ATI Proctored Exam Maternal Newborn

family ob/peds (Herzing University)

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1. A nurse is providing discharge teaching to a client following tubal ligation (occlusion). Which of the following statement by the client indicates an understanding of the teaching?

A. "premenstrual tension will no longer be present."

B. "Ovulation will remain the same."

C. "Hormone replacements will be needed following this procedure."

D. "My monthly menstrual period will be shorter."

ANS: B

Ovulation (egg release from the ovaries) will remain the same. Tubal ligation also known as having your tubes tied or tubal sterilization is a type of permanent birth control. During tubal ligation, the fallopian tubes are cut, tied or blocked to permanently prevent pregnancy. Tubal ligation prevents an egg from traveling from the ovaries through the fallopian tubes and blocks sperm from traveling up the fallopian tubes to the egg. The procedure doesn't affect your menstrual cycle it just prevents fertilization.

2. A nurse is assessing a newborn following forceps-assisted birth. Which of the following clinical manifestations should the nurse identify as a complication of the birth method?

A. Hypoglycemia

B. Polycythemia

C. Facial Palsy

D. Bronchopulmonary dysplasia

ANS: C

Difficult delivery, with or without the use of an instrument called ***forceps***, may lead to facial palsy. Facial paralysis 15 minutes after forceps birth or absence of movement on affected side is especially noticeable when infant cries.

3. A nurse is providing teaching about terbutaline to a client who is experiencing preterm labor. Which of the following statements by the client indicates understanding of the teaching?

A. "This medication could cause me to experience heart palpitations."

B. "This medication could cause me to experience blurred vision."

C. "This medication could cause me to experience ringing in my ears."

D. "This medication could cause me to experience frequent urination."

ANS: A

Beta-adrenergic agents such as terbutaline (Brethine) are associated with various side effects, including ***tachycardia***, irregular pulse, myocardial ischemia, and pulmonary edema. Therefore, these medications should not be used in women with known or suspected heart disease

4. A nurse is caring for a client who is in labor and requests nonpharmacological pain management. Which of the following nursing actions promotes client comfort?

A. Assisting the client into squatting position

B. Having the client lie in a supine position

C. Applying fundal pressure during contractions

D. Encouraging the client to void every 6 hrs.

ANS: C

Applying fundal pressure by pushing on the mother's abdomen in the direction of the birth canal is often used to assist spontaneous vaginal birth, shorten the length of the second stage and reduce the need for instrumental birth (forceps- or vacuum-assisted) or caesarean section.

5. A nurse caring for a client who is at 20 weeks of gestation and has trichomoniasis. Which of the following findings should the nurse expect?

A. Thick, White Vaginal Discharge

B. Urinary Frequency

C. Vulva Lesions

D. Malodorous Discharge

ANS: D

Although trichomoniasis may be asymptomatic, women commonly experience characteristically yellowish-to-greenish, frothy, mucopurulent, copious, **malodorous discharge**. Inflammation of the vulva, vagina, or both may be present; and the woman may complain of irritation and pruritus. Dysuria and dyspareunia are often present.

6. A nurse is caring for a client who is at 14 weeks of gestation. At which of the following locations should the nurse place the doppler device when assessing the fetal heart rate?

A. Midline 2 to 3 cm (0.8 to 1.2 in) above the symphysis pubis

B. Left Upper Abdomen

C. Two fingerbreadths above the umbilicus

D. Lateral at the Xiphoid Process

ANS: A

Toward the end of the first trimester, before the uterus is an abdominal organ, the fetal heart tones (FHTs) can be heard with an ultrasound fetoscope or an ultrasound stethoscope (Fig. 8-

8). To hear the FHTs, place the instrument in the midline just above the symphysis pubis and apply firm pressure. The woman and her family should be offered the opportunity to listen to the FHTs. The health status of the fetus is assessed at each visit for the remainder of the pregnancy.

7. A nurse is assessing a client who is at 27 weeks of gestation and has preeclampsia. Which of the following findings should the nurse report to the provider?

A. Urine protein concentration 200 mg/24 hr.

B. Creatinine 0.8 mg/ dL

C. Hemoglobin 14.8 g/ dL

D. Platelet Count 60,000/ mm^3

ANS: D

Platelets < 100,000/mm^3 (60,000/mm^3) is below the expected reference range, which can indicate DIC. The nurse should report this result to the provider. In a 24-hour specimen ***proteinuria*** is defined as a concentration at or ***> 300 mg/24 hours***.

8. A nurse is teaching about clomiphene citrate to a client who is experiencing infertility. Which of the following adverse effect should the nurse include?

A. Tinnitus

B. Urinary Frequency

C. Breast Tenderness

D. Chills

ANS: C

The adverse effects of *clomiphene citrate* are stomach upset, bloating, abdominal/pelvic fullness, flushing ("hot flashes"), **breast tenderness**, headache, or dizziness may occur. If any of these effects last or get worse, tell your doctor or pharmacist promptly.

9. A nurse is assessing a newborn upon admission to the nursery. Which of the following should the nurse expect?

A. Bulging Fontanels

B. Nasal Flaring

C. Length from head to heel of 40 cm (15.7 in)

D. Chest circumference 2 cm (0.8 in) smaller than the head circumference

ANS: D

Measure at nipple line 2-3 cm (0.8-1.2 in) less than head circumference; average 30-33 cm (11.8-13 in) ≤ 30 cm.

10. A nurse is planning care for a newborn who has neonatal abstinence syndrome. Which of the following interventions should the nurse include in the plan of care?

A. Increase the newborn's visual stimulation

B. Weigh the newborn every other day

C. Discourage parental interaction until after a social evaluation

D. Swaddle the newborn in a flexed position

ANS: D

Swaddling in a flexed position with hands midline against chest and legs loosely swaddled in lumbar flexion to decrease sensory stimulation. Minimize environmental and physical stimulation low lighting and noise level do not use TV or mobiles. Avoidance of abrupt changes in infant's environment handle gently and close to the body to increase sense of

Security.

11. A nurse is caring for a newborn who is 6 hrs. old and has a bedside glucometer reading of 65 mg/dL. The newborn's mother has type 2 diabetes mellitus. Which of the following actions should the nurse take?

A. Obtain a blood sample for a serum glucose level

B. Feed the newborn immediately

C. Administer 50 mL of dextrose solution IV

D. Reassess the blood glucose level prior to the next feeding.

ANS: D

When babies are just 1 hour to 2 hours old, the normal level is just under 2 mmol/L (36 mg/dL), but it will rise to adult levels (over 3 mmol/L or 54 mg/dL) within two to three days. In babies who need treatment for low blood glucose or are at risk for low blood glucose, a level over 2.5 mmol/L (45 mg/dL) is preferred.

12. A nurse is providing teaching to a client about exercise safety during pregnancy. Which of the following statements by the client indicates an understanding of the teaching? (Select all that apply).

A. "I will limit my time in the hot tub to 30 minutes after exercise."

B. "I should consume three 8-ounce glasses of water after I exercise."

C. "I will check my heart rate every 15 minutes during exercise sessions."

D. "I should limit exercise sessions to 30 minutes when the weather is humid."

E. "I should rest by lying on my side for 10 minutes following exercise."

ANS: B, C, E

Stay hydrated. Drink two or three 8-oz glasses of water after you exercise to replace the body fluids lost through perspiration. While exercising, drink water whenever you feel the need. Take your pulse every 10 to 15 minutes while you are exercising. If it is more than 140 beats/min, slow down until it returns to a maximum of 90 beats/min. Rest for 10 minutes after exercising, lying on your side. As the uterus grows, it puts pressure on a major vein in your abdomen, which carries blood to your heart. Lying on your side removes the pressure and promotes return circulation from your extremities and muscles to your heart, thereby increasing blood flow to your placenta and fetus.

13. A charge nurse is teaching a group of staff nurses about fetal monitoring during labor. Which of the following findings should the charge nurse instruct the staff members to report to the provider?

A. Contraction durations of 95 to 100 seconds

B. Contraction frequency of 2 to 3 min apart

C. Absent early deceleration of fetal heart rate

D. Fetal heart rate is 140/min

ANS: A

For a normal uterine activity during labor contraction duration remains fairly stable throughout first and second stages, ranging from 45-80 seconds, not generally exceeding 90 seconds.

14. A nurse in a woman's health clinic is obtaining a health history from a client. Which of the following findings should the nurse identify as increasing the client's risk for developing pelvic inflammatory disease (PID)?

A. Recurrent Cystitis

B. Frequent Alcohol Use

C. Use of Oral Contraceptives

D. Chlamydia Infection

ANS: D

Pelvic inflammatory disease is an infection of a woman's reproductive organs. It is a complication often caused by some STDs, like chlamydia and gonorrhea. Other infections that are not sexually transmitted can also cause PID.

15. A nurse is teaching a prenatal class about immunizations that newborns receive following birth. Which of the following immunizations should the nurse include in the teaching?

A. Hepatitis B

B. Rotavirus

C. Pneumococcal

D. Varicella

ANS: A

Hepatitis B immunization is recommended at birth, 1 to 2 months, and between 6 to 18 months. It is injected intramuscularly soon after birth. For newborns born to hepatitis-infected mothers, hepatitis B immune globin (HBIG) also should be administered within 12 hrs. of birth. The vastus lateralis is the preferred site of intramuscular injections in newborns, and no more than 0.5 mL should be administered in one injection. Shortly after birth, your baby should receive the first dose of the vaccine to help protect against the following disease: Hepatitis B and 1-month later RV, DTap, Hib, PCV13, & IPV.

16. A nurse is providing nutritional guidance to a client who is pregnant and follows a vegan diet. The client asks the nurse which foods she should eat to ensure adequate calcium

intake. The nurse should instruct the client that which of the following foods has the highest amount of calcium?

A. ½ cup cubed avocado

B. 1 large banana

C. 1 medium potato

D. 1 cup cooked broccoli

ANS: D

½ cup cubed avocado contains 9 mg of calcium. 1 large banana contains 7 mg of calcium. 1 medium potato 26 mg of calcium. 1 cup cooked broccoli contains 180 mg of calcium.

17. A nurse in a provider's office is assessing a client at her first antepartum visit. The client states that the first day of her last menstrual period was March 8. Use Nagele's rule to calculate the estimated date of delivery. (Use the MMDD format with four numerals and no spaces or punctuation.)

ANS: March 8 – 3 months = December 8 + 7 = **Dec. 13 because of Feb. having 29 days.**

18. A nurse is caring for a client who is in the second stage of labor. Which of the following manifestations should the nurse expect?

A. The client expels the placenta.

B. The client experiences gradual dilation of the cervix

C. The client begins to have regular contractions.

D. The client delivers the newborn.

ANS: D

The second stage of labor lasts from the time the cervix is fully dilated to the birth of the fetus.

19. A nurse is assessing a client who is at 37 weeks (about 8 and a half months) of gestation. Which of the following statement by the client requires immediate intervention by the nurse?

A. "It burns when I urinate."

B. "My feet are really swollen today."

C. "I didn't have lunch today, but I have breakfasted this morning."

D. "I have been seeing spot this morning."

ANS: A

During pregnancy, you are more susceptible to urinary tract infections. Most commonly, such infections are confined to the bladder, when they are known as cystitis. Symptoms of cystitis include a frequent, urgent need to urinate and a painful burning sensation when passing urine; there may be some blood in your urine.

20. A nurse is providing discharge teaching to a new parent about car seat safety. Which of the following statements by the parent indicates an understanding of the teaching?

A. "I should position my baby's car seat at a 45-degree angle in the car."

B. "I should place the car seat rear facing until my baby is 12 months old."

C. "I should place the harness snugly in a slot above my baby's shoulders."

D. "I should position the retainer clip at the top of my baby's abdomen."

ANS: A

Set the seat at a 45-degree angle. Your baby's head should rest at least 2 inches below the top of the car seat.

21. A nurse is developing an educational program about hemolytic diseases in newborns for a group of newly licensed nurses. Which of the following genetic information should the nurse include in the program as a cause of hemolytic disease?

A. The mother is Rh positive, and the father is Rh negative.

B. The mother is Rh negative, and the father is Rh positive.

C. The mother and the father are both Rh positive.

D. The mother and the father are both Rh negative.

ANS: B

Hemolytic Diseases in Newborns (HDN) most frequently occurs when a Rh-negative mother has a baby with a Rh-positive father. When the baby's Rh factor is positive, like the father's, problems can develop if the baby's red blood cells cross to the Rh-negative mother. This usually happens at delivery when the placenta detaches.

22. A nurse on an antepartum unit is reviewing the medical records for four clients. Which of the following clients should the nurse assess first?

A. A client who has diabetes mellitus and an HbA1c of 5.8%

B. A client who has preeclampsia and a creatinine level of 1.1 mg/ dL

C. A client who has hyperemesis gravidarum and a sodium level of 110 mEq/L

D. A client who has placenta previa and a hematocrit of 36%

ANS: C

As a consequence of this physiological adaptation, normal pregnancy is associated with reduction in serum sodium of 3-6 mmol/L and reduction in serum osmolality of 10 mOsm/kg. Hyponatremia is diagnosed if serum sodium <135 mmol/L in non-pregnant individuals, but <130 mmol/L in pregnant women.

23. A nurse is assessing a newborn immediately following a vaginal birth. For which of the following findings should the nurse intervene?

A. Molding

B. Vernix Caseosa

C. Acrocyanosis

D. Sternal retractions

ANS: D

Sternal retraction is a common clinical sign of respiratory distress in premature infants. Frontal chest radiographs show increased, ill-defined central radiolucency over the lower chest which correlates well with a curvilinear indentation seen on lateral views.

24. A nurse on the postpartum unit is caring for four clients. For which of the following clients should the nurse notify the provider?

A. A client who has a urinary output of 300 ml in 8 hr.

B. A client who reports abdominal cramping during breastfeeding

C. A client who is receiving magnesium sulfate and has absent deep tendon reflexes.

D. A client who reports lochia rubra requiring changing perineal pads every 3 hr.

ANS: C

Symptoms of magnesium sulfate toxicity are seen with the following maternal serum concentrations: ***loss of deep tendon reflexes*** (9.6-12 mg/dL) (> 7 mEq/L), ***respiratory depression*** (12-18 mg/dL) (> 10 mEq/L), and ***cardiac arrest*** (24-30mg/dL) (> 25mEq/L).

25. A nurse is caring for a client who has active genital herpes simplex virus type 2. Which of the following medications should the nurse plan to administer?

A. Metronidazole

B. Penicillin

C. Acyclovir

D. Gentamicin

ANS: C

Acyclovir is used to treat infections caused by certain types of viruses. It treats cold sores around the mouth (caused by herpes simplex), shingles (caused by herpes zoster), and chickenpox. This medication is also used to treat outbreaks of genital herpes.

26. A nurse is caring for a client following an amniocentesis. The nurse should observe the client for which of the following complications?

A. Hyperemesis

B. Proteinuria

C. Hypoxia

D. Hemorrhage

ANS: D

That is why ultrasound scanning has reduced risks previously associated with amniocentesis such as fetomaternal hemorrhage from a pierced placenta.

27. A nurse is planning care for a client who is receiving oxytocin by continuous IV infusion for labor induction. Which of the following interventions should the nurse include in the plan?

A. Increase the infusion rate every 30 to 60 min.

B. Maintain the client in a supine position.

C. Titrate the infusion rate by 4 milliunits/min.

D. Limit IV intake to 4 L per 24 hr.

ANS: A

Traditional protocols for oxytocin infusion regimens recommend increases of infusion rate at 15-20 min intervals. However, recent clinical studies agree that prolonged intervals of 30-40 or even 60 minutes are superior to shorter dosage intervals in terms of safety and efficacy.

28. A nurse is caring for a 2-day-old newborn who was born at 35 weeks of gestation. Which of the following actions should the nurse take? (Click on the "Exhibit" Button for additional information about the newborn. There are three tabs that contain separate categories of date.)

A. Administer nitric oxide inhalation therapy to the newborn

B. Insert an orogastric decompression tube with low wall suction.

C. Provide the newborn with an iron-rich formula containing vitamin B12 every 2 hr.

D. Measure the abdominal circumference at the level of the newborn's umbilicus every 2 hr.

ANS: C

E. coli can cause a severe complication that occurs most commonly in young children (age 5 and younger) called hemolytic uremic syndrome. This condition destroys platelets and red blood cells and leads to kidney failure.

29. A nurse is caring for a client who is receiving oxytocin for induction of labor and notes late decelerations of the fetal heart rate on the monitor Tracing. Which of the following action should the nurse take?

A. Decrease maintenance IV solution infusion rate.

B. Place the client in lateral position.

C. Administer misoprostol 25 mcg vaginally

D. Administer oxygen via face mask at 2 L/min

ANS: B

By laying in the left lateral recumbent position, the uterus is kept off the maternal inferior vena cava and the right iliac artery. Increasing the rate of infusion of the maintenance IV solution is an appropriate action to take when late decelerations occur, not decreasing the rate. Oxygen should be administered at a rate of 8 to 10 L/min when late decelerations occur due to uterine hyperstimulation. Though it was not listed in the multiple choice discontinue the oxytocin infusion immediately if a client is experiencing late decelerations due to uterine hyperstimulation.

30. A nurse is planning care for a client who is pregnant and has HIV. Which of the following actions should the nurse include in the plan of care?

A. Instruct the client to stop taking the antiretroviral medication at 32 weeks of gestation.

B. Use a fetal scalp electrode during labor and delivery.

C. Administer a pneumococcal immunization to the newborn within 4 hrs. following birth.

D. Bathe the newborn before initiating skin-to-skin contact

ANS: C

As early in life as possible, HIV-exposed infants and children should receive all vaccines under the Expanded Program for Immunization (EPI), including Haemophilus influenzae type B and pneumococcal vaccine.

31. A nurse is preparing to administer methylergonovine 0.2 mg orally to a client who is 2 hrs. postpartum and has a boggy uterus. For which of the following assessment findings should the nurse withhold the medication?

A. Blood pressure 142/92 mm Hg

B. Urine output 100 mL in hr.

C. Pulse 58/min

D. Respiratory rate 14/min

ANS: A

Presence of other medical problems such as HTN contraindicates with methylergonovine. Because methylergonovine is vasoconstrictive, monitor patient's blood pressure, heart rate, and uterine response prior to and during administration.

32. A nurse is reviewing laboratory results for client who is pregnant. The Nurse should expect which of the following laboratory values to increase?

A. RBC count

B. Bilirubin

C. Fasting blood glucose

D. Bun

ANS: A

RBC count increases from million/mm^3 4.2-5.4 to 5-6.25 million/mm^3 during pregnancy.

33. A nurse is caring for a client who is experiencing preterm labor and has a prescription for 4 doses of dexamethasone 6 mg IM 12 hr. Available in dexamethasone 10 mg/mL. How many mL of dexamethasone should the nurse administer per dose? (Round the answer to the nearest tenth. Use a leading zero if it applies. Do not use trailing zero.)

ANS: 0.6 mL

34. A nurse is caring for four clients. For which of the following clients should the nurse auscultate the fetal heart rate during the prenatal visit?

A. A client who has an ultrasound that confirms a molar pregnancy

B. A client who has a crown-rump length of 7 weeks gestation

C. A client who has a positive urine pregnancy test 1 week after missed menses

D. A client who has felt quickening for the first time.

ANS: D

In pregnancy terms, quickening is the moment in pregnancy when the pregnant woman starts to feel or perceive fetal movements in the uterus.

35. A nurse is planning care for a full-term newborn who is receiving phototherapy. Which of the following actions should the nurse include in the plan of care?

A. Dress the newborn in lightweight clothing.

B. Avoid using lotion or ointment on the newborn skin.

C. Keep the newborn supine throughout treatment

D. Measure the newborn's temperature every 8hr

ANS: B

Frequent skin care is important, but do not use lotions, creams, balms, or ointments on uncovered skin. These products react with the phototherapy lights and cause burns.

36. A nurse is receiving laboratory results for a term newborn who is 24 hrs. old. Which of the following results require intervention by the nurse?

A. WBC count 10,000/mm3

B. Platelets 180,000/mm3

C. Hemoglobin 20g/dL

D. Glucose 20 mg/dL

ANS: D

But at birth, it's common for a newborn to have a blood glucose level as low as 30 mg per dl, which will gradually increase to 54 to 72 mg/dl. According to guidelines from the American

Academy of Pediatrics, the generally accepted blood glucose level for treating newborn hypoglycemia is 47 mg/dl.

37. A nurse is assessing a client following an amniocentesis. Which of the following findings should the nurse recognize as complications? (select all that apply).

A. Amnionitis

B. Urinary tract infection

C. Polyhydramnios

D. Leakage of amniotic fluid

E. Preterm labor

ANS: A, D, E

Amniocentesis is a well-known procedure performed during pregnancy for diagnostic and therapeutic purposes. Typical complications of the procedure include infection of the amniotic sac, preterm labor, respiratory distress, fetal deformities, trauma, alloimmunization, and failure of the puncture wound to heal properly.

38. A nurse on a labor and delivery unit is reviewing infection control standards with a newly licensed nurse. The nurse should instruct the newly licensed nurse to don gloves for which of the following procedures?

A. Assisting a mother with breastfeeding

B. Performing a newborn's initial bath

C. Administering the measles, mumps, rubella vaccine

D. Performing umbilical cord care

ANS: D

Wear ***gloves*** when a reasonably anticipated possibility exists that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) might occur. Gloves should be worn during infant eye prophylaxis, care of the umbilical cord, circumcision site, parenteral procedures, diaper changes, contact with colostrum, and postpartum assessments. Wear gloves with fit and durability appropriate to the task.

39. A nurse is providing teaching to a client who has mild preeclampsia and will be caring for herself at home during the last 2 months of pregnancy. Which of the following statements by the client indicates an understanding of the teaching?

A. "I will count baby's kicks every other day."

B. "I will alternate the arm use to check my blood pressure."

C. "I will check my urine for protein daily."

D. "I will consume 50 grams of protein daily."

ANS: C

This urine will be tested to see if you are passing more than 300 mg of protein in a day. Any amount of protein in your urine over 300 mg in one day may indicate preeclampsia. However, the amount of protein doesn't define how severe the preeclampsia is or may get. To test your urine protein at home on a daily basis, use a simple test kit containing a urine testing strip that you dip into a fresh sample of your urine.

40. A nurse is caring for four newborns. Which of the following newborns should the nurse assess first?

A. newborn who has nasal flaring

B. newborn who has subconjunctival hemorrhage of the left eye

C. A newborn who has overlapping suture lines

D. A newborn who has not rust-stained urine

ANS: A

Based on the ABC rule, respiratory distress needs more attention. Nasal flaring occurs when the nostrils widen while breathing. It is often a sign of trouble breathing. Nasal flaring may be an indication of breathing difficulty, or even respiratory distress in infants.

41. A nurse is reviewing the electronic medical record of a postpartum client. The nurse should identify that which of the following factors places the client at risk for infection.

A. Meconium-stained fluid

B. placenta previa

C. Midline episiotomy

D. Gestational hypertension

ANS: C

Midline episiotomy puts the client in risk for infection.

42. A nurse is caring for a client who is 4 hrs. postpartum and is experiencing hypovolemic shock. Which of the following actions should the nurse take?

A. Administer indomethacin orally

B. Insert a second IV using a 22-gauge IV catheter,

C. Insert an indwelling urinary catheter.

D. Administer oxygen at 2 L/min via nasal cannula.

ANS: C

Insert an indwelling urinary catheter to monitor perfusion of kidneys. Provide additional or maintain existing IV infusion of lactated Ringer's solution or normal saline solution to restore

circulatory volume (woman should have two patent IV lines; insert second IV infusion using ***16- to 18-gauge IV catheter***). Give oxygen by ***nonrebreather face mask*** or nasal prongs at ***8 to 10 L/min***.

43. A nurse is teaching a client who is 28 weeks of gestation and not up to date on current immunization. Which of the following immunizations should the nurse inform the client to anticipate receiving following birth?

A. Pneumococcal

B. Hepatitis B

C. Human papillomavirus

D. Rubella

ANS: B

Hepatitis B immunization is recommended at birth, 1 to 2 months, and between 6 to 18 months. It is injected intramuscularly soon after birth.

44. A nurse is caring for a newborn who is 24 hrs. old. Which of the following Laboratory findings should the nurse report to the provider?

A. Hgb 20 g/dL

B. Bilirubin 2mg/dL

C. Platelets 200,000/mm3

D. WBC count 32,000/mm3

ANS: D

An abnormal number of WBCs often indicates that the newborn baby's body is fighting some sort of infection. Results of the CBC can be obtained quite quickly. Blood culture: The blood culture will determine if any bacteria can be grown in the blood.

45. A nurse is caring for newborn who is 1 hr. old and has a respiratory rate of 50/min, a heart rate of 130/min, and an axillary temperature of 36.1^{0}C (97F). Which of the following actions should the nurse take?

A. Give the newborn a warm bath.

B. Apply a cap to the newborn head.

C. Reposition the newborn.

D. Obtain an oxygen saturation level

ANS: B

A cap may be worn to decrease heat loss from the infant's head.

46. A nurse is planning care for a newborn who is scheduled to start phototherapy using a lamp. Which of the following actions should the nurse include in the plan?

A. Apply a thin layer of lotion to the newborn skin every 8 hrs.

B. Give the newborn 1oz of glucose water every 4 hrs.

C. Ensure the newborn eyes are closed beneath the shield.

D. Dress the newborn in a thin layer of clothing during therapy

ANS: C

Applying an opaque eye mask prevents damage to the newborn's retinas and corneas from the phototherapy light.

47. A nurse is caring for a client following a vaginal delivery of a term fetal demise. Which of the following statement should the nurse make?

A. "You can bathe and dress your baby if you'd like to."

B. "If you don't hold the baby, it will make letting go much harder."

C. "You should name the baby so she can have an identity."

D. “I’m sure you will be able to have another baby when you’re ready.”

ANS: B

Offer the parents the choice of holding the infant in their arms.

48. A nurse is providing teaching to a client who is at 38 weeks of gestation and has a prescription to receive misoprostol intravaginally. Which of the following statement should the nurse make?

A. “You will need to stay in a side-lying position for 30 minutes after each dose.”

B. “You will receive an IV infusion of oxytocin 1 hour after your last dose.”

C. “You will receive a magnesium supplement immediately following therapy.”

D. “You will need to have a full bladder before the therapy begins.”

ANS: A

Assist the woman to maintain a supine position with a ***lateral tilt*** or ***a side-lying position for 30 to 40 minutes*** after insertion. Initiate oxytocin for induction of labor ***no sooner than 4 hours after the last dose of misoprostol*** was administered, following agency protocol, if ripening has occurred and labor has not begun.

49. A nurse is assessing a newborn who was born post-term. Which of the following findings should the nurse expect?

A. Nails extending over tips of fingers

B. Large deposits of subcutaneous fat

C. Pale, translucent skin

D. Thin covering of fine hair on shoulders and back

ANS: A

Overgrown nails, abundant scalp hair, visible creases on palms and soles of feet, minimal fat deposits etc.

50. A nurse is planning to teach a group of clients who are pregnant about breastfeeding after returning to work. Which of the following information should the nurse include in the teaching?

A. "Thawed (defrosted) breast milk can be refrigerated for up to 72 hours."

B. "Breast milk can be stored in a deep freezer for 12 months."

C. "Breast milk can be stored at room temperature for up to 12 hours."

D. "Thawed breast milk that is unused can be refrozen."

ANS: B

Freshly expressed or pumped milk can be stored: At room temperature (77°F or colder) for up to 4 hours. In the refrigerator for up to 4 days. In the ***freezer*** for about ***6 months is best***; up to ***12 months is acceptable***.

51. A nurse on postpartum unit caring for four clients. Which of the following clients should receive Rh, (D) Immune globulin to prevent Rh- is immunization?

A. A Rh-negative mother who has a Rh-positive infant

B. A Rh-positive mother who has a Rh-negative infant

C. A Rh-positive mother who has a Rh-positive infant

D. A Rh-negative mother who has a Rh-negative infant

ANS: A

Rho(D) immune globulin is used to prevent antibodies from forming when a mother has Rh-negative blood and the baby is Rh-positive so that antibodies from the mother that crosses the placenta and attacks fetal blood cells causing hemolysis.

52. A nurse is caring for an infant who has signs of neonatal abstinence syndrome. Which of the following actions should the nurse take?

A. Provide a stimulating environment

B. Monitor blood glucose level every hr.

C. Initiate seizure precautions.

D. Place the infants on his back with legs extended.

ANS: C

Initiate ***seizure precautions*** since ***signs*** of ***withdrawal in neonates*** are Irritability • ***Seizures*** • Hyperactivity • High-pitched cry • Tremors • Exaggerated Moro reflex • Hypertonicity of muscles.

53. A nurse is reviewing signs of effective breastfeeding with a client who is 5 days postpartum. Which of the following information should the nurse include in the teaching?

A. "You should feel a tugging (pulling) sensation when the baby is sucking.

B. You should expect your baby to have two to three wet diapers in 24 hours period

C. "Your baby's urine should appear dark and concentrated".

D. "Your breast should stay firm after the baby breastfeeds".

ANS: A

Firm tugging sensation on nipple as infant sucks but no pain. Has at least three substantive bowel movements and ***six to eight*** wet diapers every ***24 hours after day 4***.

54. A nurse is teaching a client who is at 41 weeks of gestation about a non-stress test. Which of the following information should the nurse include in the teaching?

A. "This test will confirm fetal lung maturity ".

B. "This test will determine adequacy of placental perfusion".

C. “This test will detect fetal infection”.

D. “This test will predict maternal readiness for labor”.

ANS: B

The goal of a nonstress test is to provide useful information about your baby's oxygen supply by checking his or her heart rate and how it responds to your baby's movement. The test might indicate the need for further monitoring, testing or delivery. Normally, a baby's heart beats faster when he or she is active later in pregnancy. However, conditions such as fetal hypoxia when the baby doesn't get enough oxygen can disrupt this response.

55. A nurse on the labor and delivery unit is assessing four clients. Which of the following clients is a candidate for an induction of labor with misoprostol?

A. A client who has active genital herpes

B. A client who has gestational diabetes mellitus

C. A client who has a previous uterine incision

D. A client who has placenta previa

ANS: B

Induction of labor with misoprostol contraindicates with ***prior classic uterine incision, active genital herpes infection, placenta or vasa previa, & transverse fetal lie***. And there is no study that shows there a contraindication to a client with gestational diabetes.

56. A nurse is monitoring a client who has preeclampsia and is receiving magnesium sulfate by continuous IV infusion. Which of the following findings should the nurse reports to the provider?

A. Blood pressure 148/94 mmHg

B. Respiratory rate 14 breath/min

C. Urinary output 20 mL/hr.

D. 2+ deep tendon reflexes

ANS: C

The client's urine output should be at least 25 to 30 mL/hr. to promote adequate excretion of magnesium. The nurse should stop the infusion & notify the provider.

57. A nurse is caring for a client who is in the transition phase of labor and reports a pain level of 7 on a scale of 0 to 10. Which of the following actions should the nurse take?

A. Instruct the client to use effleurage

B. Apply counter pressure to the client sacral.

C. Assist the client with patterned-paced breathing.

D. Teach the client the technique of biofeedback.

ANS: B

Application of sacral counterpressure helps the woman cope with the sensations of internal pressure and pain in the lower back. It is especially helpful when back pain is caused by pressure of the occiput (back of the head) against spinal nerves, therefore counterpressure lifts the occiput off these nerves, thereby providing pain relief.

58. A nurse is caring for newborn immediately following birth and notes a large amount of mucus in the newborn's mouth and nose. Identify the sequence the nurse should follow when performing suction with a bulb syringe. (Move the steps into the box on the placing them in the selected order of performance. Use all the steps.)

A. Compress the bulb syringe

B. Place the bulb syringe in the newborn's mouth

C. Use the bulb syringe to suction the newborn's nose.

D. Assess the newborn for reflex bradycardia

ANS: A, B, C, D

Bulb must be compressed before inserting tip into mouth.

59. A community health nurse is providing education on gestational diabetes mellitus (GDM) to a group of clients who are pregnant when discussing risk factors, which of the following ethnicities should the nurse identify as having the lowest incidence of GDM?

A. Asian

B. Non-Hispanic White American

C. Hispanic

D. African American

ANS: B

GDM is more likely to occur among ***Hispanic, Native American, Asian, and African American women*** than ***Caucasians*** and is likely to recur in future pregnancies; the risk for development of overt diabetes in later life is also increased.

60. A nurse is assessing a client who is at 37 weeks of gestation. Which of the following statement by the client requires immediate intervention by the nurse?

A. "It burns when I urinate."

B. "My feet are really swollen today."

C. "I didn't have lunch today, but I have breakfasted this morning."

D. "I have been seeing spot this morning."

ANS: A

During pregnancy, you're more susceptible to urinary tract infections. Most commonly, such infections are confined to the bladder, when they are known as cystitis. Symptoms of cystitis

include a frequent, urgent need to urinate and a painful burning sensation when passing urine; there may be some blood in your urine.

61. A nurse is providing teaching about expected changes during pregnancy to a client who is at 24 weeks of gestation. Which of the following information should the nurse include?

A. "Your stomach will empty rapidly"

B. "You should expect your uterus to double in size"

C. "You should anticipate nasal stuffiness"

D. "Your nipples will become lighter in color"

ANS: B

The uterus rises gradually to the level of the umbilicus at 22 to 24 weeks of gestation and nearly reaches the xiphoid process at term.

62. A nurse is teaching a prenatal class regarding false labor. Which of the following information should the nurse include?

A. "your contraction will become more intense when walking"

B. "you will have dilation and effacement of the cervix"

C. "you will have bloody show"

D. "your contraction will become temporally regular"

ANS: D

During false labor contraction occur irregularly or become regular only temporarily. Often stop with walking or position change.

63. A nurse is caring for a client who is receiving an epidural block with an opioid analgesic. The nurse should monitor for which of the following findings as an adverse effect of the medication?

A. Hypnosis

B. Polyuria

C. Bilateral crackles

D. Hyperglycemia

ANS: C

Since opioids can sometimes cause slow breathing or other breathing problems, bilateral crackles are one of the adverse effects of epidural block with opioid analgesia.

64. A nurse is caring for a client who is receiving prenatal care and is at her 24-week appointment. Which of the following laboratory tests should the nurse plans to conduct?

A. Group B strep culture

B. 1-hr glucose tolerance test

C. Rubella titer

D. Blood type and Rh

ANS: B

A glucose challenge test is usually conducted between 24 and 28 weeks of pregnancy. Abnormal glucose levels may indicate gestational diabetes.

65. A nurse is caring for a client who has bacterial vaginosis. Which of the following medication should the nurse expect to administer?

A. Metronidazole

B. Fluconazole

C. Acyclovir

ANS: A

Treatment of *bacterial vaginosis* with ***oral metronidazole*** (Flagyl) is most effective, although vaginal preparations (e.g., metronidazole gel, clindamycin cream) are also used.

66. A nurse is caring for a client who is experiencing sore nipples from breastfeeding. Which of the following actions should the nurse take?

A. Place a snug dressing on the client's nipple when not breastfeeding.

B. Ensure the newborn's mouth is wide open before latching to the breast.

C. Encourage the client to limit the newborn's feeding to 10 min on each breast.

D. Instruct the client to begin the feeding with the nipple that is most tender.

ANS: B

To decrease nipple discomfort, the mother has to make sure that the baby's mouth is open wide before latching him or her on to the breast.

67. A nurse is assessing a preterm newborn who is at 32 weeks of gestation. Which of the following finding should the nurse expect?

A. Minimal arm recoil

B. Popliteal angle of less than 90

C. Creases over the entire sole

D. Sparse (thin) lanugo

ANS: D

Fine hair (lanugo) covering much of the body is expected with preterm newborn.

68. A nurse on a labor and delivery unit is providing teaching to a client who plans to use hypnosis to control labor pain. Which of the following information should the nurse include?

A. Focusing on controlling body functions

B. “Synchronized breathing will be required during hypnosis”

C. “Hypnosis can be beneficial in you practiced it during the prenatal period”

D. “Hypnosis does not work for controlling pain associated with labor”.

ANS: A

Hypnosis techniques used for labor and birthplace an emphasis on enhancing relaxation and diminishing fear, anxiety, and perception of pain. Women using this technique report a greater ***sense of control over painful contractions*** and a higher level of satisfaction with their childbirth experience.

69. A nurse is caring for client who is in active labor. Following epidural placement, the nurse a maternal blood pressure of 98/58 mmHg and minimal FHR variability on the fetal monitor. Which of the following images indicates the action the nurse should take?

ANS: ***turn the client to her side before calling the health care provider (HCP)***