IM8 Maternal & Newborn-C

1. A nurse is caring for a client who is in preterm labor with a current L/S ratio of 1:1. Which of the following actions should the nurse take?

   A. Infuse a bolus of IV fluid.

   B. Administer hydralazine 25 mg IV.

   C. Prepare the client for immediate delivery.

   D. Administer betamethasone 12 mg IM.

2. A nurse is caring for a client who gave birth 2 hr ago. The nurse notes that the client's blood pressure is 60/50 mm Hg. Which of the following actions should the nurse take first?

   A. Evaluate the firmness of the uterus.

   B. Initiate oxygen therapy by nonrebreather mask.

   C. Administer oxytocin infusion.

   D. Obtain a type and crossmatch.

3. A nurse is caring for a newborn immediately following birth. After assuring a patent airway, what is the priority nursing action?

   A. Administer vitamin K.

   B. Dry the skin.

   C. Administer eye prophylaxis.

   D. Place an identification bracelet.

4. A nurse is caring for a client who is considering several methods of contraception. Which of the following methods of contraception should the nurse identify as being most reliable?

   A. A male condom

   B. An intrauterine device (IUD)

   C. An oral contraceptive

   D. A diaphragm with spermicide.

5. A nurse in a prenatal clinic is caring for a client who is suspected of having a hydatidiform mole. Which of the following findings should the nurse expect to observe in this client?

   A. Rapid decline in human chorionic gonadotropin (hCG) levels

   B. Profuse, clear vaginal discharge

   C. Irregular fetal heart rate

   D. Excessive uterine enlargement

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6. A nurse is caring for a new mother who is concerned that her newborn's eyes cross. Which of the following statements is a therapeutic response by the nurse?

   A. "I will call your primary care provider to report your concerns."

   B. "I will take your baby to the nursery for further examination."

   C. "This occurs because newborns lack muscle control to regulate eye movement."

   D. "This is a concern, but strabismus is easily treated with patching."

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7. A nurse on a labor unit is admitting a client who reports painful contractions. The nurse determines that the contractions have a duration of 1 min and a frequency of 3 min. The nurse obtains the following vital signs: fetal heart rate 130/min, maternal heart rate 128/min and maternal blood pressure 92/54 mm Hg. Which of the following is the priority action for the nurse to take?

   A. Notify the provider of the findings.

   B. Position the client with one hip elevated.

   C. Ask the client if she needs pain medication.

   D. Have the client void.

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8. A nurse in the ambulatory surgery center is providing discharge teaching to a client who had a dilation and curettage (D&C) following a spontaneous miscarriage. Which of the following should be included in the teaching?

   A. Vaginal intercourse can be resumed after 2 weeks.

   B. Products of conception will be present in vaginal bleeding.

   C. Increased intake of zinc-rich foods is recommended.

   D. Aspirin may be taken for cramps.

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9. A nurse in a prenatal clinic is caring for a client who is at 38 weeks of gestation and reports heavy, red vaginal bleeding. The bleeding started spontaneously in the morning and is not accompanied by contractions. The client is not in distress and she states that she can "feel the baby moving." An ultrasound is scheduled stat. The nurse should explain to the client that the purpose of the ultrasound is to determine which of the following?

   A. Fetal lung maturity

   B. Location of the placenta

   C. Viability of the fetus

   D. The biparietal diameter

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10. A nurse is caring for a client who is in labor and has an external fetal monitor. The nurse observes late decelerations on the monitor strip and interprets them as indicating which of the following?

   A. Uteroplacental insufficiency

   B. Maternal bradycardia

   C. Umbilical cord compression

   D. Fetal head compression

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11. A nurse is caring for a client who has rubella at the time of delivery and asks why her newborn is being placed in isolation. Which of the following responses by the nurse is appropriate?

   A. "The newborn might be actively shedding the virus."

   B. "The newborn is at risk for developing a TORCH infection."

   C. "The child might develop encephalitis, a complication of rubella."

   D. "Exposure to rubella will suppress the newborn’s immune response."

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12. A nurse is assessing a client who is in active labor and notes that the presenting part is at 0 station. Which of the following is the correct interpretation of this clinical finding?

   A. The fetal head is in the left occiput posterior position.

   B. The largest fetal diameter has passed through the pelvic outlet.

   C. The posterior fontanel is palpable.

   D. The lowermost portion of the fetus is at the level of the ischial spines.

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13. A nurse is completing a health history for a client who is at 6 weeks of gestation. The client informs the nurse that she smokes one pack of cigarettes per day. The nurse should advise the client that smoking places the client's newborn at risk for which of the following complications?

    A. Hearing loss

    B. Intrauterine growth restriction

    C. Type 1 diabetes mellitus

    D. Congenital heart defects

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14. A nurse is caring for a client who is postpartum. The nurse should recognize which of the following statements by the client as an indication of inhibition of parental attachment?

    A. "He's got my husband's nose, that's for sure."

    B. "I don't need a baby bath demonstration. I know how to do it."

    C. "I wish he had more hair. I will keep a hat on his head until he grows some."

    D. "Do you think you could keep him in the nursery for the next feeding so I can get some sleep?"

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15. A nurse is caring for a client at the first prenatal visit who has a BMI of 26.5. The client asks how much weight she should gain during pregnancy. Which of the following responses should the nurse make?

    A. "It would be best if you gained about 11 to 20 pounds."

    B. "The recommendation for you is about 15 to 25 pounds."

    C. "A gain of about 25 to 35 pounds is recommended for you."

    D. "A gain of about 1 pound per week is the best pattern for you."

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16. A nurse is assessing a client who is 3 days postpartum and is breastfeeding. The nurse notes that the fundus is three fingerbreadths below the umbilicus, lochia rubra is moderate, and the breasts are hard and warm to palpation. Which of the following interpretations of these findings should the nurse make?

    A. The client is exhibiting early indications of mastitis.

    B. Additional interventions are not indicated at this time.

    C. Application of a heating pad to the breasts is indicated.

    D. The client should be advised to remove her nursing bra.

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17. A nurse in the emergency department is admitting a client who is at 40 weeks of gestation, has ruptured membranes, and the nurse observes the newborn's head is crowning. The client tells the nurse she wants to push. Which of the following statements should the nurse make? to

    A. "You should go ahead and push to assist the delivery."

    B. "You should try to pant as the delivery proceeds."

    C. "You should try to perform slow-paced breathing."

    D. "You should take a deep, cleansing breath and breathe naturally."

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18. A home health nurse is teaching a client who is breastfeeding about managing breast engorgement. Which of the following client statements indicates understanding of the teaching?

    A. "I'll let my baby drain one breast at each feeding."

    B. "I'll try drinking an herbal tea to reduce the engorgement."

    C. "I'll apply cold compresses 20 minutes before each feeding."

    D. "I'll feed my baby every 2 hours."

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19. A nurse is planning care for a newborn who is small for gestational age (SGA). Which of the following is the priority intervention the nurse should include in the newborn's plan of care?

    A. Monitor I&O.

    B. Monitor axillary temperature.

    C. Monitor blood glucose levels.

    D. Monitor weight.

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20. A nurse is preparing to administer methylergonovine IM to a client who experienced a vaginal delivery. The nurse should explain to the client that the purpose of this medication is to prevent which of the following conditions?

    A. Postpartum infection

    B. Hypertension

    C. Postpartum hemorrhage

    D. Thromboembolic events

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21. A nurse is caring for a client who is at 39 weeks of gestation and is in active labor. The nurse locates the fetal heart tones above the client's umbilicus at midline. The nurse should suspect that the fetus is in which of the following positions?

    A. Cephalic

    B. Transverse

    C. Posterior

    D. Frank breech

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22. A nurse is assessing a client who is 8 hr postpartum and multiparous. Which of the following findings should alert the nurse to the client's need to urinate?

    A. Moderate lochia rubra

    B. Fundus three fingerbreadths above the umbilicus

    C. Moderate swelling of the labia

    D. Blood pressure 130/84 mm Hg

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23. A nurse is caring for a client who is to undergo a biophysical profile. The client asks the nurse what is being evaluated during this test. Which of the following should the nurse include? (Select all that apply.)

    A. Fetal breathing

    B. Fetal motion

    C. Fetal neck translucency

    D. Amniotic fluid volume

    E. Fetal gender

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24. A nurse is caring for a client who is at 40 weeks gestation and is in active labor. The client has 6 cm of cervical dilation and 100% cervical effacement. The nurse obtains the client's blood pressure reading as 82/52 mm Hg. Which of the following nursing interventions should the nurse perform?

    A. Prepare for a cesarean birth.

    B. Assist the client to an upright position.

    C. Prepare for an immediate vaginal delivery.

    D. Assist the client to turn onto her side.

25. A nurse in a provider's office is caring for a client who is at 34 weeks of gestation and at risk for placental abruption. The nurse should recognize that which of the following is the most common risk factor for abruption?

    A. Cocaine use

    B. Hypertension

    C. Blunt force trauma

    D. Cigarette smoking

26. A nurse is assessing a newborn the day after delivery. The nurse notes a raised, bruised area on the left side of the scalp that does not cross the suture line. How should the nurse document this finding?

    A. Caput succedaneum

    B. Cephalhematoma

    C. Molding

    D. Pilonidal dimple

27. A nurse observes that a newborn has a pink trunk and head, bluish hands and feet, and flexed extremities 5 min after delivery. He has a weak and slow cry, a heart rate of 130/min, and cries in response to suctioning. The nurse should document what Apgar score for this infant?

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28. A nurse is caring for a client who is in active labor with 7 cm of cervical dilation and 100% effacement. The fetus is at 1+ station, and the client's amniotic membranes are intact. The client suddenly states that she needs to push. Which of the following actions should the nurse take?

    A. Assist the client into a comfortable position.

    B. Observe the perineum for signs of crowning.

    C. Have the client pant during the next contractions.

    D. Help the client to the bathroom to void.

29. A nurse is caring for a client 2 hr after a spontaneous vaginal birth and the client has saturated two perineal pads with blood in a 30-min period. Which of the following is the priority nursing intervention at this time?

A. Palpate the client's uterine fundus.

B. Assist the client on a bedpan to urinate.

C. Prepare to administer oxytocic medication.

D. Increase the client's fluid intake.

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30. A nurse in a prenatal clinic is caring for a client who is at 38 weeks of gestation and undergoing a contraction stress test. The test results are negative. Which of the following interpretations of this finding should the nurse make?

A. There is evidence of cervical incompetence.

B. There is no evidence of two or more accelerations in fetal heart rate in 20 min.

C. There is no evidence of uteroplacental insufficiency.

D. There are less than 3 uterine contractions in a 10-min period.

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31. A nurse is assessing a client who is receiving magnesium sulfate to treat pre-eclampsia. Which of the following findings should the nurse report to the provider?

A. Respirations 16/min

B. Headache for 30 min

C. Urinary output 40 mL in 2 hr

D. Fetal heart rate 158/min

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32. A nurse is caring for a client who had a vaginal delivery 2 hr ago. Which of the following actions should the nurse anticipate in the care of this client? (Select all that apply.)

A. Document fundal height.

B. Massage a firm fundus.

C. Observe the lochia during palpation of fundus.

D. Determine whether the fundus is midline.

E. Administer methylergonovine maleate if uterus is boggy.

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33. A nurse is caring for a client following an amniotomy who is now in the active phase of the first stage of labor.

Which of the following actions should the nurse implement with this client?

A. Maintain the client in the lithotomy position.

B. Perform vaginal examinations frequently.

C. Remind the client to bear down with each contraction.

D. Encourage the client to empty her bladder every 2 hr.

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34. A nurse is admitting a client who is at 30 weeks of gestation and is in preterm labor. The client has a new prescription for betamethasone and asks the nurse about the purpose of this medication. The nurse should provide which of the following explanations?

A. "It is used to stop preterm labor contractions."

B. "It halts cervical dilation."

C. "It promotes fetal lung maturity."

D. "It increases the fetal heart rate."

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35. A nurse is caring for a client who is at 22 weeks of gestation and has been unable to control her gestational diabetes mellitus with diet and exercise. The nurse should anticipate a prescription from the provider for which of the following medications for the client?

A. Acarbose

B. Repaglinide

C. Glyburide

D. Glipizide

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36. A nurse is caring for a client who is at 37 weeks of gestation and has placenta previa. The client asks the nurse why the provider does not do an internal examination. Which of the following explanations of the primary reason should the nurse provide?

A. "There is an increased risk of introducing infection."

B. "This could initiate preterm labor."

C. "This could result in profound bleeding."

D. "There is an increased risk of rupture of the membranes."

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37. A nurse is caring for a client who is 7 days postpartum and calls the clinic to report pain and redness of her left calf. Besides seeing her provider, which of the following interventions should the nurse suggest?

    A. Flex her knee while resting.

    B. Massage the area.

    C. Elevate her leg.

    D. Apply cold compresses.

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38. A nurse admits a woman who is at 38 weeks of gestation and in early labor with ruptured membranes. The nurse determines that the client's oral temperature is 38.9° C (102° F). Besides notifying the provider, which of the following is an appropriate nursing action?

    A. Recheck the client's temperature in 4 hr.

    B. Administer glucocorticoids intramuscularly.

    C. Assess the odor of the amniotic fluid.

    D. Prepare the client for emergency cesarean section.

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39. A nurse is preparing to administer an injection of Rho (D) immunoglobulin. The nurse should understand that the purpose of this injection is to prevent which of the following newborn complications?

    A. Hydrops fetalis

    B. Hypobilirubinemia

    C. Biliary atresia

    D. Transient clotting difficulties

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40. A nurse is caring for a client who is in labor and has an epidural anesthesia block. The client's blood pressure is 80/40 mm Hg and the fetal heart rate is 140/min. Which of the following is the priority nursing action?

    A. Elevate the client's legs.

    B. Monitor vital signs every 5 min.

    C. Notify the provider.

    D. Place the client in a lateral position
