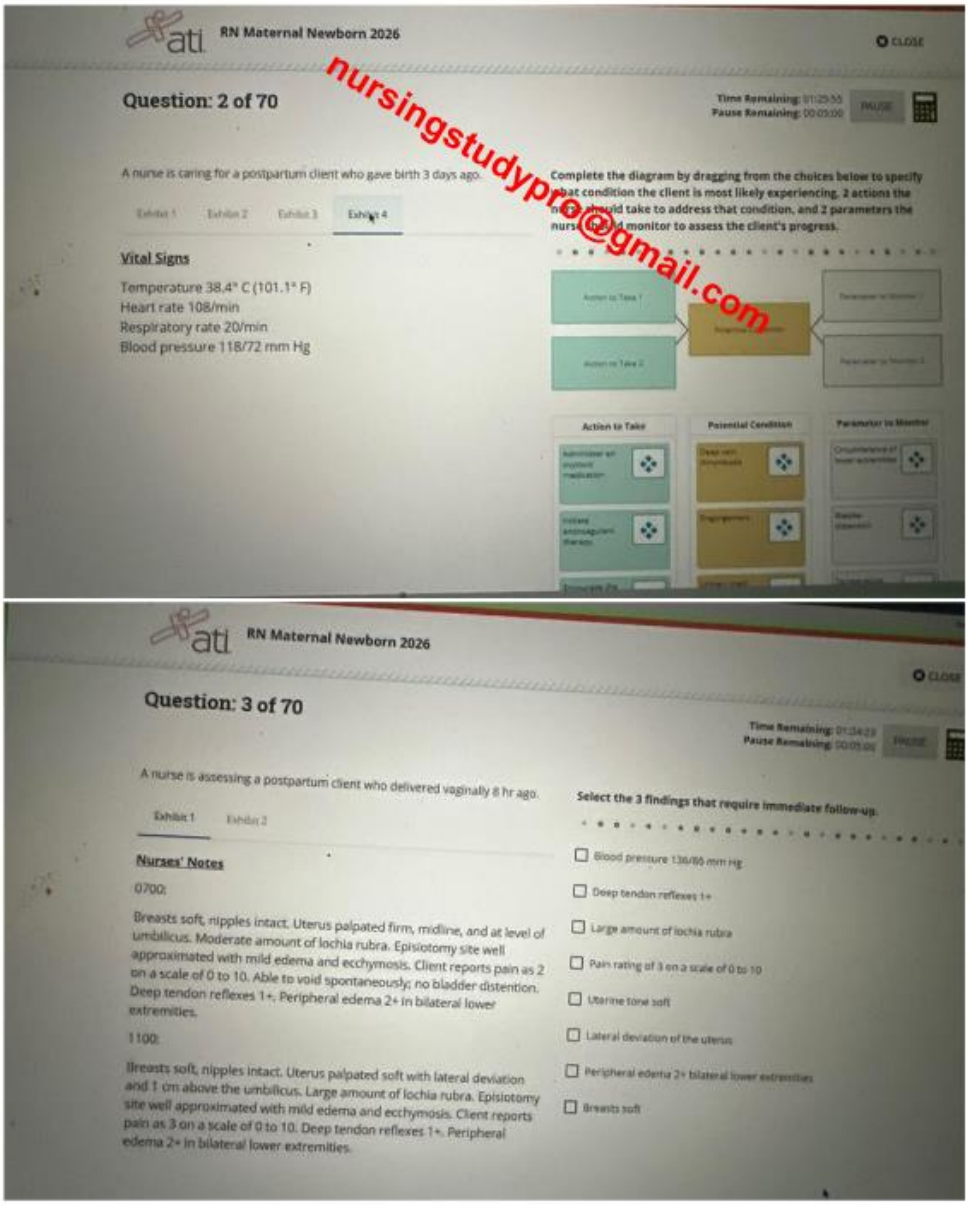
ATI RN Maternal Newborn Proctored Exam 2026 — 180 Most Tested Practice Questions with Answers & Rationales Exam Format: 180 questions | Multiple Choice, SATA, NGN Case Studies | Answers with detailed rationales | Level 3 proficiency focus



Answer: B

Rationale: Blurred or double vision is a sign of preeclampsia and should be reported immediately. Nausea, increased vaginal discharge, and leg cramps are normal discomforts of pregnancy.

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3. A nurse is assessing a client who is at 34 weeks of gestation and has a prescription for magnesium sulfate IV to treat preeclampsia. Which finding should the nurse identify as an indication of magnesium toxicity?

A. Increased urine output
B. Generalized pruritus
C. Respiratory rate of 10/min
D. Hyperreflexia (+4 patellar reflex)

Answer: C

Rationale: Magnesium sulfate is a CNS depressant. Signs of toxicity include a respiratory rate less than 12/min, urinary output less than 30 mL/hr, and diminished or absent deep tendon reflexes. Hyperreflexia is not a sign of toxicity.

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4. A client at 32 weeks gestation reports sudden painless vaginal bleeding. The nurse suspects:

A. Placenta previa
B. Placental abruption
C. Preterm labor
D. Uterine rupture

Answer: B

Rationale: Cold cabbage leaves and ice packs cause vasoconstriction and suppress lactation. Heat and nipple stimulation promote milk production.

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104. A nurse is providing discharge teaching to a breastfeeding client who is 1 day postpartum and is worried about their milk supply. Which statement should the nurse make?

A. "Colostrum is higher in fat, so it tends to keep newborns full for longer."
B. "Keeping newborn awake and latched for each feeding will help develop a good, mature milk supply."
C. "Offer formula feedings if your newborn seems hungry after breastfeeding."
D. "Your milk will come in immediately after birth."

Answer: B

Rationale: Frequent feeding and keeping the newborn awake and latched helps establish milk supply. Colostrum is lower in fat than mature milk. Formula supplementation can decrease milk supply.

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105. A nurse is teaching a new mother about breastfeeding. Which statement indicates understanding?

A. "I should wait until my breasts feel engorged before feeding."
B. "My baby will feed every 2 to 3 hours."
C. "I can give my baby water between feedings."
D. "I should wash my nipples with soap before each feeding."

C. Increased muscle tone

D. Strong cry

Answer: A

Rationale: Manifestations of neonatal hypoglycemia include jitteriness, decreased muscle tone, abnormal cry, and decreased temperature.

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148. A nurse is assessing a newborn who is 24 hr old and has sepsis. Which finding should the nurse expect?

A. Temperature instability

B. Acrocyanosis

C. Hypertension

D. Increased appetite

Answer: A

Rationale: Temperature instability is a key sign of neonatal sepsis. Other signs include lethargy, poor feeding, and respiratory distress. Acrocyanosis is a normal newborn finding.

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149. A nurse is caring for a newborn who is receiving phototherapy for an elevated bilirubin level. What action should the nurse take?

A. Apply barrier ointment to the skin

B. Remove the newborn from phototherapy for feeding

C. Keep the newborn's eyes covered

D. Dress the newborn in a onesie

Answer: A

Rationale: Bath water should be between 115–120°F (46–49°C) to prevent burns. Newborns should sleep on their backs in a crib, not on a sofa or near windows.

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154. A nurse is giving instructions to a parent about how to breastfeed their newborn. Which action should the parent take?

A. Place a few drops of water on the nipple before feeding
B. Ensure the newborn's mouth covers the areola, not just the nipple
C. Feed only when the newborn cries
D. Limit feeding to 10 minutes per breast

Answer: B

Rationale: Proper latch involves the newborn's mouth covering the areola, not just the nipple. Feeding should be on demand, and water supplementation is not recommended.

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155. A nurse is providing teaching to the parents of a newborn about bottle feedings. Which instruction should the nurse include?

A. Prop the bottle during feeding
B. Hold the newborn in a semi-upright position
C. Feed the newborn every 6 hours
D. Add cereal to the formula for better sleep

Answer: B

Rationale: Newborns should be held in a semi-upright position during bottle feeding to

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KEY TEST-TAKING STRATEGIES FOR LEVEL 3 SUCCESS

1. **Prioritization:** Remember ABCs (Airway, Breathing, Circulation) and Maslow's hierarchy. Safety always comes first.
2. **Fetal Monitoring:** Early decels = Head compression (benign). Variable decels = Cord compression (reposition). Late decels = Placental insufficiency (side-lying, oxygen, stop oxytocin).
3. **Magnesium Sulfate Toxicity:** Monitor respiratory rate (<12/min), deep tendon reflexes (diminished), and urine output (<30 mL/hr). Antidote: Calcium gluconate.
4. **Postpartum Hemorrhage:** Remember the "Four T's" — Tone (uterine atony), Trauma (lacerations), Tissue (retained placenta), Thrombin (clotting disorders).
5. **Newborn Assessment:** Normal HR 110–160, RR 30–60. Acrocyanosis is normal in the first 24 hours. Jaundice within 24 hours is pathologic.
6. **NGN Case Studies:** Read the scenario carefully, identify the key assessment findings, and apply the nursing process (Assessment → Diagnosis → Planning → Implementation → Evaluation).

Note: This comprehensive review contains 180 questions covering all major domains of the ATI RN Maternal Newborn Proctored Exam 2026. Each question is designed to reflect the NGN exam format with detailed rationales to reinforce critical thinking and clinical judgment.

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