

Which suggestion about weight gain is an accurate recommendation?

- Underweight women should gain 12.5 to 18 kg.
- Obese women should gain at least 7 kg.
- Adolescents are encouraged to strive for weight gains at the upper end of the recommended scale.
- In twin gestations, the weight gain recommended for a single fetus pregnancy should simply be doubled.
- The desirable weight gain during pregnancy varies among women.



So close!

The desirable **weight gain** during pregnancy varies among women. Underweight women need to gain the most. Obese women need to gain weight during pregnancy to equal the weight of the products of conception. Adolescents are still growing; therefore, their bodies naturally compete for nutrients with the fetus. Women bearing twins need to gain more weight (usually 16 to 20 kg) but not necessarily twice as much.

Which parameter should be closely monitored in a patient during the latent phase of the first stage of labor?

- Fetal heart rate
- Cervical dilation
- Maternal temperature
- External cephalic version



That's right!

During the first stage of labor, uterine contractions have just begun and the fetus is monitored for various parameters. The fetal heart rate is monitored at least every 30 to 60 minutes to ensure the safety of the fetus. **Cervical dilation** is assessed through vaginal examination and helps to determine the approximate time required for delivery. Maternal temperature is monitored every 2 to 4 hours to ensure the patient's safety. External cephalic version is performed to align the fetus to the birth canal.

Which patients with diabetes may develop complications if they perform exercises?

- A client who is on insulin
- A client with diabetic ketoacidosis
- A client with uncontrolled hypertension
- A client with severe peripheral neuropathy
- A client who has lost 5 kg weight after diagnosis



So close!

Exercise is usually prescribed for the prevention of complications in diabetic clients. However, a client with ketoacidosis should not do exercises, because exercises burn more fats and proteins, thereby increasing the blood ketone levels. Blood pressure increases with exercise; therefore, a client with uncontrolled blood pressure should not perform exercises. A client with severe peripheral neuropathy is susceptible to injury because of loss of sensations. Therefore, exercise is contraindicated in this client. A client with insulin dependent diabetes mellitus can perform exercises under supervision. Weight loss is a common complication associated with diabetes. A client who has lost weight can perform exercises to prevent complications of diabetes.

What is the optimal nursing intervention to minimize perineal edema after an episiotomy?

- Applying ice packs
- Offering warm sitz baths
- Administering aspirin as needed (prn)
- Elevating the hips on a pillow



So close!

Cold causes vasoconstriction and reduces edema by lessening the accumulation of blood and lymph at the **episiotomy** site; cold also deadens nerve endings and lessens the pain. Heat therapy alone does not resolve perineal edema. Aspirin is contraindicated in the early postpartum period because of the risk for hemorrhage. Elevating the hips provides minimal perineal relief.

How does a nurse identify possible developmental dysplasia of the hip (DDH) during a newborn assessment?

- Depressed dance reflex
- Limited adduction of the leg
- Asymmetry of the gluteal folds
- Shortened leg on the unaffected side



So close!

The **gluteal folds** should be symmetric, as should all planes and folds of the body. An abnormality of the hips will cause asymmetry, a shorter leg on the affected side, or both. The dance reflex is not affected in DDH. With DDH, abduction of the leg is usually limited at the hip. The leg on the affected, not unaffected, side appears to be shorter with DDH.

Test-Taking Tip: Do not select answers that contain exceptions to the general rule, controversial material, or responses that appear to be degrading.

The nurse concludes that a couple with a newborn with Erb palsy has an accurate understanding of the infant's prognosis. Which statement confirms this conclusion?

- "Surgery will correct the palsy."
- "This is a progressive disorder with no cure."
- "Recovery usually occurs in about 3 months."
- "Physical therapy will be necessary for 1 year."



So close!

The nerves that are stretched take about 3 months to recover from the trauma sustained during birth. Passive range-of-motion exercise and intermittent splinting performed by a trained family member will help facilitate [recovery](#). Only in rare instances, when avulsion of the nerves results in permanent damage, is orthopedic or surgical intervention necessary. The paralysis is not progressive, and the prognosis is usually excellent. Physical therapy is necessary for about 3 months, not 1 year.

Test-Taking Tip: Make educated guesses when necessary.

A client arrives at the fertility clinic for a diagnostic workup and is told by the nurse to prepare for a Papanicolaou (Pap) test. The client states, "I do not want this test. I want to speak to the person in charge." How should the nurse respond to this statement?

- Inform the primary healthcare provider of the client's request.
- Encourage the client to comply with clinic procedures.
- Express some disapproval of the client's lack of cooperation.
- Remind the client of the importance of early cancer detection.



So close!

The client has the right to refuse the Pap test; the nurse must accept the client's need to talk with the primary healthcare provider first. Although the client may eventually be encouraged to comply, her immediate need must be recognized first. Expressing some disapproval of the client's lack of cooperation is a subjective conclusion; the client has the right to refuse the test. Reminding the client of the importance of early cancer detection is inappropriate; this action is not client centered.

A nurse is assessing a newborn with caput succedaneum. How does the nurse explain the cause of this fetal condition to the new mother?

- Overlap of fetal bones as they pass through the maternal birth canal
- Swelling of the soft tissue of the scalp as a result of pressure during labor
- Hemorrhage of ruptured blood vessels that does not cross the suture lines
- Accumulation of fluid resulting from partial blockage of cerebrospinal fluid drainage



That's right!

Caput succedaneum is a diffuse pattern of edema above the periosteum; it results from an even distribution of pressure on the fetal head during labor. Overlap of fetal scalp bones is called molding. Swelling that does not cross the suture line is cephalhematoma, not caput succedaneum; it occurs when the fetal head is pressing on the rim of the pelvis during the birthing process. Accumulation of fluid resulting from a partial blockage of cerebrospinal fluid is hydrocephalus; in hydrocephalus the circumference of the head is larger than expected.

A 15-year-old client tells a school nurse, "I have this awful pain during my periods—it never stops." What should the nurse encourage her to do?

- Continue daily activities.
- Have a gynecologic examination.
- Eat a nutritious diet containing iron.
- Practice relaxation of abdominal muscles.



That's right!

Persistent pain of any kind during menstruation (dysmenorrhea) usually indicates a problem, and the client should seek medical attention. Although diversion is a means of altering pain perception, the presence of pain requires investigation of possible causes. Although a nutritious diet is beneficial, iron does not prevent the pain of dysmenorrhea. Voluntary relaxation of the abdominal muscles does not result in cessation of dysmenorrhea.

Test-Taking Tip: Have confidence in your initial response to an item because it more than likely is the correct answer.

A 26-year-old primigravida experiencing severe abdominal pain is brought to the emergency department by ambulance with a suspected ruptured tubal pregnancy. What should the nurse's initial action be?

- Insert an intravenous (IV) catheter.
- Ask the client to sign a surgical consent form.
- Determine whether a family member is present.
- Ascertain the first day of the client's last menstrual period.



That's right!

The client is at risk for hypovolemic shock resulting from hemorrhage; administration of IV fluids is the priority. Asking the client to sign a surgical consent form, determining whether a family member is present, or ascertaining the first day of the client's last menstrual period is not the priority in an emergency situation.

A pregnant client is scheduled for ultrasonography at the end of her first trimester. What should the nurse instruct her to do in preparation for the sonogram?

- Empty her bladder.
- Avoid eating for 8 hours.
- Take a laxative the night before the test.
- Increase fluid intake for 1 hour before the procedure.



That's right!

In the first trimester when fluid fills the bladder, the uterus is pushed up toward the abdominal cavity for optimum ultrasound viewing. The bladder must be full, not empty, for better visualization of the uterus. The gastrointestinal tract is not involved in ultrasound preparation.

A client at 10 weeks' gestation calls the clinic and tells a nurse that she has morning sickness and cannot control it. What should the nurse suggest to promote relief?

- "Eat dry crackers before you get out of bed."
- "Increase your fat intake before bedtime."
- "Drink high-carbohydrate fluids with meals."
- "Eat two small meals a day and a snack at noon."



That's right!

Nausea and vomiting in the morning occur in almost 50% of all pregnancies. Eating dry crackers before getting out of bed in the morning is a simple remedy that may provide relief. Increasing fat intake does not relieve the nausea. Drinking high-carbohydrate fluids with meals is not helpful; separating fluids from solids at mealtime is more advisable. Eating two small meals a day and a snack at noon does not meet the nutritional needs of a pregnant woman, nor will it relieve nausea. Some women find that eating five or six small meals daily instead of three large ones is helpful.

Test-Taking Tip: Study wisely, not hard. Use study strategies to save time and be able to get a good night's sleep the night before your exam. Cramming is not smart, and it is hard work that increases stress while reducing learning. When you cram, your mind is more likely to go blank during a test. When you cram, the information is in your short-term memory so you will need to relearn it before a comprehensive exam. Relearning takes more time. The stress caused by cramming may interfere with your sleep. Your brain needs sleep to function at its best.

A newborn is found to have a diaphragmatic hernia. What is the immediate intervention after the neonate is admitted to the neonatal intensive care unit?

- Hydrating the infant with isotonic enemas
- Limiting formula feedings to small amounts
- Placing the infant in the Trendelenburg position
- Providing gastric decompression via nasogastric tube



That's right!

When a diaphragmatic hernia is present, intra-abdominal pressure must be minimized; this is accomplished with the use of gastric decompression. Hydrating the infant with isotonic enemas is not beneficial. These infants are not fed orally; intravenous fluids are given with careful measurement of electrolytes and intake and output to guide replacement therapy. The Trendelenburg position is contraindicated; the abdominal organs will increase pressure on the diaphragm.

STUDY TIP: Develop a realistic plan of study. Do not set rigid, unrealistic goals.

Which sign or symptom leads the nurse to suspect that a client is experiencing a tubal pregnancy?

- A painful, tender area in the epigastric region after meals
- Lower abdominal cramping of 1 week's duration with constipation
- Leukorrhea or dysuria occurring a few days after the first missed menstrual period
- A sharp pain in the lower right or left side of the abdomen, radiating to the shoulder



That's right!

A fallopian tube is unable to contain and sustain a pregnancy to term; as the fertilized ovum grows, there is excessive stretching or rupture of the affected fallopian tube, resulting in pain. At this stage the products of conception are too small to form a mass; the pain is lateral, not centered. The pain is sudden, intense, and knifelike, not prolonged or cramping. Leukorrhea and dysuria may be indicative of a vaginal or bladder infection.

Test-Taking Tip: Become familiar with reading questions on a computer screen. Familiarity reduces anxiety and decreases errors.

A client with severe preeclampsia is hospitalized. Which action should the nurse initiate first to ensure her physical safety?

- Institute seizure precautions.
- Decrease environmental stimuli.
- Administer the prescribed sedatives.
- Strictly monitor her intake and output.



That's right!

This client may become eclamptic suddenly and have a seizure; seizure precautions are necessary to keep her from injuring herself and the fetus. Decreasing environmental stimuli is important; however, the client's safety should be ensured first. Administering sedatives will help reduce nervous system irritability; it will not ensure safety if the client has a seizure. Monitoring intake and output will be required when magnesium sulfate therapy is started.

What is the priority nursing intervention during the admission of a primigravida in labor?

- Monitoring the fetal heart rate
- Asking the client when she ate last
- Obtaining the client's health history
- Determining whether the membranes have ruptured



So close!

Determining fetal well-being supersedes all other measures; if the fetal heart rate is absent or persistently decelerating, immediate intervention is required. The health history, including the client's last meal and whether the membranes have ruptured, may be taken once fetal well-being has been established.

The nurse assures a breast-feeding mother that one way she will know that her infant is getting an adequate supply of breast milk is if the infant gains weight. What behavior does the infant exhibit if an adequate amount of milk is being ingested?

- Has several firm stools daily
- Voids six or more times a day
- Spits out a pacifier when offered
- Awakens to feed about every 4 hours



That's right!

The presence of at least six to eight wet diapers each day indicates sufficient breast milk intake. Several firm stools daily may indicate an inadequate amount of fluid ingestion; the stools of **breast-feeding neonates** should be soft to loose. Spitting out a pacifier is not an indication of adequate milk consumption; some infants need extra sucking stimulation. Awakening to feed every 4 hours is not a reliable indicator of adequate breast milk intake; sleep patterns vary.

Test-Taking Tip: Try putting questions and answers in your own words to test your understanding.

The nurse is providing care to a multiparous client in active labor. The client is requesting something for the pain. What is the nurse's priority intervention?

- Examining the client's cervix for dilation and effacement
- Determining the client's options by assessing the prescriptions in the chart
- Asking her whether she prefers an epidural or something in her intravenous line
- Evaluating the fetal monitoring strip to determine the frequency and duration of contractions



So close!

Evaluating the client's cervical dilation and effacement determines her progress in labor and reveals whether it is safe to administer analgesia or anesthesia. Assessment is the initial step of the nursing process. Options for pain management would be determined after dilation has been assessed. The client may be asked about her preferred method of analgesia, but that should be done after her degree of dilation has been determined. The stem of the question indicated that the client is in active labor; information on the fetal monitoring strip regarding contractions will not add to the assessment data.

A 7 lb, 4 oz (3289 g) boy is admitted to the nursery and placed in a warm crib. The neonate begins to choke on mucus. How should the nurse suction him with a bulb syringe?

- By suctioning the mouth before the nostrils
- By starting the oxygen and then suctioning the pharynx
- By positioning the bulb far into the throat before beginning suctioning
- By placing the bulb in the mouth, compressing the bulb, and starting suctioning



That's right!

The mouth is suctioned before the nostrils because if the nostrils are suctioned first a reflex gasp may be stimulated, resulting in aspiration of mucus from the mouth. The newborn will be unable to inhale oxygen or even breathe if the nose and throat are occluded with mucus. Placing the bulb too far into the mouth may cause trauma or reflex bradycardia. The bulb should be compressed before it is placed in the newborn's mouth; timing of bulb compression is essential, or mucus may be forced farther into the throat.

Test-Taking Tip: Prepare for exams when and where you are most alert and able to concentrate. If you are most alert at night, study at night. If you are most alert at 2 am, study in the early morning hours. Study where you can focus your attention and avoid distractions. This may be in the library or in a quiet corner of your home.

Typical signs of neonatal abstinence syndrome related to opioid withdrawal usually begin within 24 hours after birth. What characteristics should the nurse anticipate in the infant of a suspected or known drug abuser?

- Tremors
- Dehydration
- Hyperactivity
- Muscle hypotonicity
- Prolonged sleep periods



So close!

Opioid dependence in the newborn is physiologic; as the drug is cleared from the body, signs of **drug withdrawal** become evident. Tremors and hyperactivity are typical signs of cerebral irritability. Dehydration is a result of inadequate feeding, not a direct result of opioid withdrawal. Muscle hypertonicity, not hypotonicity, occurs with opioid withdrawal. Signs of opioid withdrawal include excessive activity and sleep disturbances.

A 16-year-old primigravida who appears to be at or close to term arrives at the emergency department stating that she is in labor and complaining of pain continuing between contractions. The nurse palpates the abdomen, which is firm and shows no sign of relaxation. What problem does the nurse conclude that the client is experiencing?

- Placenta previa
- Precipitous birth
- Abruption placentae
- Breech presentation



So close!

Abruption placentae indicates a premature placental separation; the classic signs are abdominal rigidity, a tetanic uterus, and dark-red bleeding. Placenta previa occurs with a low-lying placenta and is manifested by painless bright-red bleeding. Information on cervical effacement, dilation, and station is required before the nurse can come to a conclusion regarding precipitous birth. Fetal presentation is not related to the client's signs and symptoms.

A newborn is admitted to the nursery with a spiral scalp electrode from an internal monitor in place. How should the nurse remove the electrode?

- Giving the electrode a quick jerk
- Turning the electrode clockwise until it is free
- Untwisting the wires before pulling the electrode out
- Twisting the electrode counterclockwise until it is free



So close!

For the spiral electrode to be removed it must be turned counterclockwise. Quickly jerking the electrode may result in a lacerating injury to the scalp. The electrode is attached by turning it clockwise. It is unnecessary to untwist the wires; the electrode should not be pulled, because this may cause a scalp laceration.

Next

The postpartum nurse is delegating tasks to an unlicensed health care worker. Which task should the nurse delegate?

- Evaluation of a postpartum client's lochia
- Vital signs on a client 4 hours after delivery
- Assessment of a postpartum client's episiotomy
- Assisting the postpartum client to breastfeed for the first time



That's right!

Evaluating the client's lochia, assessing the client's episiotomy, and helping the client breastfeed for the first time would involve assessment, teaching, or evaluation and should not be delegated. The only task that does not require any of these is taking vital signs 4 hours after delivery.

Test-Taking Tip: The most reliable way to ensure that you select the correct response to a multiple-choice question is to recall it. Depend on your learning and memory to furnish the answer to the question. To do this, read the stem, and then stop! Do not look at the response options yet. Try to recall what you know and, based on this, what you would give as the answer. After you have taken a few seconds to do this, then look at all of the choices and select the one that most nearly matches the answer you recalled. It is important that you consider all the choices and not just choose the first option that seems to fit the answer you recall. Remember the distractors. The second choice may look okay, but the fourth choice may be worded in a way that makes it a slightly better choice. If you do not weigh all the choices, you are not maximizing your chances of correctly answering each question.

A client visits the prenatal clinic for the first time. The client tells the nurse that her last menstrual period began June 10. The nurse uses the Nägele rule to calculate the EDB. What is the EDB?

- April 7
- March 7
- April 10
- March 17



That's right!

The EDB is March 17. Using the Nägele rule, subtract 3 months and add 1 year and 7 days to the first day of the last menstrual period. April 7, March 7, and April 10 all represent inaccurate applications of the Nägele rule.

STUDY TIP: You have a great resource in your classmates. We all have different learning styles, strengths, and perspectives on the material. Participating in a study group can be a valuable addition to your nursing school experience.

A couple in their late 30s, expecting their first child, plan to have an amniocentesis. The couple is anxious to have the testing completed as soon as possible. The nurse explains that the test will be scheduled at what time?

- When quickening is felt
- During the last trimester
- At the tenth week of gestation
- After the fourteenth week of pregnancy



That's right!

In the fourteenth week, amniotic fluid is present, and small amounts may be withdrawn for testing. Amniocentesis may be performed before quickening is established; a nullipara may not feel quickening until the eighteenth week or later. Although amniocentesis may be performed any time after the fourteenth week, it should be done as early as possible after the fourteenth week. Older couples have a higher risk of having a fetus with chromosomal anomalies, and the earlier amniocentesis will aid the parents in decision-making. There is insufficient amniotic fluid present at 10 weeks for amniocentesis, although chorionic villi sampling can be done by the tenth week.

While changing a newborn girl's diaper a nurse observes a brick-red stain on the diaper. How does the nurse interpret this clinical finding?

- A sign of low iron excretion
- An uncommon benign occurrence
- An expected occurrence in female newborns
- The result of a medication administered during labor



That's right!

The brick-red color in the urine is caused by albumin and urates that are found in the first week of life. Iron is eliminated by way of the gastrointestinal tract. The finding is unrelated to the sex of the infant; it is not hormonally based. No medication administered during labor will cause this discoloration.

Which characteristic does the nurse anticipate in an infant born at 32 weeks' gestation?

- Barely visible areolae and nipples
- Ear pinnae that spring back when folded
- Definite creases of the infant's palms and soles
- A zero-degree angle on the square window sign



So close!

Breast tissue is not palpable in a newborn of less than 33 weeks' gestation. The ear pinnae spring back in an infant at 36 weeks' gestation. Creases of the palms and soles are not clearly defined until after the 37th week of gestation. A zero-degree square window sign is present in an infant at 40 to 42 weeks' gestation.

Test-Taking Tip: Identify option components as correct or incorrect. This may help you identify a wrong answer. *Example: If you are being asked to identify a diet that is specific to a certain condition, your knowledge about that condition would help you choose the correct response (e.g., cholecystectomy = low-fat, high-protein, low-calorie diet).*

A woman's 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?

- "We don't really know when such defects occur."
- "It depends on what caused the defect."
- "They occur between the third and fifth weeks of development."
- "They usually occur in the first 2 weeks of development."



That's right!

Blood vessel and blood formation begin in the **third week**, and the heart is developmentally complete in the fifth week. Stating that it is not known when the defects occur is inaccurate. Regardless of the cause, the heart is vulnerable during its period of development, the third to fifth weeks. The cardiovascular system is the first organ system to function in the developing human.

The nurse is monitoring the fetal heart rate of a pregnant client. Which fetal heart rate is indicative of adequate fetal oxygen supply?

- Fetal heart rate is 90 beats/minute
- Fetal heart rate is 100 beats/minute
- Fetal heart rate is 130 beats/minute
- Fetal heart rate is 170 beats/minute



That's right!

The fetal heart rate needs to be at a certain level to ensure a sufficient oxygen supply to the infant from the maternal blood. An insufficient supply of oxygen leads to hypoxia in the fetus. If the fetal heart rate is from 110 beats/minute to 160 beats/minute, it indicates that the fetus has adequate circulation and is obtaining a sufficient amount of oxygen from the maternal blood. The fetus with a heart rate of 130 beats/minute is normal. Fetal heart rates of 90 beats/minute or 100 beats/minute are indications of fetal bradycardia. A heart rate of 170 beats/minute in a fetus indicates tachycardia. Both conditions indicate impaired cardiac activity in the fetus.

Test-Taking Tip: Read carefully and answer the question asked; pay attention to specific details in the question.

A pregnant client who is nearing her due date informs the nurse that she would like a vaginal delivery. The nurse observes in the medical records that the presenting part is the sacrum. What does the nurse tell the client?

- "Vaginal delivery may not be possible."
- "There will be no complications during labor."
- "You may have to lose weight for a safe delivery."
- "The infant may have congenital physical defects."



That's right!

If the presenting part of the fetus is the sacrum, it indicates a breech presentation. Vaginal delivery of a fetus in breech position carries increased risks and it is more likely that the client will have to have a caesarean delivery. It is inaccurate to inform the client that there will be no complications during the birth, because this is not something that the nurse can predict. A breech presentation does not indicate that the client needs to lose weight. Environmental and biologic factors are associated with congenital defects.