growth occurs between 36 and 40 weeks of postconceptual age. The head is the first to experience catch-up growth.

DIF: Cognitive Level: Understand REF: IM: 820 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

12. A nurse practicing in the perinatal setting should promote kangaroo care regardless of an infants gestational age. Which statement regarding this intervention is *most* appropriate?

a. Kangaroo care was adopted from classical British nursing traditions.
b. This intervention helps infants with motor and CNS impairments.
c. Kangaroo care helps infants interact directly with their parents and enhances their temperature regulation.
d. This intervention gets infants ready for breastfeeding.

ANS: C

Kangaroo care is skin-to-skin holding in which the infant, dressed only in a diaper, is placed directly on the parents bare chest and then covered. The procedure helps infants interact with their parents and regulates their temperature, among other developmental benefits. Kangaroo care was established in Bogota, Colombia, assists the infant in maintaining an organized state, and decreases pain perception during heelsticks. Even premature infants who are unable to suckle benefit from kangaroo care. This practice fosters increased vigor and an enhanced breastfeeding experience as the infant matures.

DIF: Cognitive Level: Knowledge REF: IM: 833

TOP: Nursing Process: Implementation MSC: Client Needs: Health Promotion and Maintenance

13. For clinical purposes, the *most* accurate definition of preterm and postterm infants is defined as what?

a. *Preterm*: Before 34 weeks of gestation if the infant is appropriate for gestational age (AGA); before 37 weeks if the infant is small for gestational age (SGA)
b. *Postterm*: After 40 weeks of gestation if the infant is large for gestational age (LGA); beyond 42 weeks if the infant is AGA
c. *Preterm*: Before 37 weeks of gestation and postterm beyond 42 weeks of gestation; no matter the size for gestational age at birth
d. *Preterm*: Before 38 to 40 weeks of gestation if the infant is SGA; *postterm*, beyond 40 to 42 weeks gestation if the infant is LGA

ANS: C

Preterm and postterm are strictly measures of timebefore 37 weeks and beyond 42 weeks, respectivelyregardless of the size for gestational age.

DIF: Cognitive Level: Understand REF: IM: 817 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Health Promotion and Maintenance

14. With regard to an eventual discharge of the high-risk newborn or the transfer of the newborn to a different facility, which information is essential to provide to the parents?

a. Infants stay in the NICU until they are ready to go home.
b. Once discharged to go home, the high-risk infant should be treated like any healthy term newborn.
c. Parents of high-risk infants need special support and detailed contact information.
d. If a high-risk infant and mother need to be transferred to a specialized regional center, then waiting until after the birth and until the infant is stabilized is best.

ANS: C

High-risk infants can cause profound parental stress and emotional turmoil. Parents need support, special teaching, and quick access to various resources available to help them care for their baby. Parents and their high-risk infant should get to spend a night or two in a predischarge room, where care for the infant is provided away from the NICU. Simply because high-risk infants are eventually discharged does not mean they are normal, healthy babies. Follow-up by specialized practitioners is essential. Ideally, the mother and baby are transported with the fetus in utero; this reduces neonatal morbidity and mortality.

DIF: Cognitive Level: Apply REF: IM: 847 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

15. By understanding the four mechanisms of heat transfer (convection, conduction, radiation, and evaporation), the nurse can create an environment for the infant that prevents temperature instability. Which significant symptoms will the infant display when experiencing cold stress?

a. Decreased respiratory rate

b. Bradycardia, followed by an increased heart rate
c. Mottled skin with acrocyanosis
d. Increased physical activity

ANS: C

The infant has minimal-to-no fat stores. During times of cold stress, the skin becomes mottled and acrocyanosis develops, progressing to cyanosis. Even if the infant is being cared for on a radiant warmer or in an isolette, the nurses role is to observe the infant frequently to prevent heat loss and to respond quickly if signs and symptoms of cold stress occur. The respiratory rate increases, followed by periods of apnea. The infant initially tries to conserve heat and burns more calories, after which the metabolic system goes into overdrive. In the preterm infant who is experiencing heat loss, the heart rate initially increases, followed by periods of bradycardia. In the term infant, increased physical activity is the natural response to heat loss. However, in a term infant who is experiencing respiratory distress or in a preterm infant, physical activity is decreased.

DIF: Cognitive Level: Analyze REF: IM: 823 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

16. When evaluating the preterm infant, the nurse understands that compared with the term infant, what information is important for the nurse to understand?

a. Few blood vessels visible through the skin
b. More subcutaneous fat
c. Well-developed flexor muscles
d. Greater surface area in proportion to weight

ANS: D

Preterm infants have greater surface area in proportion to their weight. More subcutaneous fat and well-developed muscles are indications of a more mature infant.

DIF: Cognitive Level: Analyze REF: IM: 818

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

17. When providing an infant with a gavage feeding, which infant assessment should be documented each time?

a. Abdominal circumference after the feeding
b. Heart rate and respirations before feeding
c. Suck and swallow coordination
d. Response to the feeding

ANS: D

Documentation of a gavage feeding should include the size of the feeding tube, the amount and quality of the residual from the previous feeding, the type and quantity of the fluid instilled, and the infants response to the procedure. Abdominal circumference is not measured after a gavage feeding. Although vital signs may be obtained before feeding, the infants response to the feeding is more important. Similarly, some older infants may be learning to suck; the most important factor to document would still be the infants response to the feeding, including the attempts to suck.

DIF: Cognitive Level: Apply REF: IM: 830 TOP: Nursing Process: Evaluation

MSC: Client Needs: Physiologic Integrity

18. An infant at 26 weeks of gestation arrives intubated from the delivery room. The nurse weighs the infant, places him under the radiant warmer, and attaches him to the ventilator at the prescribed settings. A pulse oximeter and cardiorespiratory monitor are placed. The pulse oximeter is recording oxygen saturations of 80%. The prescribed saturations are 92%. What is the nurses *most* appropriate action at this time?

a. Listening to breath sounds, and ensuring the patency of the endotracheal tube, increasing oxygen, and notifying a physician
b. Continuing to observe and making no changes until the saturations are 75%
c. Continuing with the admission process to ensure that a thorough assessment is completed

d. Notifying the parents that their infant is not doing well

ANS: A

Listening to breath sounds and ensuring the patency of the endotracheal tube, increasing oxygen, and notifying a physician are appropriate nursing interventions to assist in optimal oxygen saturation of the infant. Oxygen saturation should be maintained above 92%, and oxygenation status of the infant is crucial. The nurse should delay other tasks to stabilize the infant. Notifying the parents that the infant is not doing well is not an appropriate action. Further assessment and intervention are warranted before determining fetal status.

DIF: Cognitive Level: Apply REF: IM: 824

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

19. Necrotizing enterocolitis (NEC) is an inflammatory disease of the gastrointestinal mucosa. The signs of NEC are nonspecific. What are generalized signs and symptoms of this condition?

a. Hypertonia, tachycardia, and metabolic alkalosis
b. Abdominal distention, temperature instability, and grossly bloody stools
c. Hypertension, absence of apnea, and ruddy skin color
d. Scaphoid abdomen, no residual with feedings, and increased urinary output

ANS: B

Some generalized signs of NEC include decreased activity, hypotonia, pallor, recurrent apnea and bradycardia, decreased oxygen saturation values, respiratory distress, metabolic acidosis, oliguria, hypotension, decreased perfusion, temperature instability, cyanosis, abdominal distention, residual gastric aspirates, vomiting, grossly bloody stools, abdominal tenderness, and erythema of the abdominal wall. The infant may display hypotonia, bradycardia, and metabolic acidosis.

DIF: Cognitive Level: Understand REF: IM: 839

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

20. In caring for the preterm infant, what complication is thought to be a result of high arterial blood oxygen level?

a. NEC
b. ROP
c. BPD
d. Intraventricular hemorrhage (IVH)

ANS: B

ROP is thought to occur as a result of high levels of oxygen in the blood. NEC is caused by the interference of blood supply to the intestinal mucosa. Necrotic lesions occur at that site. BPD is caused by the use of positive pressure ventilation against the immature lung tissue. IVH results from the rupture of the fragile blood vessels in the ventricles of the brain and is most often associated with hypoxic injury, increased blood pressure, and fluctuating cerebral blood flow.

DIF: Cognitive Level: Understand REF: IM: 837

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

21. Which condition might premature infants who exhibit 5 to 10 seconds of respiratory pauses, followed by 10 to 15 seconds of compensatory rapid respiration, be experiencing?

a. Suffering from sleep or wakeful apnea
b. Experiencing severe swings in blood pressure
c. Trying to maintain a neutral thermal environment
d. Breathing in a respiratory pattern common to premature infants

ANS: D

Breathing in a respiratory pattern is called *periodic breathing* and is common to premature infants. This pattern may still require nursing intervention of oxygen and/or ventilation. Apnea is the cessation of respirations for 20 seconds or longer and should not be confused with periodic breathing.

DIF: Cognitive Level: Understand REF: IM: 817

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

22. With regard to infants who are SGA and intrauterine growth restriction (IUGR), the nurse should be aware of which information?

a. In the first trimester, diseases or abnormalities result in asymmetric IUGR.
b. Infants with asymmetric IUGR have the potential for normal growth and development.
c. In asymmetric IUGR, weight is slightly larger than SGA, whereas length and head circumference are somewhat less than SGA.
d. Symmetric IUGR occurs in the later stages of pregnancy.

ANS: B

IUGR is either symmetric or asymmetric. The symmetric form occurs in the first trimester; infants who are SGA have reduced brain capacity. The asymmetric form occurs in the later stages of pregnancy. Weight is less than the 10th percentile; head circumference is greater than the 10th percentile. Infants with asymmetric IUGR have the potential for normal growth and development.

DIF: Cognitive Level: Understand REF: IM: 844 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

23. NEC is an acute inflammatory disease of the gastrointestinal mucosa that can progress to perforation of the bowel. Approximately 2% to 5% of premature infants succumb to this fatal disease. Care is supportive; however, known interventions may decrease the risk of NEC. Which intervention has the *greatest* effect on lowering the risk of NEC?

a. Early enteral feedings
b. Breastfeeding
c. Exchange transfusion
d. Prophylactic probiotics

ANS: B

A decrease in the incidence of NEC is directly correlated with exclusive breastfeeding. Breast milk enhances the maturation of the gastrointestinal tract and contains immune factors that contribute to a lower incidence or severity of NEC, Crohn disease, and celiac illness. The NICU nurse can be very supportive of the mother in terms of providing her with equipment to pump breast milk, ensuring privacy, and encouraging skin-to-skin contact with the infant. Early enteral feedings of formula or hyperosmolar feedings are a risk factor known to contribute to the development of NEC. The mother should be encouraged to pump or feed breast milk exclusively. Exchange transfusion may be necessary; however, it is a known risk factor for the development of NEC. Although still early, a study in 2005 found that the introduction of prophylactic probiotics appeared to enhance the normal flora of the bowel and therefore decrease the severity of NEC when it did occur. This treatment modality is not as widespread as encouraging breastfeeding; however, it is another strategy that the care providers of these extremely fragile infants may have at their disposal.

DIF: Cognitive Level: Apply REF: IM: 839 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

24. Because of the premature infants decreased immune functioning, what nursing diagnosis should the nurse include in a plan of care for a premature infant?

a. Delayed growth and development
b. Ineffective thermoregulation
c. Ineffective infant feeding pattern
d. Risk for infection

ANS: D

The nurse needs to understand that decreased immune functioning increases the risk for infection. Growth and development, thermoregulation, and feeding may be affected, although only indirectly.

DIF: Cognitive Level: Apply REF: IM: 821 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

25. What is the *most* important nursing action in preventing neonatal infection?

a. Good handwashing
b. Isolation of infected infants
c. Separate gown technique
d. Standard Precautions

ANS: A

Virtually all controlled clinical trials have demonstrated that effective handwashing is responsible for the prevention of nosocomial infection in nursery units. Measures to be taken include Standard Precautions, careful and thorough cleaning, frequent replacement of used equipment, and disposal of excrement and linens in an appropriate manner. Overcrowding must be avoided in nurseries. However, the most important nursing action for preventing neonatal infection is effective handwashing.

DIF: Cognitive Level: Apply REF: IM: 819

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

MULTIPLE RESPONSE

1. Which risk factors are associated with NEC? *(Select all that apply.)*

a. Polycythemia
b. Anemia
c. Congenital heart disease
d. Bronchopulmonary dysphasia
e. Retinopathy

ANS: A, B, C

Risk factors for NEC include asphyxia, RDS, umbilical artery catheterization, exchange transfusion, early enteral feedings, patent ductus arteriosus (PDA), congenital heart disease, polycythemia, anemia, shock, and gastrointestinal infection. Bronchopulmonary dysphasia and retinopathy are not associated with NEC.

DIF: Cognitive Level: Understand REF: IM: 839

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

2. Infants born between 34 0/7 and 36 6/7 weeks of gestation are called *late-preterm infants* because they have many needs similar to those of preterm infants. Because they are more stable than early-preterm infants, they may receive care that is similar to that of a full-term baby. These infants are at increased risk for which conditions? *(Select all that apply.)*

a. Problems with thermoregulation
b. Cardiac distress
c. Hyperbilirubinemia
d. Sepsis
e. Hyperglycemia

ANS: A, C, D

Thermoregulation problems, hyperbilirubinemia, and sepsis are all conditions related to immaturity and warrant close observation. After discharge, the infant is at risk for rehospitalization related to these problems. Association of Womens Health, Obstetric and Neonatal Nurses (AWHONN) launched the Near-Term Infant Initiative to study the problem and ways to ensure that these infants receive adequate care. The nurse should ensure that this infant is adequately feeding before discharge and that parents are taught the signs and symptoms of these complications. Late-preterm infants are also at increased risk for respiratory distress and hypoglycemia.

Chapter 35: Acquired Problems of the Newborn

MULTIPLE CHOICE

1. A macrosomic infant is born after a difficult forceps-assisted delivery. After stabilization, the infant is weighed, and the birth weight is 4550 g (9 lb, 6 oz). What is the nurses *first* priority?

a. Leave the infant in the room with the mother.
b. Immediately take the infant to the nursery.
c. Perform a gestational age assessment to determine whether the infant is large for gestational age.
d. Frequently monitor blood glucose levels, and closely observe the infant for signs of hypoglycemia.

ANS: D

Regardless of gestational age, this infant is macrosomic (defined as fetal weight more than 4000 g) and is at high risk for hypoglycemia, which affects many macrosomic infants. Blood glucose levels should be frequently monitored, and the infant should be closely observed for signs of hypoglycemia. Close observation can be achieved in the mothers room with nursing interventions. However, depending on the condition of the infant, observation may be more appropriate in the nursery.

DIF: Cognitive Level: Apply REF: IM: 856

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

2. A 3.8-kg infant was vaginally delivered at 39 weeks after a 30-minute second stage. A nuchal cord was found at delivery. After birth, the infant is noted to have petechiae over the face and upper back. Which information regarding petechiae is *most* accurate and should be provided to the parents?

a. Are benign if they disappear within 48 hours of birth
b. Result from increased blood volume
c. Should always be further investigated
d. Usually occur with a forceps-assisted delivery

ANS: A

Petechiae, or pinpoint hemorrhagic areas, acquired during childbirth may extend over the upper portion of the trunk and face. These lesions are benign if they disappear within 2 days of childbirth and no new lesions appear. Petechiae may result from decreased platelet formation. In this situation, the presence of petechiae is most likely a soft-tissue injury resulting from the nuchal cord at birth. Unless the lesions do not dissipate in 2 days, alarming the family is not necessary. Petechiae usually occur with a breech presentation vaginal birth.

DIF: Cognitive Level: Apply REF: IM: 853

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

3. What information regarding a fractured clavicle is *most* important for the nurse to take into consideration when planning the infants care?

a. Prone positioning facilitates bone alignment.
b. No special treatment is necessary.
c. Parents should be taught range-of-motion exercises.
d. The shoulder should be immobilized with a splint.

ANS: B

Fractures in newborns generally heal rapidly. Except for gentle handling, no accepted treatment for a fractured clavicle exists. Movement should be limited, and the infant should be gently handled. Performing range-of-motion exercises on the infant is not necessary. A fractured clavicle does not require immobilization with a splint.

DIF: Cognitive Level: Apply REF: IM: 854

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

4. Which conditions are infants of diabetic mothers (IDMs) at a higher risk for developing?

a. Iron deficiency anemia
b. Hyponatremia
c. Respiratory distress syndrome

d. Sepsis

ANS: C

IDMs are at risk for macrosomia, birth trauma, perinatal asphyxia, respiratory distress syndrome, hypoglycemia, hypocalcemia, hypomagnesemia, cardiomyopathy, hyperbilirubinemia, and polycythemia. IDMs are not at risk for anemia, hyponatremia, or sepsis.

DIF: Cognitive Level: Understand REF: IM: 856 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

5. A pregnant woman at 37 weeks of gestation has had ruptured membranes for 26 hours. A cesarean section is performed for failure to progress. The fetal heart rate (FHR) before birth is 180 beats per minute with limited variability. At birth the newborn has Apgar scores of 6 and 7 at 1 and 5 minutes and is noted to be pale and tachypneic. Based on the maternal history, what is the *most* likely cause of this newborns distress?

a. Hypoglycemia
b. Phrenic nerve injury
c. Respiratory distress syndrome
d. Sepsis

ANS: D

The prolonged rupture of membranes and the tachypnea (before and after birth) suggest sepsis. A differential diagnosis can be difficult because signs of sepsis are similar to noninfectious problems such as anemia and hypoglycemia. Phrenic nerve injury is usually the result of traction on the neck and arm during childbirth and is not applicable to this situation. The earliest signs of sepsis are characterized by lack of specificity (e.g., lethargy, poor feeding, irritability), not respiratory distress syndrome.

DIF: Cognitive Level: Understand REF: IM: 858

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. What is the *most* important nursing action in preventing neonatal infection?

a. Good handwashing
b. Isolation of infected infants
c. Separate gown technique
d. Standard Precautions

ANS: A

Virtually all controlled clinical trials have demonstrated that effective handwashing is responsible for the prevention of health careassociated infection in nursery units. Overcrowding must be avoided in nurseries, and infants with infectious processes should be isolated. Separate gowns should be worn in caring for each infant in the special care nursery. Soiled linens should be disposed of in an appropriate manner. Measures to be taken include Standard Precautions, careful and thorough cleaning, frequent replacement of used equipment, and disposal of excrement and linens in an appropriate manner. Ideally infants should remain with their mothers.

DIF: Cognitive Level: Apply REF: IM: 860

TOP: Nursing Process: Implementation

MSC: Client Needs: Safe and Effective Care Environment

7. A pregnant woman arrives at the birth unit in labor at term, having had no prenatal care. After birth, her infant is noted to be small for gestational age with small eyes and a thin upper lip. The infant also is microcephalic. Based on her infants physical findings, this woman should be questioned about her use of which substance during pregnancy?

a. Alcohol
b. Cocaine
c. Heroin
d. Marijuana

ANS: A

The description of the infant suggests fetal alcohol syndrome, which is consistent with maternal alcohol consumption during pregnancy. Fetal brain, kidney, and urogenital system malformations have been associated with maternal cocaine ingestions. Heroin use in pregnancy frequently results in intrauterine growth restriction (IUGR). The infant may have a shrill cry and sleep-cycle disturbances and may exhibit with poor feeding, tachypnea, vomiting, diarrhea, hypothermia or hyperthermia, and sweating. Studies have found a higher incidence of meconium staining in infants born of mothers who used marijuana during pregnancy.

DIF: Cognitive Level: Understand REF: IM: 870

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

8. For an infant experiencing symptoms of drug withdrawal, which intervention should be included in the plan of care?

a. Administering chloral hydrate for sedation
b. Feeding every 4 to 6 hours to allow extra rest between feedings
c. Snugly swaddling the infant and tightly holding the baby
d. Playing soft music during feeding

ANS: C

The infant should be snugly wrapped to reduce self-stimulation behaviors and to protect the skin from abrasions. Phenobarbital or diazepam may be administered to decrease central nervous system (CNS) irritability. The infant should be fed in small, frequent amounts and burped well to diminish aspiration and maintain hydration. The infant should not be stimulated (such as with music), because stimulation will increase activity and potentially increase CNS irritability.

DIF: Cognitive Level: Apply REF: IM: 873

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

9. Human immunodeficiency virus (HIV) may be transmitted perinatally or during the postpartum period. Which statement regarding the method of transmission is *most* accurate?

a. Only in the third trimester from the maternal circulation
b. From the use of unsterile instruments
c. Only through the ingestion of amniotic fluid
d. Through the ingestion of breast milk from an infected mother

ANS: D

Postnatal transmission of the HIV through breastfeeding and breast milk may occur. Transmission of the HIV from the mother to the fetus may occur through the placenta at various gestational ages. Transmission of the HIV from the use of unsterile instruments is highly unlikely; most health care facilities must meet sterility standards for all instrumentation.

DIF: Cognitive Level: Understand REF: IM: 863 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

10. Which substance, when abused during pregnancy, is the *most* significant cause of cognitive impairment and dysfunction in the infant?

a. Alcohol
b. Tobacco
c. Marijuana
d. Heroin

ANS: A

Alcohol abuse during pregnancy is recognized as one of the leading causes of neurodevelopmental disorders in the United States. Alcohol is a teratogen; maternal ethanol abuse during gestation can lead to identifiable fetal alcohol spectrum disorders that include alcohol-related neurodevelopmental disorders. Cigarette smoking is linked to adverse pregnancy outcomes; the risk for placenta previa, placenta abruption, and premature rupture of membranes is twice that of nonsmokers. Marijuana is the most common illicit drug used by pregnant women. Marijuana crosses the placenta, and its use during pregnancy can result in shortened gestation

and a higher incidence of IUGR. Heroin crosses the placenta and often results in IUGR, stillbirth, and congenital anomalies.

DIF: Cognitive Level: Remember REF: IM: 870

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

11. During a prenatal examination, a woman reports having two cats at home. The nurse informs her that she should not be cleaning the litter box while she is pregnant. The client questions the nurse as to why. What is the nurses*most* appropriate response?

a. Your cats could be carrying toxoplasmosis. This is a zoonotic parasite that can infect you and have severe effects on your unborn child.
b. You and your baby can be exposed to the HIV in your cats feces.
c. Its just gross. You should make your husband clean the litter boxes.
d. Cat feces are known to carry *Escherichia coli*, which can cause a severe infection in you and your baby.

ANS: A

Toxoplasmosis is a multisystem disease caused by the protozoal *Toxoplasma gondii* parasite, commonly found in cats, dogs, pigs, sheep, and cattle. Approximately 30% of women who contract toxoplasmosis during gestation transmit the disease to their offspring. Clinical features ascribed to toxoplasmosis include hydrocephalus or microcephaly, chorioretinitis, seizures, or cerebral calcifications. HIV is not transmitted by cats. Although cleaning the litter boxes is just gross, this statement is not appropriate, fails to answer the clients question, and is not the nurses best response. *E. coli* is found in normal human fecal flora and is not transmitted by cats.

DIF: Cognitive Level: Apply REF: IM: 860 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

12. A primigravida has just delivered a healthy infant girl. The nurse is about to administer erythromycin ointment in the infants eyes when the mother asks, What is that medicine for? How should the nurse respond?

a. It is an eye ointment to help your baby see you better.
b. It is to protect your baby from contracting herpes from your vaginal tract.
c. Erythromycin is prophylactically given to prevent a gonorrheal infection.
d. This medicine will protect your babys eyes from drying out over the next few days.

ANS: C

With the prophylactic use of erythromycin, the incidence of gonococcal conjunctivitis has declined to less than 0.5%. Eye prophylaxis is administered at or shortly after birth to prevent ophthalmia neonatorum. Erythromycin has no bearing on enhancing vision, is used to prevent an infection caused by gonorrhea, not herpes, and is given to prevent infection, not for lubrication.

DIF: Cognitive Level: Apply REF: IM: 861 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

13. The nurse should be cognizant of which condition related to skeletal injuries sustained by a neonate during labor or childbirth?

a. Newborns skull is still forming and fractures fairly easily.
b. Unless a blood vessel is involved, linear skull fractures heal without special treatment.
c. Clavicle fractures often need to be set with an inserted pin for stability.
d. Other than the skull, the most common skeletal injuries are to leg bones.

ANS: B

Approximately 70% of neonatal skull fractures are linear. Because the newborn skull is flexible, considerable force is required to fracture it. Clavicle fractures need no special treatment. The clavicle is the bone most often fractured during birth.

DIF: Cognitive Level: Understand REF: IM: 853 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

14. The nurse is evaluating a neonate who was delivered 3 hours ago by vacuum-assisted delivery. The infant has developed a cephalhematoma. Which statement is *most* applicable to the care of this neonate?

a. Intracranial hemorrhage (ICH) as a result of birth trauma is more likely to occur in the preterm, low-birth-weight infant.
b. Subarachnoid hemorrhage (the most common form of ICH) occurs in term infants as a result of hypoxia.
c. In many infants, signs of hemorrhage in a full-term infant are absent and diagnosed only through laboratory tests.
d. Spinal cord injuries almost always result from vacuum-assisted deliveries.

ANS: C

Abnormalities in lumbar punctures or red blood cell counts, for instance, or in visuals on computed tomographic (CT) scans might reveal a hemorrhage. ICH as a result of birth trauma is more likely to occur in the full-term, large infant. Subarachnoid hemorrhage in term infants is a result of trauma; in preterm infants, it is a result of hypoxia. Spinal cord injuries are almost always from breech births; however, spinal cord injuries are rare today because cesarean birth is used for breech presentation.

DIF: Cognitive Level: Apply REF: IM: 855 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

15. Near the end of the first week of life, an infant who has not been treated for any infection develops a copper-colored maculopapular rash on the palms and around the mouth and anus. The newborn is displaying signs and symptoms of which condition?

a. Gonorrhea
b. Herpes simplex virus (HSV) infection
c. Congenital syphilis
d. HIV

ANS: C

A copper-colored maculopapular rash is indicative of congenital syphilis with lesions that may extend over the trunk and extremities. This rash is not an indication that the neonate has contracted gonorrhea. Rather, the neonate with gonorrheal infection might have septicemia, meningitis, conjunctivitis, and scalp abscesses. Infants affected with the HSV display growth restriction, skin lesions, microcephaly, hypertonicity, and seizures. Typically, the HIV-infected neonate is asymptomatic at birth. Most often the infant develops an opportunistic infection and rapid progression of immunodeficiency.

DIF: Cognitive Level: Understand REF: IM: 861 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

16. What bacterial infection is definitely decreasing because of effective drug treatment?

a. *Escherichia coli* infection
b. Tuberculosis
c. Candidiasis
d. Group B streptococci (GBS) infection

ANS: D

Penicillin has significantly decreased the incidence of GBS infection. *E. coli* may be increasing, perhaps because of the increasing use of ampicillin (resulting in a more virulent *E. coli* resistant to the drug). Tuberculosis is increasing in the United States and in Canada. Candidiasis is a fairly benign fungal infection.

DIF: Cognitive Level: Understand REF: IM: 866 TOP: Nursing Process: Evaluation

MSC: Client Needs: Health Promotion and Maintenance

17. Providing care for the neonate born to a mother who abuses substances can present a challenge for the health care team. Nursing care for this infant requires a multisystem approach. What is the first step in the provision of care for the infant?

a. Pharmacologic treatment

b. Reduction of environmental stimuli
c. Neonatal abstinence syndrome (NAS) scoring
d. Adequate nutrition and maintenance of fluid and electrolyte balance

ANS: C

NAS describes the cohort of symptoms associated with drug withdrawal in the neonate. The NAS system evaluates CNS, metabolic, vasomotor, respiratory, and gastrointestinal (GI) disturbances. This evaluation tool enables the health care team to develop an appropriate plan of care. The infant is scored throughout his or her length of stay, and the treatment plan is adjusted accordingly. Pharmacologic treatment is based on the severity of the withdrawal symptoms, which are determined by using a standard assessment tool. Medications of choice are morphine, phenobarbital, diazepam, or diluted tincture of opium. Swaddling, holding, and reducing environmental stimuli are essential in providing care to the infant who is experiencing withdrawal. These nursing interventions are appropriate for the infant who displays CNS disturbances. Poor feeding is one of the GI symptoms common to this client population. Fluid and electrolyte balance must be maintained, and adequate nutrition provided. These infants often have a poor suck reflex and may need to be fed via gavage.

DIF: Cognitive Level: Apply REF: IM: 873

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

18. An infant was born 2 hours ago at 37 weeks of gestation and weighs 4.1 kg. The infant appears chubby with a flushed complexion and is very tremulous. The tremors are *most* likely the result of what condition?

a. Birth injury
b. Hypocalcemia
c. Hypoglycemia
d. Seizures

ANS: C

Hypoglycemia is common in the macrosomic infant. Signs of hypoglycemia include jitteriness, apnea, tachypnea, and cyanosis.

DIF: Cognitive Level: Understand REF: IM: 856

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

19. Which information regarding to injuries to the infants plexus during labor and birth is *most* accurate?

a. If the nerves are stretched with no avulsion, then they should completely recover in 3 to 6 months.
b. Erb palsy is damage to the lower plexus.
c. Parents of children with brachial palsy are taught to pick up the child from under the axillae.
d. Breastfeeding is not recommended for infants with facial nerve paralysis until the condition resolves.

ANS: A

If the nerves are stretched with no avulsion, then they should recover completely in 3 to 6 months. However, if the ganglia are completely disconnected from the spinal cord, then the damage is permanent. Erb palsy is damage to the upper plexus and is less serious than brachial palsy. Parents of children with brachial palsy are taught to avoid picking up the child under the axillae or by pulling on the arms. Breastfeeding is not contraindicated, but both the mother and the infant will need help from the nurse at the start.

DIF: Cognitive Level: Understand REF: IM: 854 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

MULTIPLE RESPONSE

1. A number of common drugs of abuse may cross into the breast milk of a mother who is currently using these substances, which may result in behavioral effects in the newborn. Which

substances are contraindicated if the mother elects to breastfeed her infant? *(Select all that apply.)*

a. Cocaine
b. Marijuana
c. Nicotine
d. Methadone
e. Morphine

ANS: A, B, C

The use of cocaine, marijuana, and nicotine are contraindicated during breastfeeding because of their reported effects on the infant. Morphine is a medication often used to treat neonatal abstinence syndrome. Maternal methadone maintenance is not a contraindication to breastfeeding.

Chapter 36: Hemolytic Disorders and Congenital Anomalies

MULTIPLE CHOICE

1. To explain hemolytic disorders in the newborn to new parents, the nurse who cares for the newborn population must be aware of the physiologic characteristics related to these conditions. What is the *most* common cause of pathologic hyperbilirubinemia?

a. Hepatic disease
b. Hemolytic disorders
c. Postmaturity
d. Congenital heart defect

ANS: B

Hemolytic disorders in the newborn are the most common cause of pathologic hyperbilirubinemia (jaundice). Although hepatic damage, prematurity, and congenital heart defects may cause pathologic hyperbilirubinemia, they are not the most common causes.

DIF: Cognitive Level: Apply REF: IM: 882 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

2. Which infant is *most* likely to express Rh incompatibility?

a. Infant of an Rh-negative mother and a father who is Rh positive and homozygous for the Rh factor
b. Infant who is Rh negative and a mother who is Rh negative
c. Infant of an Rh-negative mother and a father who is Rh positive and heterozygous for the Rh factor
d. Infant who is Rh positive and a mother who is Rh positive

ANS: A

If the mother is Rh negative and the father is Rh positive and homozygous for the Rh factor, then all the offspring of this union will be Rh positive. Only Rh-positive offspring of an Rh-negative mother are at risk for Rh incompatibility. Only the Rh-positive offspring of an Rh-negative mother are at risk. If the mother is Rh negative and the father is Rh positive and heterozygous for the factor, a 50% chance exists that each infant born of this union will be Rh positive, and a 50% chance exists that each will be born Rh negative. No risk for incompatibility exists if both the mother and the infant are Rh positive.

DIF: Cognitive Level: Understand REF: IM: 883 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. What is the *highest* priority nursing intervention for an infant born with myelomeningocele?

a. Protect the sac from injury.
b. Prepare the parents for the childs paralysis from the waist down.

c. Prepare the parents for closure of the sac when the child is approximately 2 years of age.
d. Assess for cyanosis.

ANS: A

A major preoperative nursing intervention for a neonate with a myelomeningocele is the protection of the protruding sac from injury to prevent its rupture and the resultant risk of central nervous system (CNS) infection. The long-term prognosis in an affected infant can be determined to a large extent at birth, with the degree of neurologic dysfunction related to the level of the lesion, which determines the nerves involved. A myelomeningocele should be surgically closed within 24 hours. Although the nurse should assess for multiple potential problems in this infant, the major nursing intervention is to protect the sac from injury.

DIF: Cognitive Level: Understand REF: IM: 892

TOP: Nursing Process: Planning | Nursing Process: Implementation

MSC: Client Needs: Physiologic Integrity

4. Which nursing diagnosis is *most* appropriate for a newborn diagnosed with a diaphragmatic hernia?

a. Risk for impaired parent-infant attachment
b. Imbalanced nutrition, related to less than body requirements
c. Risk for infection
d. Impaired gas exchange

ANS: D

Herniation of the abdominal viscera into the thoracic cavity may cause severe respiratory distress and represent a neonatal emergency. Oxygen therapy, mechanical ventilation, and the correction of acidosis are necessary in infants with large defects. Although imbalanced nutrition, related to less than body requirements, may be a factor in providing care to a newborn with a diaphragmatic hernia, the priority nursing diagnosis relates to the oxygenation issues arising

from the lung hypoplasia that occurs with diaphragmatic hernia. The nutritional needs of this infant may be a clearly identified need; however, at this time the nurse should be most concerned about impaired gas exchange. This infant is at risk for infection, especially once the surgical repair has been performed. The extent of the herniation may have hindered normal development of the lungs in utero, resulting in respiratory distress.

DIF: Cognitive Level: Apply REF: IM: 894 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Physiologic Integrity

5. What is the clinical finding *most* likely to be exhibited in an infant diagnosed with erythroblastosis fetalis?

a. Edema
b. Immature red blood cells
c. Enlargement of the heart
d. Ascites

ANS: B

Erythroblastosis fetalis occurs when the fetus compensates for the anemia associated with Rh incompatibility by producing large numbers of immature erythrocytes to replace those hemolyzed. Edema occurs with hydrops fetalis, a more severe form of erythroblastosis fetalis. The fetus with hydrops fetalis may exhibit effusions into the peritoneal, pericardial, and pleural spaces, as well as demonstrate signs of ascites.

DIF: Cognitive Level: Understand REF: IM: 883

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

6. Which statement regarding congenital anomalies of the cardiovascular and respiratory systems is *correct*?

a. Cardiac disease may demonstrate signs and symptoms of respiratory illness.

b. Screening for congenital anomalies of the respiratory system need only be performed for infants experiencing respiratory distress.
c. Choanal atresia can be corrected with the use of a suction catheter to remove the blockage.
d. Congenital diaphragmatic hernias are diagnosed and treated after birth.

ANS: A

The cardiac and respiratory systems function together; therefore, initial findings will be related to respiratory illness. Screening for congenital respiratory system anomalies is necessary, even for infants who appear normal at birth. All newborns should have critical congenital heart disease (CCHD) screening performed before discharge. Choanal atresia requires emergency surgery. Congenital diaphragmatic hernias are prenatally discovered on ultrasound.

DIF: Cognitive Level: Understand REF: IM: 889

TOP: Nursing Process: Assessment MSC: Client Needs: Physiologic Integrity

7. When attempting to screen and educate parents regarding the treatment of developmental dysplasia of the hip (DDH), which intervention should the nurse perform?

a. Be able to perform the Ortolani and Barlow tests.
b. Teach double or triple diapering for added support.
c. Explain to the parents the need for serial casting.
d. Carefully monitor infants for DDH at follow-up visits.

ANS: D

Because DDH often is not detected at birth, infants should be carefully monitored at follow-up visits. The Ortolani and Barlow tests must be performed by experienced clinicians to prevent fracture or other damage to the hip. Double or triple diapering is not recommended because it promotes hip extension, thus worsening the problem. Serial casting is recommended for clubfoot, not DDH.

DIF: Cognitive Level: Apply REF: IM: 899 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

8. The nurse is assigned a home care visit of a 5-day-old infant for the treatment of jaundice. A thorough assessment is completed, and a health history is obtained. Which sign or symptom indicates that the infant may be displaying the initial phase of encephalopathy?

a. High-pitched cry
b. Severe muscle spasms (opisthotonos)
c. Fever and seizures
d. Hypotonia, lethargy, and poor suck

ANS: D

The early and most subtle symptoms of bilirubin encephalopathy include hypotonia, lethargy, poor suck, and a depressed or absent Moro reflex. Should the infant display symptoms such as a high-pitched cry, severe muscle spasms, hyperreflexia, or an arching of the back, the nurse should be aware that the baby has progressed beyond the more subtle signs of the first phase of encephalopathy. Medical attention is immediately necessary. Symptoms may progress from the subtle indications of the first phase to fever and seizures in as few as 24 hours. Only approximately one half of these infants survive, and those that do will have permanent sequelae, including auditory deficiencies, intellectual deficits, and movement abnormalities.

DIF: Cognitive Level: Analyze REF: IM: 884

TOP: Nursing Process: Assessment MSC: Client Needs: Health Promotion and Maintenance

9. Most congenital anomalies of the CNS result from defects in the closure of the neural tube during fetal development. Which factor has the *greatest* impact on this process?

a. Maternal diabetes
b. Maternal folic acid deficiency
c. Socioeconomic status
d. Maternal use of anticonvulsant

ANS: B

All of these environmental influences may affect the development of the CNS. Maternal folic acid deficiency has a direct bearing on the failure of neural tube closure. As a preventative measure, folic acid supplementation (0.4 mg/day) is recommended for all women of childbearing age.

DIF: Cognitive Level: Analyze REF: IM: 891 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

10. The condition, hypospadias, encompasses a wide range of penile abnormalities. Which information should the nurse provide to the anxious parents of an affected newborn?

a. Mild cases involve a single surgical procedure.
b. Infant should be circumcised.
c. Repair is performed as soon as possible after birth.
d. No correlation exists between hypospadia and testicular cancer.

ANS: A

Mild cases of hypospadias are often repaired for cosmetic reasons, and repair involves a single surgical procedure, enabling the male child to urinate in a standing position and to have an adequate sexual organ. These infants are not circumcised; the foreskin will be needed during the surgical repair. Repair is usually performed between 1 and 2 years of age. A correlation between hypospadias and testicular cancer exists; therefore, these children will require long-term follow-up observation.

DIF: Cognitive Level: Apply REF: IM: 902

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

11. The nurse is instructing a family how to care for their infant in a Pavlik harness to treat DDH. What information should be included in the teaching?

a. Apply lotion or powder to minimize skin irritation.
b. Remove the harness several times a day to prevent contractures.
c. Return to the clinic every 1 to 2 weeks.
d. Place a diaper over the harness, preferably using an absorbent disposable diaper.

ANS: C

Infants have a rapid growth pattern. Therefore, the child needs to be assessed by the practitioner every 1 to 2 weeks for possible adjustments. Lotions and powders should not be used with the harness, and the harness should not be removed, except as directed by the practitioner. A thin disposable diaper can be placed under the harness.

DIF: Cognitive Level: Understand REF: IM: 900

TOP: Nursing Process: Implementation MSC: Client Needs: Physiologic Integrity

12. A neonate is born with mild clubfeet. When the parents ask the nurse how this will be corrected, how should the nurse respond?

a. Traction is tried first.
b. Surgical intervention is needed.
c. Frequent, serial casting is tried first.
d. Children outgrow this condition when they learn to walk.

ANS: C

Serial casting, the preferred treatment, is begun shortly after birth and before discharge from the nursery. Successive casts allows for gradual stretching of skin and tight structures on the medial side of the foot. Manipulation and casting of the leg are frequently repeated (every week) to accommodate the rapid growth of early infancy. Surgical intervention is performed only if serial casting is not successful. Children do not improve without intervention.

DIF: Cognitive Level: Understand REF: IM: 901 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

13. Which statement regarding hemolytic diseases of the newborn is *most* accurate?

a. Rh incompatibility matters only when an Rh-negative child is born to an Rh-positive mother.
b. ABO incompatibility is more likely than Rh incompatibility to precipitate significant anemia.
c. Exchange transfusions are frequently required in the treatment of hemolytic disorders.
d. The indirect Coombs test is performed on the mother before birth; the direct Coombs test is performed on the cord blood after birth.

ANS: D

An indirect Coombs test may be performed on the mother a few times during pregnancy. Only the Rh-positive child of an Rh-negative mother is at risk. ABO incompatibility is more common than Rh incompatibility but causes less severe problems; significant anemia, for instance, is rare with ABO. Exchange transfers infrequently are needed because of the decrease in the incidence of severe hemolytic disease in newborns from Rh incompatibility.

DIF: Cognitive Level: Understand REF: pp. 884, 885 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. Cleft lip or palate is a common congenital midline fissure, or opening, in the lip or palate resulting from the failure of the primary palate to fuse. Multiple genetic and, to a lesser extent, environmental factors may lead to the development of a cleft lip or palate. Which factors are included? *(Select all that apply.)*

a. Alcohol consumption
b. Female gender
c. Use of some anticonvulsant medications
d. Maternal cigarette smoking
e. Antibiotic use in pregnancy

ANS: A, C, D

Factors associated with the potential development of cleft lip or palate are maternal infections, alcohol consumption, radiation exposure, corticosteroid use, use of some anticonvulsant medications, male gender, Native-American or Asian descent, and maternal smoking during pregnancy. Cleft lip is more common in male infants. Antibiotic use in pregnancy is not associated with the development of cleft lip or palate.

DIF: Cognitive Level: Understand REF: IM: 895 TOP: Nursing Process: Planning

MSC: Client Needs: Physiologic Integrity

2. The most widespread use of postnatal testing for genetic disease is the routine screening of newborns for inborn errors of metabolism (IEM). Which conditions are considered metabolic disorders? *(Select all that apply.)*

a. Phenylketonuria (PKU)
b. Galactosemia
c. Hemoglobinopathy
d. Cytomegalovirus (CMV)
e. Rubella

ANS: A, B, C

PKU is an IEM that can be diagnosed with newborn screening. Galactosemia is a metabolic defect that falls under the category of an IEM. Sickle cell disease and thalassemia are hemoglobinopathies that can be detected by newborn screening. CMV and rubella cannot be detected by newborn screening and are not metabolic disorders; rather, they are viruses contracted by the fetus.

DIF: Cognitive Level: Understand REF: IM: 904 TOP: Nursing Process: Planning

MSC: Client Needs: Health Promotion and Maintenance

3. The nurse is caring for an infant with DDH. Which clinical manifestations should the nurse expect to observe? *(Select all that apply.)*

a. Positive Ortolani click
b. Unequal gluteal folds
c. Negative Babinski sign
d. Trendelenburg sign
e. Telescoping of the affected limb

ANS: A, B

A positive Ortolani test and unequal gluteal folds are clinical manifestations of DDH observed from birth to 2 to 3 months of age. A negative Babinski sign, Trendelenburg sign, and telescoping of the affected limb are not clinical manifestations of DDH.

Chapter 37: Perinatal Loss, Bereavement, and Grief

MULTIPLE CHOICE

1. A family is visiting two surviving triplets. The third triplet died 2 days ago. What action indicates that the family has begun to grieve for the dead infant?

a. Refers to the two live infants as twins
b. Asks about the dead triplets current status
c. Brings in play clothes for all three infants
d. Refers to the dead infant in the past tense

ANS: D

Accepting that the infant is dead (in the past tense of the word) demonstrates an acceptance of the reality and that the family has begun to grieve. Parents of multiples are challenged with the task of parenting and grieving at the same time. Referring to the two live infants as twins does not acknowledge an acceptance of the existence of their third child. Bringing in play clothes for

all three infants indicates that the parents are still in denial regarding the death of the third triplet. The death of the third infant has imposed a confusing and ambivalent induction into parenthood for this couple. If the two live infants are referred to as twins and/or if play clothes for all three infants are still considered, then the family is clearly still in denial regarding the death of one of the triplets.

DIF: Cognitive Level: Understand REF: IM: 927

TOP: Nursing Process: Assessment MSC: Client Needs: Psychosocial Integrity

2. A newborn in the neonatal intensive care unit (NICU) is dying as a result of a massive infection. The parents speak to the neonatologist, who informs them of their sons prognosis. When the father sees his son, he says, He looks just fine to me. I cant understand what all this is about. What is the *most* appropriate response or reaction by the nurse at this time?

a. Didnt the physician tell you about your sons problems?
b. This must be a difficult time for you. Tell me how youre doing.
c. Quietly stand beside the infants father.
d. Youll have to face up to the fact that he is going to die sooner or later.

ANS: B

The phase of intense grief can be very difficult, especially for fathers. Parents should be encouraged to share their feelings during the initial steps in the grieving process. This father is in a phase of acute distress and is reaching out to the nurse as a source of direction in his grieving process. Shifting the focus is not in the best interest of the parent. Nursing actions may help the parents actualize the loss of their infant through a sharing and verbalization of their feelings of grief. Telling the father that his son is going to die sooner or later is dispassionate and an inappropriate statement on the part of the nurse.

DIF: Cognitive Level: Apply REF: IM: 911 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

3. During the initial acute distress phase of grieving, parents still must make unexpected and unwanted decisions about funeral arrangements and even naming the baby. What is the nurses role at this time?

a. To take over as much as possible to relieve the pressure
b. To encourage the grandparents to take over
c. To ensure that the parents, themselves, approve the final decisions
d. To leave them alone to work things out

ANS: C

The nurse is always the clients advocate. Nurses can offer support and guidance and yet leave room for the same from grandparents. In the end, however, nurses should let the parents make the final decisions. For the nurse to be able to present options regarding burial and autopsy, among other issues, in a sensitive and respectful manner is essential. The nurse should assist the parents in any way possible; however, taking over all arrangements is not the nurses role. Grandparents are often called on to help make the difficult decisions regarding funeral arrangements or the disposition of the body because they have more life experiences with taking care of these painful, yet required arrangements. Some well-meaning relatives may try to take over all decision-making responsibilities. The nurse must remember that the parents, themselves, should approve all of the final decisions. During this time of acute distress, the nurse should be present to provide quiet support, answer questions, obtain information, and act as a client advocate.

DIF: Cognitive Level: Understand REF: IM: 921

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

4. A nurse caring for a family during a loss might notice that a family member is experiencing survivor guilt. Which family member is most likely to exhibit this guilt?

a. Siblings
b. Mother
c. Father

d. Grandparents

ANS: D

Survivor guilt is sometimes felt by grandparents because they feel that the death is out of order; they are still alive, while their grandchild has died. They may express anger that they are alive and their grandchild is not. The siblings of the expired infant may also experience a profound loss. A young child will respond to the reactions of the parents and may act out. Older children have a more complete understanding of the loss. School-age children are likely to be frightened, whereas teenagers are at a loss on how to react. The mother of the infant is experiencing intense grief at this time. She may be dealing with questions such as, Why me? or Why my baby? and is unlikely to be experiencing survival guilt. Realizing that fathers can be experiencing deep pain beneath their calm and quiet appearance and may need help acknowledging these feelings is important. This need, however, is not the same as survivor guilt.

DIF: Cognitive Level: Understand REF: IM: 916 TOP: Nursing Process: Evaluation

MSC: Client Needs: Psychosocial Integrity

5. When assisting the mother, father, and other family members to actualize the loss of an infant, which action is most helpful?

a. Using the words *lost* or *gone* rather than *dead* or *died*
b. Making sure the family understands that naming the baby is important
c. Ensuring the baby is clothed or wrapped if the parents choose to visit with the baby
d. Setting a firm time for ending the visit with the baby so that the parents know when to let go

ANS: C

Presenting the baby as nicely as possible stimulates the parents senses and provides pleasant memories of their baby. Baby lotion or powder can be applied, and the baby should be wrapped in a soft blanket, clothed, and have a cap placed on his or her head. Nurses must use the words *dead* and *died* to assist the bereaved in accepting the reality. Although naming the baby can be

helpful, creating the sense that the parents have to name the baby is not important. In fact, some cultural taboos and religious rules prohibit the naming of an infant who has died. Parents need different times with their baby to say good-bye. Nurses need to be careful not to rush the process.

DIF: Cognitive Level: Apply REF: IM: 919 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

6. Parents are often asked if they would like to have an autopsy performed on their infant. Nurses who are assisting parents with this decision should be aware of which information?

a. Autopsies are usually covered by insurance.
b. Autopsies must be performed within a few hours after the infants death.
c. In the current litigious society, more autopsies are performed than in the past.
d. Some religions prohibit autopsy.

ANS: D

Some religions prohibit autopsies or limit the choice to the times when it may help prevent further loss. The cost of the autopsy must be considered; it is not covered by insurance and can be very expensive. There is no rush to perform an autopsy unless evidence of a contagious disease or maternal infection is present at the time of death. The rate of autopsies is declining, in part because of a fear by medical facilities that errors by the staff might be revealed, resulting in litigation.

DIF: Cognitive Level: Understand REF: IM: 921 TOP: Nursing Process: Planning

MSC: Client Needs: Safe and Effective Care Environment

7. Parents have asked the nurse about organ donation after that infants death. Which information regarding organ donation is important for the nurse to understand?

a. Federal law requires the medical staff to ask the parents about organ donation and then to contact their states organ procurement organization (OPO) to handle the procedure if the parents agree.

b. Organ donation can aid grieving by giving the family an opportunity to see something positive about the experience.

c. Most common donation is the infants kidneys.

d. Corneas can be donated if the infant was either stillborn or alive as long as the pregnancy went full term.

ANS: B

Evidence indicates that organ donation can promote healing among the surviving family members. The federal Gift of Life Act made state OPOs responsible for deciding whether to request a donation and for making that request. The most common donation is the cornea. For cornea donation, the infant must have been born alive at 36 weeks of gestation or later.

DIF: Cognitive Level: Understand REF: IM: 921 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

8. Which statement is the *most* appropriate for the nurse to make when caring for bereaved parents?

a. This happened for the best.

b. You have an angel in heaven.

c. I know how you feel.

d. What can I do for you?

ANS: D

Acknowledging the loss and being open to listening is the best action that the nurse can do. No bereaved parent would find the statement This has happened for the best to be comforting in any way, and it may sound judgmental. Nurses must resist the impulse to speak about the afterlife to people in pain. They should also resist the temptation to give advice or to use clichs. Unless the nurse has lost a child, he or she does not understand how the parents feel.

DIF: Cognitive Level: Apply REF: IM: 922

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

9. After giving birth to a stillborn infant, the woman turns to the nurse and says, I just finished painting the babys room. Do you think that caused my baby to die? What is the nurses *most* appropriate response?

a. Thats an old wives tale; lots of women are around paint during pregnancy, and this doesnt happen to them.
b. Thats not likely. Paint is associated with elevated pediatric lead levels.
c. Silence.
d. I can understand your need to find an answer to what caused this. What else are you thinking about?

ANS: D

The statement I can understand your need to find an answer to what caused this. What else are you thinking about? is very appropriate for the nurse. It demonstrates caring and compassion and allows the mother to vent her thoughts and feelings, which is therapeutic in the process of grieving. The nurse should resist the temptation to give advice or to use clichs in offering support to the bereaved. In addition, trying to give bereaved parents answers when no clear answers exist or trying to squelch their guilt feeling does not help the process of grieving. Silence would probably increase the mothers feelings of guilt. One of the most important goals of the nurse is to validate the experience and feelings of the parents by encouraging them to tell their stories and then listening with care. The nurse should encourage the mother to express her thoughts.

DIF: Cognitive Level: Apply REF: IM: 922

TOP: Nursing Process: Implementation MSC: Client Needs: Psychosocial Integrity

10. Which options for saying good-bye would the nurse want to discuss with a woman who is diagnosed with having a stillborn girl?

a. The nurse should not discuss any options at this time; plenty of time will be available after the baby is born.
b. Would you like a picture taken of your baby after birth?

c. When your baby is born, would you like to see and hold her?
d. What funeral home do you want notified after the baby is born?

ANS: C

Mothers and fathers may find it helpful to see their infant after delivery. The parents wishes should be respected. Interventions and support from the nursing and medical staff after a prenatal loss are extremely important in the healing of the parents. The initial intervention should be directly related to the parents wishes concerning seeing or holding their dead infant. Although information about funeral home notification may be relevant, this information is not the most appropriate option at this time. Burial arrangements can be discussed after the infant is born.

DIF: Cognitive Level: Apply REF: IM: 919 TOP: Nursing Process: Planning

MSC: Client Needs: Psychosocial Integrity

11. During a follow-up home visit, the nurse plans to evaluate whether parents have progressed to the second stage of grieving (phase of intense grief). Which behavior would the nurse *not* anticipate finding?

a. Guilt, particularly in the mother
b. Numbness or lack of response
c. Bitterness or irritability
d. Fear and anxiety, especially about getting pregnant again

ANS: B

The second phase of grieving encompasses a wide range of intense emotions, including guilt, anger, bitterness, fear, and anxiety. What the nurse would hope not to see is numbness or unresponsiveness, which indicates that the parents are still in denial or shock.

DIF: Cognitive Level: Analyze REF: IM: 914 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

12. Which finding would indicate to the nurse that the grieving parents have progressed to the reorganization phase of grieving?

a. The parents say that they feel no pain.
b. The parents are discussing sex and a future pregnancy, even if they have not yet sorted out their feelings.
c. The parents have abandoned those moments of bittersweet grief.
d. The parents questions have progressed from Why? to Why us?

ANS: B

Many couples have conflicting feelings about sexuality and future pregnancies. A little pain is always present, certainly beyond the first year when recovery begins to peak. Bittersweet grief describes the brief grief response that occurs with reminders of a loss, such as anniversary dates. Most couples never abandon these reminders. Recovery is ongoing. Typically, a couples search for meaning progresses from Why? in the acute phase to Why me? in the intense phase to What does this loss mean to my life? in the reorganizational phase.

DIF: Cognitive Level: Understand REF: IM: 914 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

13. Which statement *most* accurately describes complicated grief?

a. Occurs when, in multiple births, one child dies and the other or others live
b. Is a state during which the parents are ambivalent, as with an abortion
c. Is an extremely intense grief reaction that persists for a long time
d. Is felt by the family of adolescent mothers who lose their babies

ANS: C

Parents showing signs of complicated grief should be referred for counseling. Multiple births, in which not all of the babies survive, create a complicated parenting situation but not complicated bereavement. Abortion can generate complicated emotional responses, but these responses do

not constitute complicated bereavement. Families of lost adolescent pregnancies may have to deal with complicated issues, but these issues are not complicated bereavement.

DIF: Cognitive Level: Understand REF: IM: 927 TOP: Nursing Process: Diagnosis

MSC: Client Needs: Psychosocial Integrity

14. A client is diagnosed with having a stillborn infant. At first, she appears stunned by the news, cries a little, and then asks the nurse to call her mother. What is the proper term for the phase of bereavement that this client is experiencing?

a. Anticipatory grief
b. Acute distress
c. Intense grief
d. Reorganization

ANS: B

The immediate reaction to news of a perinatal loss or infant death encompasses a period of acute distress. Disbelief and denial can occur. However, parents also feel very sad and depressed. Intense outbursts of emotion and crying are normal. However, a lack of affect, euphoria, and calmness may occur and may reflect numbness, denial, or personal ways of coping with stress. Anticipatory grief applies to the grief related to a potential loss of an infant. The parent grieves in preparation of the infants possible death, although he or she clings to the hope that the child will survive. Intense grief occurs in the first few months after the death of the infant. This phase encompasses many different emotions, including loneliness, emptiness, yearning, guilt, anger, and fear. Reorganization occurs after a long and intense search for meaning. Parents are better able to function at work and home, experience a return of self-esteem and confidence, can cope with new challenges, and have placed the loss in perspective.