A.T.I RN Maternity

Version-1

A nurse is collecting data from a client who is 12 hr postpartum following a spontaneous vaginal delivery. The nurse should expect to find the uterine fundus at which of the following positions on the client's abdomen?

At the level of the umbilicus

Within 12 hr, the fundus should rise to the level of the umbilicus and then recede 1 to 2 cm each day.

A nurse is caring for a client who is 4 hr postpartum. The nurse finds a small amount of lochia rubra on the client's perineal pad. The fundus is midline and firm at the umbilicus. Which of the following actions should the nurse take?

Perform fundal massage

The nurse notes that the fundus is midline and firm; therefore, fundal massage is not indicated at this time.

A nurse is preparing to palpate the uterine fundus of a client who is at 22 weeks of gestation to measure fundal height. At which of the following locations should the nurse expect to find the fundus?

At the umbilicus

At 22 weeks of gestation, the fundal height should be around the level of the umbilicus. The distance in centimeters from the symphysis pubis to the top of the fundus is a rough estimate of gestational age.

ATI Maternity

28. A client is admitted to the hospital for induction of labor. Which are the main indications for labor induction?

Incorrect: These are contraindications for labor induction.

Correct: Induction of labor is the stimulation of contractions (usually by the use of Pitocin) before they begin on their own. Maternal indications for induction of labor include: pregnancy induced hypertension, chorioamnionitis, gestational diabetes, chronic hypertension and premature rupture of membranes. Fetal indications include intrauterine growth retardation, post-term dates and fetal demise.

Incorrect: These are contraindications for labor induction.

Incorrect: These are contraindications for labor induction. They are indications for a C-section.

Placenta previa and twins

Pregnancy-induced hypertension and postterm fetus

Breech position and prematurity

Cephalopelvic disproportion and fetal distress

29. A client in active labor receives a regional anesthetic. Which is the main purpose of regional anesthetics?

Incorrect: This choice describes general anesthesia.

Correct: Regional anesthetics provide numbness and loss of pain sensation to an area. The most common regional blocks are: local, pudendal, epidural, and spinal.

Incorrect: Pain sensations travel to the central nervous system not away from it.

Incorrect: This choice describes the action for narcotic medications, not regional anesthetics.

To relieve pain by decreasing the client's level of consciousness

To provide general loss of sensation by blocking sensory nerves to an area

To provide pain relief by blocking descending impulses from the central nervous system

To relieve pain by decreasing the perception of pain leading to the pain centers in the brain

in parallel play. One way of dealing with negativism is to decrease opportunities for "no" answers.

Have the toddler dress himself.

Offer the toddler finger foods for snacks.

Provide opportunities to share toys with others.

Ask the child simple yes or no questions.

50 A nurse is caring for a 3-year-old child with strabismus. Which of the following actions should the nurse advise the parents to implement to help prevent amblyopia?

Biconcave lenses are used to correct myopia. While trauma should be avoided to prevent eye damage, this is not an implementation to prevent amblyopia (impairment of vision or blindness) from strabismus. Strabismus, or cross eye, is when one eye deviates from the point of fixation. If the misalignment is constant, the weak eye becomes lazy and the brain eventually suppresses the image. If not corrected by the age of 4 to 6 years, blindness from disuse or amblyopia may result. Treatment includes covering the strong eye to strengthen the muscles in the weak eye. Dry eyes are not a manifestation of strabismus.

Wear corrective biconcave lenses.

Prevent trauma to the eyes.

Patch the strong eye.

Instill artificial tears.

51 A nurse is caring for an infant with a history of vomiting due to gastroenteritis. Which of the following nursing interventions is considered the priority?

Maintaining the infant's airway is of the highest priority. A child who is vomiting should be positioned on the side or in a semi-reclining position to prevent aspiration. Administration of fluids and electrolytes is important to prevent or correct dehydration and electrolyte imbalances, but is not of the highest priority. Antiemetic medications are administered as prescribed if necessary. This is not the first priority. Of major importance is avoiding ketosis. A dietary intake high in carbohydrates spares the body protein and avoids ketosis which can result from exhaustion of the glycogen stores. This is not the highest priority.

Place the infant in a side or semi-reclined position.

5 R: first 30 min's of a newborns life the rest rate can range from 20-100/min. A resp. ratethis low at the time requires further evaluation and intervention by the nurse

9. A nurse us assessing a client who is at 26wks gestation. Which of the following clinicalmanifestations should the nurse report to the provider?
    a. Decreased urine output

5 R: increased B/P, proteinuria and decreased fetal activity can be indication ofpreeclampsia and should be notified to the provider

10. A nurse is providing teaching to a client about the physiological changes that occur during preg. The client is at 10 wks of gestation and has a BMI w/in the expected reference range. Which of the following client statements indicate an understanding of the teaching?
    a. "I will likely need to use alternative positions for sexual intercourse"

5 R: The weight of the preg will change positions of sexual intercourse thereforeunderstanding physiological changes during preg

11. A nurse in a woman health clinic is providing teaching about nutritional intake to a client who is at 8wks of gestation. The nurse should instruct the client to increase her daily intake of which of the following nutrients?
    a. Iron

5 R: for the woman who are pregnant, it is 27 mg/day. the recommendations for womannot preg is 15/mg day, for women younger than 19 yr old and 18 mg/day for women between the ages of 19 and 50 years old.

12. A nurse is assessing a client who is in active labor and notes early decelerations in the FHR on the monitor tracing. The client is at 39 wks of gestation and is receiving a continuous IV infusion of oxytocin. Which of the following actions should the nurse take?
    a. Continue monitoring the client

5 R: early decelerations are due to fetal head during contractions, vaginal examinationsand pushing during the second stage of labor. They are ok and normal

13. A nurse is caring for a newborn who was transferred to the nursery 30 min after delivery. Which of the following actions should the nurse take first?
    a. Verify the newborn's ID

    5 R: for safety / risk reduction

14. A nurse is providing education about the family bonding to parents who recently adopted a newborn. The nurse should make which of the following suggestions to aid the family 7-yr old in accepting the new family member?
    a. Obtain a gift from the newborn to present to the sibling
15. A nurse is teaching a client who has pre-gestational type 1 DM about management during preg. Which of the following statements by the client indicates an understanding of the teaching?
    a. "I will continue to take my insulin if I experience n/v"

5 R: Teach the client to continue to take insulin as prescribed during illness to preventhypoglycemic and hyperglycemic episodes

16. A nurse is providing d/c teaching to a client who is postpartum. For which of the following clinical manifestations should the nurse instruct the client to monitor and report to the provider?
    a. Unilateral breast pain

d. Apply cold compresses to the affected calf

27. A nurse is providing discharge teaching to a client who has a cesarean birth 3 days ago.Which of the following instructions should the nurse include?
    a. "you can resume sexual activity in 1 week"
    b. "you won't need to do kegel exercises since you had a cesarean" c. "you can still become pregnant if you are breastfeeding" - quizlet
    d. "you are safe to start adding sit-ups to your exercise routine in 2 weeks"
28. A nurse is performing a physical assessment of a newborn. Which of the following clinical findings should the nurse expect?
    a. Heart rate 154/min
    b. Axillary temperature 36c. Respiratory rate 58/min
    d. Length 43 cm
    e. Weight 2,600 g (5 lb 12 oz)
29. A nurse is performing a routine assessment on a client who is at 18 weeks of gestation.Which of the following findings should the nurse expect?
    a. Deep tendon reflexes 4+
    b. Fundal height 14 cm
    c. Urine protein 2+d. FHR 152/min
30. A nurse is reviewing the prenatal laboratory results for a client who is at 12 weeks of gestation following an initial prenatal visit. Which of the following laboratory findings should the nurse report to the provider?
    a. Hemoglobin 10g/dL
    b. WBC count 10,000/mm3
    c. Platelets 250,000/mm3
    d. Fasting blood glucose 90 mg/dL
31. A nurse is developing a plan of care for a newborn who is to undergo phototherapy for hyperbilirubinemia. Which of the following actions should the nurse include in the plan?
    a. Feed the newborn 1 oz of water every 4 hours
    b. Apply lotion to the newborn's skin three times per day
    c. Remove all clothing from the newborn except the diaper - quizlet
    d. Discontinue therapy if the newborn develops a rash
32. A nurse is caring for a client who is at 15 weeks of gestation, is Rh-negative, and has just had an amniocentesis. Which of the following interventions is the nurse's priorityfollowing the procedure?
    a. Check the client's temperature
    b. Observe for uterine contractions
    c. Administer Rh0(D) immune globulin
    d. Monitor the FHR
33. A nurse in an antepartum clinic is assessing a client who is at 32 weeks of gestation.Which of the following findings should the nurse report to the provider?
    a. Fundal height 34 cm

Instruct the mother to breathe slowly because this is a sign of hyperventilation.

Decrease the amount of Pitocin because this is a sign of hypertonic uterine contractions.

Turn the woman onto her left side to relieve pressure on the umbilical cord.

Reduce the oral and IV fluids to decrease circulatory overload.

49. The nursery nurse delays the first bottle feeding of a newborn. Which is the most common reason for the nurse's actions? The infant has:

Incorrect: One method of increasing an infant's low blood sugar is by feeding him.

Correct: Bottle feeding of an infant who is tachypneic (resp. rate > 60) is contraindicated due to risk of aspiration.

Incorrect: Acrocyanosis (blue hands and feet) is a normal finding for the first 24 hours.

Incorrect: It is not unusual for the nurse to hear a heart murmur shortly after birth.

a blood glucose of 45 gm/dL.

a respiratory rate above 60.

blue hands and feet.

a heart murmur.

50. During active labor, after a sudden slowing of the fetal heart rate, the nurse assesses the woman's perineum and observes a prolapsed cord. Which nursing action is most appropriate?

Correct: With a sterile gloved hand, the nurse should push the presenting part away from the cord, thus preventing cord compression. The cord supplies the fetus with oxygen and nutrients. The fetus is already showing signs of distress because of the slowing of the heart rate. In addition, the nurse should prepare for immediate delivery.

Continue monitoring the client.

- Early decelerations in the FHR are considered benign and occur due to compression of the fetal head during contractions, vaginal exams, and pushing during the second stage of labor. No interventions are necessary for early decelerations.

A nurse is teaching a group of parents about newborn safety. Which of the following statements by a parent indicates an understanding of the teaching?

‖I will dress my baby in flame-retardant clothing.‖

- Flame-retardant clothing will help prevent injury to the baby. Parents should avoid using plastic in the crib or bibs around the newborn's neck at night to avoid suffocation and choking. The parents should not heat formula in a microwave to prevent uneven warming.

A nurse is assessing a client who is 1 day postpartum and has a vaginal hematoma. Which of the following manifestations should the nurse expect?

Vaginal pressure

- The nurse should expect a client with a vaginal hematoma to report pressure in the vagina due to the blood that leaked into the tissues and persistent vaginal or rectal pain. Lochia serosa vaginal drainage is a manifestation for a client who is 4-10 days postpartum.

A charge nurse on the postpartum unit is observing a newly licensed nurse who is preparing to administer pain medication to a client. The charge nurse should intervene when the newly licensed nurse uses which of the following secondary identifiers to identify the client?

The client's room number

- The client's room number can change and places the client at risk for a medication error.

A nurse is providing discharge teaching to a client who had a cesarean birth 3 days ago. Which of the following instructions should the nurse include?

‖You can still become pregnant if you are breastfeeding.‖

b. In true labor walking will cause contractions to slow down
c. In true labor the presenting part is engaged
d. In true labor contractions are felt in the abdomen above the umbilicus
a. In true labor the cervix will dilate and efface

Progressive changes in dilation and effacement are the ultimate signs of true labor.

The nurse is observing sibling adaptation behaviors to the newborn infant during a family visit. To facilitate sibling acceptance, which action by the parents can assist with bonding?

Select one:
a. Provide the sibling a stuffed animal that they care for while the parents nurture the newborn.
b. Discuss with the sibling the importance of being more independent.
c. Encourage the sibling to spend time primarily with the babysitter.
d. Create new traditions and routines.
a. Provide the sibling a stuffed animal that they care for while the parents nurture the newborn.

this will help the sibling feel they are a part of the new family experience.

A nurse is caring for a client who has been prescribed magnesium sulfate as tocolytic therapy. Several hours after the infusion was started, contractions ceased. Which of the following is the best analysis of this data?

Select one:
a. The drug is having a therapeutic effect
b. The medication dose should be decreased

27) A nurse in a family planning clinic for a client who requests an oral contraceptive. Which of the following findings in the client's history should the nurse recognize as a contraindication to oral contraceptives?

1- Cholecystitis

2-Hypertension

3-Migraine headaches

28) A nurse is caring for a client who is at 40 weeks of gestation and is in a early labor. The client has a platelet count of 75,000/mm^3 and is requesting pain relief. Which of the following treatment modalities should the nurse anticipate?

Attention- focusing

29) A nurse is caring for a client who has recently experienced a perinatal death. Which of the following statements should the nurse make to the client?

I'm sad for you

30) A nurse is assessing a full-term newborn 15 min after birth. Which of the following findings require interventions by the nurse?

Respiratory rate 18/min

31) A nurse is assessing four newborns. Which of following findings should the nurse report tothe provider?

A newborn who is 18 hrs. old and has an axillary temperature of 37.7

32) A nurse is providing discharge teaching to a client who had a cesarean birth 3 days ago. Which of the following instructions should the nurse include?

You can still become pregnant if you are breastfeeding

33) A nurse is providing discharge teaching to a parent whose newborn has just had a circumcision. Which of the following instructions should the nurse include?

Apply slight pressure with a sterile gauze pad for mild bleeding

A nurse is completing a health history and assessment for a client who reports she is pregnant. Which of the following findings is a presumptive sign of pregnancy?

Positive pregnancy test

INCORRECT

A positive serum or urine pregnancy test is a probable sign of pregnancy. False positive results can occur for many reasons, such as the use of medications, liver disease, substance use, and hormone-producing tumors.

Amenorrhea

CORRECT

A client can present with amenorrhea for a variety of reasons besides pregnancy; therefore, the nurse should consider it a presumptive sign of pregnancy.

Fetal heart sounds

INCORRECT My Answer

The presence of a fetal heart tone is a positive sign of pregnancy. The nurse should be able to auscultate fetal heart tones by Doppler stethoscope at 8 to 17 weeks of gestation.

Chadwick sign

INCORRECT

Chadwick sign, the bluish coloration of the cervix and vaginal mucosa, is a probable sign of pregnancy.

12. A 5-year-old child is admitted to the pediatric unit with fever and pain secondary to a sickle cell crisis. Which intervention should the nurse implement first?

A. Obtain a culture of any sputum or wound drainage.

· Obtain a culture of any sputum or wound drainage

· Initiate normal saline IV at 50 ml/hr

· Administer a loading dose of penicillin IM

· Administer the initial dose of folic acid PO

Note: Therapeutic management page 1497 MB.

13. A child has been vomiting for 3 days is admitted for correction of fluid and electrolyte imbalances. What acid base imbalance is this child likely to exhibit?

· Respiratory alkalosis

· Respiratory acidosis

· Metabolic alkalosis

· Metabolic acidosis

Note: In the book under Vomiting topic I did not find any but I know that when the people has frequent vomits it's at risk for developing metabolic alkalosis related to the loss of hydrochloric acid.

14. A child admitted with diabetic ketoacidosis is demonstrating Kussmaul respiration. The nurse determines that the increased respiratory rate is a compensatory mechanism for which acid base alteration?

· Respiratory alkalosis

· Respiratory acidosis

· Metabolic acidosis

· Metabolic alkalosis

Note: page 1617 MB under ketoacidosis.

15. The nurse is caring for a 5-year-old child with Reye's syndrome. Which goal of treatment most clearly relates to caring for this child?

· Reduce cerebral edema and lower intracranial pressure

· Avert hypotension and septic shock

· Prevent cardiac arrhythmias and heart failure

· Promote kidney perfusion and normal blood pressure.

Note: Page 1581 MB under therapeutic and nursing care management.

3-hour old male infant's hands are feet are cyanotic, and he has an axillary temperature of 96.5 F, a respiratory rate of 40 breaths/min, and a heart rate of 165 beats/min. Which nursing intervention is best for the nurse to implement?

A. Perform a heel- stick to monitor blood glucose level
B. Gradually warm the infant under a radiant heat source
C. Administer oxygen by mask at 2L/minute
D. Notify the pediatrician of the infant's unstable vital signs

17- The nurse is assessing a 35-week primigravida with a breech presentation who is experiencing moderate uterine contraction every 3-5 minutes. During the examination the client tells the nurse, "I think my water just broke". Inspection of the perineal area reveals the umbilical cord protruding from the vagina. After activating the call bell system for assistance, what intervention should the nurse implement?

A. Administer oxygen at 10 liters via face mask
B. Don gloves and push the cord back into the vagina
C. Wrap the umbilical cord with sterile gauze
D. Position the client into a knee-chest position

18- At 34- weeks' gestation, a primigravida is assessed at her bimonthly clinic visits, which assessment finding is important for the nurse to report to the hcp?

A. Increased appetite
B. Fetal heart rate of 110 beats/minute
C. Fundus below the xiphoid
D. Weight gain of 7 pou

19- A 36-week primigravida is admitted to labor and delivery with severe abdominal pain and bright red vaginal bleeding. Her abdomen is rigid and tender to touch. The fetal heart rate FHR) is 90 beats/minute, and the maternal heart rate is 120 beats minute. What action should the nurse implement first?

A- Alert the neonatal team and prepare for neonatal resuscitation

B- Notify the healthcare provider from the client's bedside

C-Obtain written consent for an emergency cesarean section

D-Draw a blood sample for stat hemoglobin and hematocrit