N432 Unit 5 practice questions Name_____

1. A nurse is preparing to assess a newborn who is large for gestational age (LGA). Which of the following findings should the nurse expect? (Select all that apply)

A. Hypoglycemia
B. Wide skull sutures from inadequate bone growth
C. Plump and full-faced from increased subcutaneous fat
D. Weight above 90th percentile (4,000 g)
E. Large head

2. Which of the following newborns are at higher risk for respiratory distress?

A. Baby born vaginally
B. Baby who has lost 6% body weight by 3 days after birth.
C. Baby born by cesarean section
D. Baby who is born at 39 weeks gestation

3. A nurse observes a 2-day-old term newborn that is starting to appear mildly jaundiced. What might explain this condition?

A. Physiological jaundice
B. Hemolytic disease of the newborn due to blood incompatibility
C. Exposing the newborn to high levels of oxygen
D. Overfeeding the newborn with too much glucose water.

4. After teaching a group of nursing students about thermoregulation and appropriate measures to prevent heat loss by evaporation, which of the following student behaviors would indicate successful teaching?

A. Transporting the newborn in a warmed enclosed isolette
B. Maintaining a warm room temperature
C. Placing the newborn on a warmed surface
D. Drying the newborn immediately after birth

5. After birth, the nurse would expect which fetal structure to close as a result of increases in the pressure gradients on the left side of the heart?

A. Foramen ovale

B. Ductus arteriosus
C. Ductus venosus
D. Umbilical vein

6. Which of the following newborns could be described as breathing normally?

A. Newborn A is breathing deeply, with a regular rhythm, at a rate of 20 bpm
B. Newborn B is breathing diaphragmatically with sternal retractions, at a rate of 70 bpm.
C. Newborn C is breathing shallowly, with 40-second periods of apnea and cyanosis.
D. Newborn D is breathing shallowly, at a rate of 36 bpm, with short periods of apnea.

7. When assessing a term newborn (6 hours old), the nurse auscultates bowel sounds and documents recent passing of meconium. These finding would indicate

A. Abnormal gastrointestinal newborn transition and needs to be reported.
B. An intestinal anomaly that needs immediate surgery
C. A patent anus with not bowel obstruction and normal peristalsis
D. A malabsorption syndrome resulting in fatty stools

8. A nursing student questions the nurse as to why they don't bathe the newborn immediately upon after birth.. The nurse states that this would increase the risk of.

A. Jaundice
B. Infection
C. Hypothermia
D. Anemia

9. Because the newborn's red blood cells break down much sooner than those of an adult, what might result?

A. Anemia
B. Bruising
C. Apnea
D. Jaundice

10. The nurse performs a physical examination on a newborn 2 hours after birth. Which of the following findings indicate a need a pediatric consultation? (Select all that apply)

A. Respiratory rate of 50 breaths per minutes
B. Intermittent episodes of apnea, lasting <10 seconds each
C. Absent Moro reflex when startled

D. Preauricular skin tag noted on the left ear
E. White raised bumps noted on nose and face
F. Yellow blanching of the skin when pressure applied to the nose.

11. The nurse observes that a newborn has a pink body with cyanotic hands and feet; a heart rate greater than 100 beats/minute; ; slow weak cry; some flexion of extremities; and cries when suctioned. The nurse should document what Apgar score for this infant?

12. The nurse is explaining phototherapy to the parents of a newborn. The nurse would include which of the following as the purpose?

A. Increase surfactant levels
B. Stabilize the newborn's temperature
C. Destroy Rh-negative antibodies
D. Oxidize bilirubin on the skin

13. The nurse administers a dose of vitamin K intramuscularly to a newborn after birth to promote:

A. Conjugation of bilirubin
B. Blood clotting
C. Foreman ovale closure
D. Digestion of complex proteins

14. A prophylactic agent is instilled in both eyes of all newborns to prevent which of the following conditions?

A. Gonorrhea and chlamydia
B. Thrush and Enterobacter
C. *Staphylococcus* and syphilis
D. Hepatitis B and herpes

15. The AAP (American Academy of Pediatrics) recommends that all newborns be placed on their backs to sleep to reduce the risk of:

A. Respiratory distress syndrome
B. Bottle mouth syndrome
C. Sudden infant death syndrome
D. GI regurgitation syndrome

16. Which of the following immunizations is most commonly received by newborns before hospital discharge?

A. Pneumococcus
B. Varicella
C. Hepatitis A
D. Hepatitis B

17. Which of the following findings in a newborn would the nurse document as abnormal when assessing the newborn head?

A. Two soft spots palpated between the cranial bones
B. A spongy area of edema outlined on the head
C. Head circumference 32 cm, chest 34 cm.
D. Asymmetry of the head with overriding bones.

18. Which of the following findings in a newborn would be considered normal?

A. Passage of meconium within the first 24 hours.
B. Respiratory rate of 80 breaths per minute
C. Yellow skin tones at 10 hours after birth
D. Bleeding from the umbilical area

19. The nurse documents that a newborn is postterm based on the understanding that he was born after:

A. 38 Weeks' gestation
B. 40 Weeks' gestation
C. 42 Weeks' gestation
D. 44 Weeks' gestation

20. Which of the following instructions should the postpartum nurse include in discharge instructions for the newborn? (Select all that apply)

A. Give the infant a sponge bath until the umbilical cord completely dries up and falls of at around 8-10 days after birth.
B. Microwave expressed breast milk or formula for 30 seconds prior to feeding the infant.
C. Position the infant's car seat in the back seat of the vehicle facing backwards.
D. If the infant doesn't take all a bottle of formula, refrigerate the remaining bottle until the next feeding.
E. Feed the infant no more often than every 4 hours.
F. Your baby should wet 6 to 8 diapers per day.

21. Which of the following signs and symptoms would the nurse expect to see in an infant with neonatal abstinence syndrome? (Select all that apply)

A. The infant will have decreased muscle tone
B. The infant will have a continuous high-pitched cry
C. The newborn will sleep for 2 to 3 hours after a feeding.
D. The newborn will have moderate to severe tremors when disturbed.

22. A nurse is explaining to a group of new parents about the changes that occur in the neonate to sustain extrauterine life, describing the cardiac and respiratory systems as undergoing the most changes. Which information would the nurse integrate into the explanation to support this description?

A. The cardiac murmur heard at birth disappears by 48 hours of age.
B. Pulmonary vascular resistance (PVR) is decreased as lungs begin to function.
C. Heart rate remains elevated after the first few moments of birth.
D. Breath sounds will have rhonchi for at least the first day of life as fluid is absorbed.

23. A nurse is conducting a refresher in-service program for a group of neonatal nurses. After teaching the group about hepatic system adaptations after birth, the nurse determines that the teaching was successful when the group identifies which process as reflective of the change of bilirubin from a fat-soluble product to a water-soluble product?

A. hemolysis
B. conjugation
C. jaundice
D. hyperbilirubinemia

24. Twenty minutes after birth, a baby begins to move his head from side to side, making eye contact with the mother, and pushes his tongue out several times. The nurse interprets this as:

A. a good time to initiate breast-feeding.
B. the period of decreased responsiveness preceding sleep.
C. a sign that the infant is being overstimulated.
D. evidence that the newborn is becoming chilled.

25. A new mother is changing the diaper of her 12-hour-old newborn and asks why the stool is black and sticky. Which response by the nurse would be most appropriate?

A. “You probably took iron during your pregnancy and that is what causes this type of stool.”
B. “This is meconium stool and is normal for a newborn.”
C. “I'll take a sample and check it for possible bleeding.”
D. “This is unusual, and I need to report this to your pediatrician. “

26. A client expresses concern that her 2-hour-old newborn is sleepy and difficult to awaken. The nurse explains that this behavior indicates:

A. normal progression of behavior.
B. probable hypoglycemia.
C. physiological abnormality.
D. inadequate oxygenation.

27. After the birth of a newborn, which action would the nurse do first to assist in thermoregulation?

A. Dry the newborn thoroughly.
B. Put a hat on the newborn's head.
C. Check the newborn's temperature.
D. Wrap the newborn in a blanket.

28. When teaching new parents about the sensory capabilities of their newborn, which sense would the nurse identify as being the least mature?

A. hearing
B. touch
C. taste
D. vision

29. The nurse places a warmed blanket on the scale when weighing a newborn to minimize heat loss via which mechanism?

a. evaporation
b. conduction
c. convection
d. radiation

30. A nurse is assessing a newborn. Which finding would alert the nurse to the possibility of respiratory distress in a newborn?

a. symmetrical chest movements
b. periodic breathing
c. respirations of 40 breaths/minute
d. sternal retractions

31. The nurse is teaching a group of parents about the similarities and differences between newborn skin and adult skin. Which statement by the group indicates that additional teaching is needed?

A. The newborn's skin and that of an adult are similar in thickness.
B. The newborn's sweat glands function fully, just like those of an adult.
C. Skin development in the newborn is not complete at birth.
D. The newborn has fewer fibrils connecting the dermis and epidermis

32. The nurse is assessing the respirations of several newborns. The nurse would notify the health care provider for the newborn with which respiratory rate at rest?

A. 38 breaths per minute
B. 46 breaths per minute
C. 54 breaths per minute
D. 68 breaths per minute

33. A new mother asks the nurse, "Why has my baby lost weight since he was born?" The nurse integrates knowledge of which cause when responding to the new mother?

A. insufficient calorie intake
B. shift of water from extracellular space to intracellular space
C. increase in stool passage
D. overproduction of bilirubin

34. A newborn is experiencing cold stress. Which findings would the nurse expect to assess? Select all that apply.

A. respiratory distress
B. decreased oxygen needs
C. hypoglycemia
D. metabolic alkalosis
E. jaundice

35. A nurse is reviewing the laboratory test results of a newborn. Which result would the nurse identify as a cause for concern?

A. hemoglobin 19 g/dL
B. platelets 75,000/uL
C. white blood cells 20,000/mm3
D. hematocrit 52%

36. A nurse is preparing a class on newborn adaptations for a group of soon-to-be parents. When describing the change from fetal to newborn circulation, which information would the nurse most likely include? Select all that apply.

A. Decrease in right atrial pressure leads to closure of the foramen ovale.
B. Increase in oxygen levels leads to a decrease in systemic vascular resistance.
C. Onset of respirations leads to a decrease in pulmonary vascular resistance.
D. Increase in pressure in the left atrium results from increases in pulmonary blood flow.
E. Closure of the ductus venosus eventually forces closure of the ductus arteriosus.

37. When explaining how a newborn adapts to extrauterine life, the nurse would describe which body systems as undergoing the most rapid changes?

a. gastrointestinal and hepatic
b. urinary and hematologic
c. respiratory and cardiovascular
d. neurological and integumentary

38. The nurse dries the neonate thoroughly and promptly changes wet linens. The nurse does so to minimize heat loss via which mechanism?

a. evaporation
b. conduction
c. convection
d. Radiation

39. Prior to discharging a 24-hour-old newborn, the nurse assesses her respiratory status. What would the nurse expect to assess?

a. respiratory rate 45, irregular
b. costal breathing pattern
c. nasal flaring, rate 65
d. crackles on auscultation

40. The nurse encourages the mother of a healthy newborn to put the newborn to the breast immediately after birth for which reason?

a. to aid in maturing the newborn's sucking reflex
b. to encourage the development of maternal antibodies
c. to facilitate maternal–infant bonding
d. to enhance the clearing of the newborn's respiratory passages

41. When making a home visit, the nurse observes a newborn sleeping on his back in a bassinet. In one corner of the bassinet is some soft bedding material, and at the other end is a bulb syringe. The nurse determines that the mother needs additional teaching because:

a. the newborn should not be sleeping on his back.
b. soft bedding material should not be in areas where infants sleep.
c. the bulb syringe should not be kept in the bassinet.
d. this newborn should be sleeping in a crib.

42. Just after delivery, a newborn's axillary temperature is 94° F (34.4° C). What action would be most appropriate?

a. Assess the newborn's gestational age.
b. Rewarm the newborn gradually.
c. Observe the newborn every hour.
d. Notify the primary care provider if the temperature goes lower.

43. When assessing a newborn 1 hour after birth, the nurse measures an axillary temperature of 95.8° F (35.4° C), an apical pulse of 114 beats/minute, and a respiratory rate of 60 breaths/minute. The nurse would identify which area as the highest priority?

a. Hypoglycemia
b. Impaired parenting
c. Deficient fluid volume
d. Risk for infection

44. The nurse places a newborn with jaundice under the phototherapy lights in the nursery to achieve which goal?

a. Prevent cold stress.
b. Increase surfactant levels in the lungs.
c. Promote respiratory stability.
d. Decrease the serum bilirubin level.

45. During a physical assessment of a newborn, the nurse observes bluish markings across the newborn's lower back. The nurse interprets this finding as:

a. milia.
b. Mongolian spots.
c. stork bites.
d. birth trauma.

46. While making rounds in the nursery, the nurse sees a 6-hour-old baby girl gagging and turning bluish. What would the nurse do first?

a. Alert the primary care provider stat, and turn the newborn to her right side.
b. Administer oxygen via facial mask by positive pressure.
c. Lower the newborn's head to stimulate crying.
d. Aspirate the oral and nasal pharynx with a bulb syringe.

47. While performing a physical assessment of a newborn boy, the nurse notes diffuse edema of the soft tissues of his scalp that crosses suture lines. The nurse documents this finding as:

a. molding.
b. microcephaly.
c. caput succedaneum.
d. cephalhematoma.

48. The nurse administers vitamin K intramuscularly to the newborn based on which rationale?

a. Stop Rh sensitization.
b. Increase erythropoiesis.
c. Enhance bilirubin breakdown.
d. Promote blood clotting.

49. The nurse is assessing the skin of a newborn and notes a rash on the newborn's face and chest. The rash consists of small papules and is scattered with no pattern. The nurse interprets this finding as:

a. harlequin sign.
b. nevus flames.
c. erythema toxicum
d. port wine stain.

50. A nurse is conducting a refresher program for a group of nurses working in the newborn nursery. After teaching the group about variations in newborn head size and appearance, the nurse determines that the teaching was successful when the group identifies which variation as normal? Select all that apply.

a. Milia on the bridge of the nose
b. molding
c. closed fontanels
d. caput succedaneum
e. posterior fontanel diameter 1.5 cm

51. The nurse is assessing a newborn's eyes. Which finding would the nurse identify as normal? Select all that apply.

a. slow blink response
b. able to track object to midline
c. transient deviation of the eyes
d. involuntary repetitive eye movement
e. absent red reflex

52. The nurse is auscultating a newborn's heart and places the stethoscope at the point of maximal impulse at which location?

a. just superior to the nipple, at the midsternum
b. lateral to the midclavicular line at the fourth intercostal space
c. at the fifth intercostal space to the left of the sternum
d. directly adjacent to the sternum at the second intercostals space

53. When assessing a newborn's reflexes, the nurse strokes the newborn's cheek, and the newborn turns toward the side that was stroked and begins sucking. The nurse documents which reflex as being positive?

a. palmar grasp reflex
b. tonic neck reflex
c. Moro reflex
d. rooting reflex

54. A new mother who is breast-feeding her newborn asks the nurse, "How will I know if my baby is drinking enough?" Which response by the nurse would be most appropriate?

a. "If he seems content after feeding, that should be a sign."
b. "Make sure he drinks at least 5 minutes on each breast."
c. "He should wet between 6 to 12 diapers each day."
d. "If his lips are moist, then he's okay."

55. A nurse is teaching postpartum client and her partner about caring for their newborn's umbilical cord site. Which statement by the parents indicates a need for additional teaching?

a. "We can put him in the tub to bathe him once the cord falls off and is healed."
b. "The cord stump should change from brown to yellow."
c. "Exposing the stump to the air helps it to dry."
d. "We need to call the primary care provider if we notice a funny odor."

56. A newborn is scheduled to undergo a screening test for phenylketonuria (PKU). The nurse prepares to obtain the blood sample from the newborn's:

a. finger.
b. heel.
c. scalp vein.
d. umbilical vein.

57. The nurse completes the initial assessment of a newborn. Which finding would lead the nurse to suspect that the newborn is experiencing difficulty with oxygenation?

a. respiratory rate of 54 breaths/minute
b. abdominal breathing
c. nasal flaring
d. acrocyanosis
e.

58. A woman with diabetes has just given birth. While caring for this neonate, the nurse is aware that the child is at risk for which complication?

a. anemia
b. hypoglycemia
c. nitrogen loss
d. thrombosis

59. A client with diabetes gives birth to a full-term neonate who weights 10 lb, 1 oz (4.6 kg). While caring for this large-for-gestational age (LGA) neonate, the nurse palpates the clavicles for which reason?

a. Neonates of mothers with diabetes have brittle bones.
b. Clavicles are commonly absent in neonates of mothers with diabetes.
c. One of the neonate's clavicles may have been broken during birth.
d. LGA neonates have glucose deposits on their clavicles.

60. When caring for a neonate of a mother with diabetes, which physiologic finding is most indicative of a hypoglycemic episode? Select all that apply.

a. hyperalert state
b. jitteriness
c. loud and forceful crying
d. lethargy
e. diaphoresis
f. serum glucose level of 60 mg/dl

61. A newborn with high serum bilirubin is receiving phototherapy. Which is the most appropriate nursing intervention for this client?

a. Application of eye covering to the infant
b. Placing light 6 inches above the newborn's bassinet
c. Delay of feeding until bilirubin levels are normal
d. Gentle shaking of the baby
e. Assessing the skin
f. Assessing the infant's temperature

62. A neonate born at 40 weeks' gestation, weighing 2300 grams (5 lb, 1 oz) is admitted to the newborn nursery for observation only. What is the nurse's first observation about the infant?

a. The neonate is average for its gestational age.
b. The neonate is small for its gestational age.
c. The neonate is large for its gestational age.
d. The neonate is fetal growth restricted.

63. When discussing heat loss in newborns, placing a newborn on a cold scale would be an example of what type of heat loss?

a. evaporation
b. convection
c. radiation
d. conduction

64. A client has just given birth at 42 weeks' gestation. What would the nurse expect to find during her assessment of the neonate?

a. a sleepy, lethargic neonate
b. lanugo covering the neonate's body
c. peeling and wrinkling of the neonate's epidermis
d. vernix caseosa covering the neonate's body

65. A neonate is born at 42 weeks' gestation weighing 4.4 kg (9 lb, 7 oz) with Apgar scores of 7 and 9. Two hours later birth the neonate's blood sugar indicates hypoglycemia. Which symptoms would the baby demonstrate? Select all that apply.

a. poor sucking
b. respiratory distress
c. weak cry
d. jitteriness
e. blood glucose >40 mg/dl

66. The nurse caring for a small for gestational age newborn in the special care nursery. What characteristics are commonly documented? Select all that apply.

a. Poor skin turgor
b. Tight and moist skin
c. Sparse or absent hair
d. Narrow skull sutures
e. Diminished muscle tissue
f. increased fatty tissue

67. A nurse is caring for a baby girl born at 34 weeks' gestation. Which feature should the nurse identify as those of a preterm newborn?

a. paper-thin eyelids
b. shiny heels with few creases on the sole of the foot
c. labia majora and labia minora are equally prominent
d. scant coating of vernix
e. prominent blood vessels seen on the abdomen

68. Which information would the nurse include when teaching a new mother about the difference between pathologic and physiologic jaundice?

a. Physiologic jaundice results in kernicterus.
b. Pathologic jaundice appears within 24 hours after birth.
c. Both are treated with exchange transfusions of maternal O- blood.
d. Physiologic jaundice requires transfer to the NICU.