N432 Spring 2022 Unit 1 Practice Quiz Answer Key

1. A nurse is reviewing the medical record of a pregnant woman and notes that she is gravida II. The nurse interprets this to indicate the number of:

a. births.
b. pregnancies.
c. spontaneous abortions.
d. preterm births.

Difficulty1 of 100

Explanation Gravida refers to a pregnant woman—gravida I (primigravida) during the first pregnancy, gravida II (secundigravida) during the second pregnancy, and so on. Para refers to the number of births at 20 weeks or greater that a woman has, regardless of whether the newborn is born alive or dead. “A” would be used to denote the number of abortions and “P” would be used to denote the number of preterm births when using the GTPAL system.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 12: Nursing Management During Pregnancy, p. 405.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Critical Thinking

2. A nurse measures a pregnant woman's fundal height and finds it to be 28 cm. The nurse interprets this to indicate that the client is at how many weeks' gestation?

a. 14 weeks' gestation
b. 20 weeks' gestation
c. 28 weeks' gestation
d. 36 weeks' gestation

Difficulty1 of 100

Explanation Typically, the height of the fundus is measured when the uterus arises out of the pelvis to evaluate fetal growth. At 12 weeks' gestation the fundus can be palpated at the symphysis pubis. At 16 weeks' gestation the fundus is midway between the symphysis and the umbilicus. At 20 weeks the fundus can be palpated at the umbilicus and measures approximately 20 cm from the symphysis pubis. By 36 weeks the fundus is just below the xiphoid process and measures approximately 36 cm.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 12: Nursing Management During Pregnancy, p. 407.

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction, Nursing Concepts: Health Promotion , Nursing Concepts: Technical Skills

3. A client is preparing to leave the clinic after her first prenatal visit. What is important for the woman to do before she leaves the office?

a. Choose a hospital for birth.
b. Choose a name for the baby.
c. Make a follow-up appointment.
d. Sign up for a Lamaze class.

Difficulty2 of 100

Explanation Before leaving an initial prenatal appointment the woman should schedule a follow-up appointment. Establishing a pattern of regular appointments is crucial to providing effective prenatal care. Naming the baby, choosing a hospital, and signing up for a Lamaze class are not normally done this early in the pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 12: Nursing Management During Pregnancy, p. 409.

Bloom's Taxonomy . Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction . Nursing Concepts: Wellness , Nursing Concepts: Health Promotion

4. A pregnant client is excited that she is beginning to feel her baby move within her. The nurse explains that these first fetal movements are known as:

a. amenorrhea.
b. lactation.
c. lordosis.
d. quickening.

Difficulty3 of 100

Explanation The first fetal movements that the pregnant woman feels are called quickening and usually occur between 18 and 20 weeks' gestation. Amenorrhea is the absence of menstruation and is one of the first indications of pregnancy. Lactation is the production of breast milk in preparation for breastfeeding. Lordosis is the inward curve of the lower back, which becomes exaggerated during pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 12: Nursing Management During Pregnancy, p. 411.

Bloom's Taxonomy . Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Sensory Perception , Nursing Concepts: Psychosocial Well-Being

5. A client at 36 weeks' gestation comes in for her weekly primary care provider visit. She tells the nurse, "I am having contractions, but they are irregular and go away when I rest. Do you think I am going into labor?" The **best** response by the nurse would be:

a. "I think you are going into labor. We may need to give you medications to stop the contractions."
b. "These are called Braxton-Hicks contractions and are preparing your body for labor but are not 'true' labor contractions."
c. "I think we better send you to the hospital for admission. You could be in labor."
d. "It is too early for you too be in labor. Something may be wrong with the pregnancy."

Difficulty4 of 100

Explanation Braxton-Hicks contractions prepare the body for labor. They are usually irregular in frequency and duration, with fewer than five contractions occurring in 1 hour. They are also short but may be painful. They may begin as early as the second trimester, especially for women who have had babies before, but are more common in the third trimester. They often resolve with position changes, a hot shower, hydration, or relaxation.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 366.

Bloom's Taxonomy Apply
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Comfort / Rest, Nursing Concepts: Reproduction ,Nursing Concepts: Sensory Perception

6. During a prenatal visit, a client in her second trimester of pregnancy verbalizes positive feelings about the pregnancy and conceptualizes the fetus. Which is the **most** appropriate nursing intervention when the client expresses such feelings?

a. Encourage the client to focus on herself, not on the fetus.
b. Inform the primary health care provider about the client's feeling.
c. Inform the client that it is too early to conceptualize the fetus.
d. Offer support and validation about the client's feelings.

Difficulty5 of 100

Explanation During the second trimester, many women will verbalize positive feelings about the pregnancy and will conceptualize the fetus. The woman may accept her new body image and talk about the new life within her. Generating a discussion about the woman's feelings and offering support and validation at prenatal visits are important nursing interventions. The nurse should encourage the client in her first trimester to focus on herself, not on the fetus; this is not required when the client is in her second trimester. The client's feelings are normal for the second trimester of pregnancy; hence, it is not necessary either to inform the primary health care provider about the client's feelings or to tell the client that it is too early to conceptualize the fetus.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 386.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Caring Interventions , Nursing Concepts: Therapeutic Communication

7. A pregnant client who is beginning her third trimester asks the nurse why she feels like she is sometimes having labor contractions. The nurse would explain that:

a. she is having “practice” contractions called Braxton Hicks contractions and they are normal.
b. she may be beginning labor, so monitor for her water to break.
c. if these contractions occur late in the day, she should be concerned.
d. she needs to call her doctor immediately to report the contractions.

Difficulty5 of 100

Explanation Braxton Hicks contractions begin in the second trimester as painless, intermittent “practice” contractions and continue into the third trimester, when the mother may experience some discomfort. Braxton Hicks contractions are irregular and usually go away with rest. Braxton Hick contractions normally occur later in the day, not early. It is thought that as the day slows down, the mother is more attuned to these mild, irregular contractions. There is no need to call the doctor unless the contractions become regular, which would be suggestive of labor.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 366

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Comfort / Rest , Nursing Concepts: Reproduction , Nursing Concepts: Teaching & Learning / Patient Education

8. A pregnant client’s last menstrual period was March 10. Using Naegele’s rule, the nurse estimates the date of birth to be:

a. January 7.
b. December 17.
c. February 21.
d. January 30.

Difficulty8 of 100

Explanation Naegele’s rule can be used to establish the estimated date of birth (EDB). Using this rule, the nurse should subtract 3 months and then add 7 days to the first day of the last normal menstrual period. On the basis of Naegele’s rule, the EDB will be December 17 because the client started her last menstrual period on March 10. January 7, February 21, and January 30 are not the EDB according to Naegele’s rule.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 12: Nursing Management During Pregnancy, p. 404.

Bloom's Taxonomy Understand
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Critical Thinking,

9. A client in her first trimester reports frequent urination and asks the nurse for suggestions. The nurse should teach the client that the urination is most likely related to which cause?

a. Pressure on the bladder from the uterus
b. Increased concentration of urine
c. Addition of fetal urine to maternal urine
d. Decreased glomerular selectivity

Difficulty8 of 100

Explanation Early in pregnancy, the expanding uterus presses on the bladder. During the second trimester there is some relief when the uterus lifts, but the pressure returns again as the fetus continues to grow. Urine concentration does not affect frequency. Fetal urine does not enter the mother's renal system, except through increases in circulatory volume. The glomeruli should not be affected by pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 366.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Critical Thinking , Nursing Concepts: Elimination

10. .Assessment of a pregnant woman reveals that she compulsively craves ice. The nurse documents this finding as:

a. quickening.
b. pica.
c. ballottement.
d. linea nigra.

Difficulty11 of 100

Explanation Pica refers to the compulsive ingestion of nonfood substances such as ice. Quickening refers to the mother's sensation of fetal movement. Ballottement refers to the feeling of rebound from a floating fetus when an examiner pushes against the woman's cervix during a pelvic examination. Linea nigra refers to the pigmented line that develops in the middle of the woman's abdomen.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 385.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Nutrition , Nursing Concepts: Assessment , Nursing Concepts: Behaviors / Addiction

11. A pregnant client reports an increase in a thick, whitish vaginal discharge. Which response by the nurse would be **most** appropriate?

a. "You should refrain from any sexual activity."
b. "You need to be assessed for a fungal infection."
c. "This discharge is normal during pregnancy."
d. "Use a local antifungal agents regularly."

Difficulty18 of 100

Explanation During pregnancy, the vaginal secretions become more acidic, white, and thick. Most women experience an increase in a whitish vaginal discharge, called leukorrhea, during pregnancy. The nurse should inform the client that the vaginal discharge is normal except when it is accompanied by itching and irritation, possibly suggesting Candida albicans infection, a monilial vaginitis, which is a very common occurrence in this glycogen-rich environment. Monilial vaginitis is a benign fungal condition and is treated with local antifungal agents. The client need not refrain from sexual activity when there is an increase in a thick, whitish vaginal discharge.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 367.

Bloom's Taxonomy Apply

Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Acid-Base Balance, Nursing Concepts: Sexuality

12. A client in her 39th week of gestation arrives at the maternity clinic stating that earlier in her pregnancy, she experienced shortness of breath. However, for the past few days, she has been able to breathe easily, but she has also begun to experience increased urinary frequency. A nurse is assigned to perform the physical examination of the client. Which observation is **most** likely?

a. Fundal height has dropped since the last recording.
b. Fundal height is at its highest level at the xiphoid process.
c. The fundus is at the level of the umbilicus and measures 20 cm.
d. The lower uterine segment and cervix have softened.

Difficulty22 of 100

Explanation

Between 38 and 40 weeks of gestation, the fundal height drops as the fetus begins to descend and engage into the pelvis. Because it pushes against the diaphragm, many women experience shortness of breath. By 40 weeks, the fetal head begins to descend and engage into the pelvis. Although breathing becomes easier because of this descent, the pressure on the urinary bladder now increases, and women experience urinary frequency. The fundus reaches its highest level at the xiphoid process at approximately 36, not 39, weeks. By 20 weeks' gestation, the fundus is at the level of the umbilicus and measures 20 cm. At between 6 and 8 weeks of gestation, the cervix begins to soften (Goodell sign) and the lower uterine segment softens (Hegar's sign).

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 366.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Oxygenation / Gas Exchange, Nursing Concepts: Elimination

13. A client in her 29th week of gestation reports dizziness and clamminess when assuming a supine position. During the assessment, the nurse observes there is a marked decrease in the client's blood pressure. Which intervention should the nurse implement to help alleviate this client's condition?

a. Keep the client's legs slightly elevated.
b. Place the client in an orthopneic position.
c. Keep the head of the client's bed slightly elevated.
d. Place the client in the left lateral position.

Difficulty24 of 100

Explanation

The symptoms experienced by the client indicate supine hypotension syndrome. When the pregnant woman assumes a supine position, the expanding uterus exerts pressure on the inferior vena. The nurse should place the client in the left lateral position to correct this syndrome and optimize cardiac output and uterine perfusion. Elevating the client's legs, placing the client in an orthopneic position, or keeping the head of the bed elevated will not help alleviate the client's condition.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 366.

Bloom's Taxonomy Apply
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Reproduction, Nursing Concepts: Health Promotion , Nursing Concepts: Oxygenation / Gas Exchange

14. A client in her first trimester is concerned about how weight gain will affect her appearance and questions the nurse concerning dietary restrictions. How much weight gain should the nurse point out will be safe for this cleint with a low BMI?

a. 25 to 35 pounds (11 to 16 kilograms)
b. 28 to 40 pounds (13 to 18 kilograms)
c. 15 to 25 pounds (7 to 11 kilograms)
d. 16 to 30 pounds (7.25 to 14 kilograms)

Difficulty57 of 100

Explanation The recommendation for average weight gain is 25 to 35 lbs (11 to 16 kilograms). The woman who is underweight with a low BMI should gain 28 to 40 pounds (13 to 18 kilograms). Less than 28 pounds (13 kilograms) may hinder fetal development, and weight gain over 40 pounds (18 kilograms) may be dangerous to the mother. Individuals with a high BMI should gain 15 to 25 pounds (7 to 11 kilograms). A weight gain of less than 16 pounds (7.25 kilograms) may result in a low-birth-weight infant and gains over 30 pounds (14 kilograms) may necessitate a cesarean section.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 382.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction, Nursing Concepts: Wellness, Nursing Concepts: Nutrition

15. A nurse is educating a client on the basal body temperature method as a form of contraception. Which statement by the client indicates and understanding of when she can expect to see a rise in her temperature?

a. “My temperature will increase with the start of my menses.”
b. “If I am pregnant, I will have a temperature spike.”
c. “There will be an increase in my temperature right before I ovulate.”
d. “Immediately following ovulation my temperature will increase.”

Difficulty62 of 100

Explanation

The basal body temperature dips immediately prior to ovulation; when ovulation occurs there will be an increase in temperature.

Reference: _Chapter 4: Common Reproductive Issues - Page 141

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction, Nursing Concepts: Teaching & Learning / Patient Education , Nursing Concepts: Thermoregulation

16. After teaching a group of women about the signs of pregnancy, the nurse understands that teaching was successful if the group makes which statement about positive signs?

a. "They will be able to hear the fetal heart rate on auscultation."
b. "The woman will have amenorrhea."
c. "There will be a positive Hegar's sign."
d. "The client will experience quickening."

Difficulty62 of 100

Explanation

The positive signs of pregnancy confirm that a fetus is growing in the uterus. Visualizing the fetus by ultrasound, palpating for fetal movements, and hearing a fetal heartbeat are all signs that make the pregnancy a certainty. Amenorrhea is a presumptive sign of pregnancy. Hegar's sign is a probable sign of pregnancy. Quickening is a presumptive sign of pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 365.

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction ,Nursing Concepts: Perfusion

17. A nurse is assessing a client who may be pregnant. The nurse reviews the client's history for presumptive signs. Which signs would the nurse **most** likely note? Select all that apply.

Correct : A, B

a. amenorrhea
b. nausea
c. abdominal enlargement
d. Braxton-Hicks contractions
e. fetal heart sounds

Difficulty63 of 100

Explanation

Presumptive signs include amenorrhea, nausea, breast tenderness, urinary frequency and fatigue. Abdominal enlargement and Braxton-Hicks contractions are probable signs of pregnancy. Fetal heart sounds are a positive sign of pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 363.

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Assessment, Nursing Concepts: Evidence-Based Practice

18. The nurse has determined that based on the client's physical examination she is at high risk for developing varicose veins. Which suggestions might the nurse teach the client to help reduce her risk? Select all that apply.

Correct : A, B, C

a. Elevate the feet and legs.
b. Walk daily.
c. Use thigh-high support hose.
d. Sit in a hot tub at least three times a week.
e. Use knee-high support hose.

Difficulty66 of 100

Explanation Vascular changes during pregnancy manifested in the integumentary system include varicosities of the legs, vulva, and perineum. Varicose veins commonly are the result of distention, instability, and poor circulation. Various interventions to reduce the risk of developing varicosities include elevating both legs when sitting or lying down; avoiding prolonged standing or sitting; walking daily for exercise; avoiding tight clothing or knee-high hosiery; and wearing support hose if varicosities are a preexisting condition to pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 372.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education , Nursing Concepts: Perfusion

19. The nurse is putting together information for a nutritional class for nullipara women. Which information would be **most** important for the nurse to include? Select all that apply.

Correct : A, B, C

a. Increase consumption of fruits, vegetables, and whole grains.
b. Avoid the intake of alcohol.
c. Decrease intake of saturated fats, trans fats, and cholesterol.
d. Consume at least one quart of water daily.
e. Increase caloric intake.

Difficulty66 of 100

Explanation: For a pregnant woman to meet recommended DRIs, she should eat according to the U.S. Depart ment of Agriculture (USDA) food guide, MyPlate . Some of these guidelines include eating a variety of food from all food groups, using portion control; increase intake of vitamins, minerals, and dietary fiber; lower intake of saturated fats, trans fats, and cholesterol; increase intake of fruits, vegetables, and whole grains; and balance calorie intake with exercise to maintain ideal healthy weight.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 378.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education , Nursing Concepts: Nutrition , Nursing Concepts: Health Policy

20. A nurse is preparing a class for a group of young adult women about emergency contraceptives (ECs). What information would the nurse need to stress to the group? Select all that apply.

Correct : C, D, E

a. ECs induce an abortion-like reaction.
b. ECs provide some protection against STIs.
c. ECs are birth control pills in higher, more frequent doses.
d. ECs are not to be used in place of regular birth control.
e. ECs provide little protection for future pregnancies.

Difficulty66 of 100

Explanation Important points to stress concerning ECs are that ECs do not offer any protection against STIs or future pregnancies; they should not be used in place of regular birth control, as they are less effective; they are regular birth control pills given at higher doses and more frequently; and they are contraindicated during pregnancy. Contrary to popular belief, ECs do not induce abortion and are not related to mifepristone or RU-486, the so-called abortion pill approved by the FDA in 2000.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 4: Common Reproductive Issues, p. 152.

Bloom's Taxonomy Apply
Client Needs Physiological Integrity: Pharmacological And Parenteral Therapies

Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Teaching & Learning / Patient Education , Nursing Concepts: Pharmacology

21. An obstetrical nurse is conducting a program for pregnant women who are in their first trimester. The program focuses on the changes occurring in the woman's body as a result of the pregnancy. When describing the effect of changing hormonal levels, which information would the nurse most likely include? Select all that apply.

Correct : A, B, E, F

a. Maintenance of the endometrium so that the embryo can implant
b. Maternal metabolic changes to make nutrients available for mother and fetus
c. Decrease in maternal blood volume and red blood cell mass to increase oxygen delivery
d. Decrease in blood supply to the gastrointestinal tract and slowing of peristaltic waves
e. Relaxation of the ligaments that connect the pelvic bones, allowing them to spread slightly
f. Preparing the breasts for lactation, keeping the milk from coming in until birth occurs

Difficulty67 of 100

Explanation The hormonal effects of pregnancy include the following:
• Maintaining the endometrium so that the embryo can implant, causing changes in the mother's metabolism so that nutrients are available for both
• Relaxing the ligaments that connect the pelvic bones, allowing them to spread slightly
• Preparing the breasts for lactation, keeping the milk from coming in until birth occurs
• Increasing the mother's blood volume and red blood cell mass to increase oxygen
• Increasing the blood supply to the gastrointestinal tract and slowing peristaltic waves

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 376.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Metabolism , Nursing Concepts: Critical Thinking

22. A nurse is assessing a pregnant woman on a routine checkup. When assessing the woman's gastrointestinal tract, what would the nurse expect to find? Select all that apply.

Correct : A, C, D, E

a. hyperemic gums
b. increased peristalsis
c. reports of bloating
d. heartburn
e. nausea

Difficulty69 of 100

Explanation
Gastrointestinal system changes include hyperemic gums due to estrogen and increased proliferation of blood vessels and circulation to the mouth; slowed peristalsis; acid indigestion and heartburn; bloating and nausea and vomiting.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 367.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Assessment , Nursing Concepts: Evidence-Based Practice

23. Which physical change would the nurse expect to find in a pregnant client? Select all that apply.

Correct : A, C

a. Increased blood volume
b. Decreased clotting factors
c. Supine hypotension
d. Negative Hagar sign
e. Increased hemoglobin

Difficulty69 of 100

Explanation

The pregnant client will experience blood volume increases of 40-4 over prepregnancy levels. Supine hypotension occurs when the pregnant client lies down on her back in the latter half of the pregnancy and the uterus pushes down on the aorta and vena cava, decreasing cardiac return. The hemoglobin decreases due to physiologic hemodilution. The blood clotting factors increase during pregnancy, not decrease. A positive Hagar sign is one of the presumptive signs of pregnancy.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 366, 369

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction ,Nursing Concepts: Perfusion

24. A nurse is providing nutritional counseling to a pregnant woman and gives her suggestions about consuming foods that are high in folic acid. As part of the plan of care, the client is to keep a food diary that the client and nurse will review at the next visit. When reviewing the client's diary, which meals would indicate to the nurse that the client is increasing her intake of folic acid? Select all that apply.

Correct : A, B, D

a. chicken breast with baked potato and broccoli
b. cheeseburger with spinach and baked beans
c. pork chop with mashed potatoes and green beans
d. strawberry walnut salad with romaine lettuce
e. fried chicken sandwich with mayonnaise and avocado

Difficulty70 of 100

Explanation Good food sources of folic acid include dark green vegetables, such as broccoli, romaine lettuce, and spinach; baked beans; black-eyed peas; citrus fruits; peanuts; and liver. So the meals containing chicken breast with baked potato and broccoli, cheeseburger with spinach and baked beans, and the strawberry walnut salad with romaine lettuce demonstrate an intake of foods high in folic acid.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 379.

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Nutrition , Nursing Concepts: Wellness

25. A woman comes to the clinic reporting her period is late and she is wondering if she is pregnant. Which assessment findings by the nurse would indicate she is exhibiting probable signs of pregnancy? Select all that apply.

Correct : A, D, F

a. positive pregnancy test
b. ultrasound visualization of the fetus
c. auscultation of a fetal heart beat
d. ballottement
e. absence of menstruation
f. softening of the cervix

Difficulty72 of 100

Explanation

Probable signs of pregnancy include a positive pregnancy test, ballottement, and softening of the cervix (Goodell's sign). Ultrasound visualization of the fetus, auscultation of a fetal heart beat, and palpation of fetal movements are considered positive signs of pregnancy. Absence of menstruation is a presumptive sign of pregnancy.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 364.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Assessment , Nursing Concepts: Evidence-Based Practice

26. A nurse is teaching a group of pregnant young women about sexually transmitted infections (STIs) and the possible effects that may occur in the fetus or newborn. Which STIs would the nurse describe as being transmitted to the newborn during birth? Select all that apply.

Correct : A, B, C, E

a. chlamydia
b. gonorrhea
c. genital herpes
d. syphilis
e. HIV

Difficulty77 of 100

Explanation Chlamydia, gonorrhea, and genital herpes can be transmitted to the fetus/newborn during birth. An infected mother can transmit HIV infection to her newborn before or during birth and through breastfeeding. Syphilis can be transmitted to the fetus while in utero.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 5: Sexually Transmitted Infections, p. 176.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction, Nursing Concepts: Sexuality, Nursing Concepts: Infection

27. What physical changes take place when a woman becomes pregnant? Select all that apply.

Correct : B, D, E

a. The uterus becomes pear-shaped.
b. Heart rate increases 10 to 15 beats per minute.
c. Respiratory rate increases 2.
d. The areola becomes more prominent.
e. Nasal congestion increases due to edema.

Difficulty78 of 100

Explanation The pregnant uterus is globular shaped, not pear-shaped. The heart rate usually increases 10 to 15 beats per minute over the pre-pregnancy rate of 60 to 100 beats per minute. The respiratory rate is essentially unchanged. The areolas of the breasts become more prominent with a deepened pigmentation. Mothers report that they experience more nasal congestion during pregnancy that occurs secondary to edema found in the nasal passages.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 367, 369, 370

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Perfusion,

28. A client reports prolonged nausea, vomiting every morning for the past week, and no appetite. The pregnancy test comes back positive. What recommendation should the nurse give this client? Select all that apply.

Correct : A, B, C

a. Take small amounts of liquids between, not with meals.
b. Eat a saltine cracker before getting out of bed in the morning.
c. Delay eating breakfast until the nausea and vomiting has passed.
d. Eat a low-fat diet and eliminate all caffeine.
e. Eat a high-protein, low-carb snack during the night.

Difficulty78 of 100

Explanation Eating a saltine cracker before getting out of bed, delaying breakfast, and taking small amount of liquids between meals are all appropriate interventions to cope with morning sickness. Morning

sickness is related to hormone levels. The fat, protein, or carbohydrate content of the diet is not the causative factor.

Reference: Chapter 12: Nursing Management During Pregnancy - Page 422

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Fluid & Electrolyte Balance, Nursing Concepts: Comfort / Rest

29. A sex trade worker is seen at the sexual health clinic reporting dysuria, mucopurulent vaginal discharge with bleeding between periods, conjunctivitis, and a painful rectal area. What sexually transmitted infection would the nurse suspect?

Correct : B

a. syphilis
b. chlamydia
c. genital herpes
d. gonorrhea

Difficulty79 of 100

Explanation Chlamydial symptoms include dysuria, mucopurulent vaginal discharge, and dysfunctional uterine bleeding. It can cause inflammation of the rectum and conjunctiva. Syphilis starts with a chancre on vulva or vagina but can develop in other parts of the body. Secondary infection is maculopapular rash on hands and feet with a sore throat. Genital herpes symptoms include itching, tingling, and pain in genital area followed by small pustules and blister-like genital lesions. Gonorrhea vaginal discharge is yellowish color and very foul smelling.

Reference: Chapter 5: Sexually Transmitted Infections - Page 187

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education , Nursing Concepts: Sexuality , Nursing Concepts: Assessment , Nursing Concepts: Behaviors / Addiction , Nursing Concepts: Infection

30. A lactose intolerant client is concerned about getting enough calcium in her diet. Which foods could the nurse suggest she include in her diet to increase her calcium intake?

Correct : A, B, C, D

a. peanuts
b. almonds
c. broccoli
d. molasses
e. carrots

Difficulty80 of 100

Explanation The best source of calcium is milk and dairy products, but for women with lactose intolerance, adaptations are necessary. Additional sources of calcium may be necessary. These may include

peanuts, almonds, sunflower seeds, broccoli, salmon, kale, and molasses. In additional, encourage the woman to drink lactose-free dairy products or calcium-enriched orange juice or soy milk.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 384.

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Teaching & Learning / Patient Education, Nursing Concepts: Nutrition

31. A woman being assessed by the nurse reports that she is 6 weeks pregnant. If her report is accurate, when will the nurse predict the client conceived?

a. 4 weeks ago
b. 6 weeks ago
c. 8 weeks ago
d. 10 weeks ago

Difficulty81 of 100

Explanation The length of a pregnancy is more commonly measured from the first day of the last menstrual period (gestational age). Because ovulation and fertilization take place about 2 weeks after the last menstrual period, the ovulation age of the fetus is always 2 weeks less than the length of the pregnancy or the gestational age. Therefore this client conceived 4 weeks ago.

Reference: Chapter 10: Fetal Development and Genetics - Page 404

Bloom's Taxonomy . Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction, Nursing Concepts: Assessment

32. A nurse is conducting a nutrition class for a group of pregnant women. What information accurately addresses this issue? Select all that apply.

Correct : B, C, D

a. The baby will require increased protein for development, so the mother needs to ingest 8 to 9 g of additional protein per day above her nonpregnant requirements.
b. Total iron requirements equal 1,000 mg, with the greatest need being in the second trimester.
c. Calcium supplements may decrease the chance of developing pre-eclampsia in women who had a pre-existing deficiency.
d. Since an iodine deficiency can cause intellectual deficits in infants, mothers are recommended to use iodized salt.
e. Folic acid is needed during the third trimester to reduce the chance of birth defects such as neural tube defects and cleft lip/palate.

Difficulty83 of 100

Explanation Pregnant women need an increase of 5 to 6 g (not 8 to 9 g) of protein above their prepregnancy amounts to support fetal growth. The iron requirements increase dramatically after 20 weeks' gestation to build the fetus’s RBC supply. Women who take calcium supplements during pregnancy may have a

reduced chance of pre-eclampsia, if they had a prepregnancy deficit. Iodine deficiencies can lead to cretinism, which causes mental deficits and stunted growth, so an easy fix is to use iodized salt while pregnant until there are other health issues that contradict its use. Folic acid is needed in the first trimester, not the third one, to reduce the incidence of neural tube defects because her fetus's spinal column forms early in the pregnancy.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 376, 378-379

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction ,Nursing Concepts: Teaching & Learning / Patient Education , Nursing Concepts: Nutrition

33. A pregnant client questions the nurse about when her baby's heartbeat can be heard. The nurse would respond that the fetal heartbeat can be heard:

a. by 16 week by Doppler technology.
b. by 18-20 weeks with a fetoscope.
c. by 6-8 weeks by Doppler technology.
d. by 14-16 weeks by fetoscope.

Difficulty83 of 100

Explanation The fetal heartbeat can be heard by Doppler technology at 9 to 10 weeks and by fetoscope by 18-20 weeks.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 365

Bloom's Taxonomy Understand
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Perfusion

34. During a preconception teaching session, the nurse tells participants to increase their intake of which food groups to reduce the incidence of neural tube disorders? Select all that apply.

Correct : A, C, E

a. Leafy green vegetables
b. Lean meats
c. Sunflower seeds
d. Milk
e. Orange fruits

Difficulty83 of 100

Explanation Entering pregnancy with an optimum folic acid level decreases the incidence of neural tube closure failures. Leafy green vegetables, sunflower seeds and orange fruits are naturally high in folic acid. Lean meats and milk provide protein.

Reference: Chapter 10: Fetal Development and Genetics - Page 397

Bloom's Taxonomy Remember
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Nutrition, Nursing Concepts: Health Promotion

35. A woman is concerned about the safety of continuing sex with her partner during pregnancy. Which suggestion should the nurse mention to her? Select all that apply.

Correct : A, B, C, D

a. Sex is to be avoided after your membranes have ruptured.
b. Sex is generally not harmful to the fetus.
c. Partner oral–female genital contact due to risk of air embolism.
d. A nonmonogamous sexual partner should wear a condom.
e. Sex on the expected date of your period can initiate labor.
f. Sex can cause rupture of the membranes.

Difficulty84 of 100

ExplanationChapter 12: Nursing Management During Pregnancy
Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Teaching & Learning / Patient Education, Nursing Concepts: Sexuality

36. What physiological changes would be noted in a pregnant woman? Select all that apply.

Correct : C, D, E

a. prolactin levels
b. Increased hemoglobin and hematocrit
c. Enlarged pituitary gland
d. Lordosis
e. Delayed gastric emptying and decreased peristalsis

Difficulty86 of 100

Explanation During pregnancy, the pituitary gland increases in size 13 to accommodate the increased need of the hormones being produced. Lordosis occurs to counterbalance the protuberant abdomen of the pregnant woman. Due to the increased uterine size that protrudes into the abdominal cavity and decreased motility, decreased gastric emptying may occur leading to heartburn and decreased peristalsis, which leads to constipation.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 368, 371, 373

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Elimination , Nursing Concepts: Mobility

37. A pregnant woman questions the nurse about changes she is noticing in her breasts and is concerned if they are normal. Which reported changes would the nurse recognize as normal breast changes during pregnancy? Select all that apply.

Correct : A, B, C, D

a. Secretions from sebaceous glands on the areola
b. Appearance of striae
c. Darkening of the areola
d. Nodular tissue upon palpation
e. Red rash over the anterior breast tissue

Difficulty86 of 100

Explanation Changes in breast tissue during pregnancy begin early and continue until delivery. Striae or stretch marks appear, the areola darkens, and the breast tissue may feel nodular from the stimulated glandular production and the Montgomery tubercles product secretions to lubricate the nipples. A red rash is not a normal finding.

Reference: Chapter 11: Maternal Adaptation During Pregnancy - Page 367

Bloom's Taxonomy Apply
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Tissue Integrity

38. A woman in her 16th week of pregnancy comes to the health center for a follow up visit. Which physiologic change would the nurse expect to assess? Select all that apply.

Correct : A, B

a. a uterus that is palpable
b. colostrum that can be expelled from the nipples
c. increased blood pressure
d. linea nigra and melasma (chloasma)
e. varicosities of the vulva, rectum, and/or legs

Difficulty86 of 100

Explanation A uterus is palpable by the end of the 12th week of pregnancy, and by the 16th week of pregnancy colostrum can be expelled from the nipples. Blood pressure in women usually does not rise because the increased heart action takes care of the greater amount of circulating volume. Because of melanocyte-stimulating hormone from the pituitary, extra pigmentation can lead to linea nigra and melasma (chloasma) about the 24th week of pregnancy. Varicosities in the vulva, rectum, and legs tend to occur in the third trimester due to the pressure of the expanding uterus.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 11: Maternal Adaptation During Pregnancy, p. 363.

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Assessment

39. The nurse is reviewing all of the documentation on determining estimated date of delivery. Which objective data is included? Select all that apply.

Correct : A, C, E

a. sonogram

b. CT Scan
c. fundal height
d. last day of menstrual period
e. calculating Naegele rule
f. Pelvic exam findings

Difficulty86 of 100

Explanation The following provide objective data on the estimated date of delivery (EDD). The sonogram (a gold standard) provides detailed fetal measurements confirming the gestational age. The fundal height provides growth data, and Nagele rule calculates the estimated date of delivery using the first day of the last menstrual period. A CT scan is not ordered. Pelvic exam findings provide data that the client is pregnant and can also provide data that true labor has begun.

Reference: Chapter 12: Nursing Management During Pregnancy - Page 404

Bloom's Taxonomy Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Technical Skills,

40. A client's recent prenatal ultrasound assessment reveals a normal placenta. Which outcomes would the nurse expect? Select all that apply.

Correct : B, D, E

a. The placenta will filter out toxins that the mother ingests.
b. The hormones made by the placenta support fetal growth.
c. The placenta removes the fetal waste products such as stool.
d. The placenta protects the fetus from an immune attack created by the mother.
e. The placenta produces hormones that ready the fetus for extrauterine life.

Difficulty86 of 100

Explanation The placenta will not filter out all toxins. The placenta begins to make hormones that control the basic physiology of the mother so the fetus is supplied with the nutrients and oxygen needed for growth. The placenta also protects the fetus from immune attack by the mother and removes waste products from the fetus. The placenta produces hormones that ready fetal organs for life outside the uterus.

Reference: Chapter 10: Fetal Development and Genetics - Page 342

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Wellness , Nursing Concepts: Critical Thinking

41. A woman in her first trimester shares with the nurse that she has been experiencing terrible nausea when she gets up in the morning. Which action should the nurse suggest? Select all that apply.

Correct : A, B, C, D

a. Eat some saltine crackers before rising in the morning.
b. Suck on sour candies.
c. Delay breakfast until 10 or 11 AM.
d. Try eating a snack before bedtime

e. Eat two regular meals later in the day.
f. Use a scopolamine patch.

Difficulty87 of 100

Explanation The traditional solution for preventing nausea is for women to keep dry crackers, such as saltines, by their bedside and eat a few before rising, as increasing carbohydrates seems to relieve nausea better than any other nutritional remedy. Sucking on sour candies may serve the same purpose. A woman can then eat a light breakfast or delay breakfast until 10 or 11 am, past the time her nausea seems to persist. To be certain she maintains a good food intake during pregnancy even in the face of nausea, urge her to compensate for any missed meals later in the day; thus, eating two regular meals later in the day would not be adequate and could lead to hypoglycemia. Caution women against self-medicating for nausea by using a scopolamine patch (a drug used for motion sickness) as it is not intended for long-term use. Eating a snack before bedtime may be helpful so that delaying breakfast won't cause the woman to go a long time between meals.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 12: Nursing Management During Pregnancy, pp. 421-422.

Bloom's Taxonomy Apply
Client Needs Physiological Integrity: Basic Care And Comfort
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Fluid & Electrolyte Balance, Nursing Concepts: Nutrition

42. After teaching a class about conception, the nursing instructor asks the attendees to explain the process of fertilization. Which statement indicates the students need additional teaching? Select all that apply.

Correct : B, D

a. The ovum is receptive to conception 12 to 23 hours after ovulation.
b. Sperm are viable for only about 48 hours after ejaculation.
c. Sperm are able to fertilize the ovum from 3 days before until 2 days after ovulation.
d. Sperm are able to fertilize the ovum up to 12 hours after ejaculation, and the ovum remains fertile for at least 24 hours after ovulation.
e. This activity usually occurs in the ampulla of the fallopian tube.

Difficulty94 of 100

Explanation Once the mature ovum is released (i.e., ovulation), fertilization must occur fairly quickly because an ovum is capable of fertilization for only about 24 to 48 hours. After that time, it atrophies and becomes nonfunctional. Because the functional life of a spermatozoon is also about 24 to 72 hours, the total critical time span during which sexual relations must occur for fertilization to be successful is from 3 days (72 hours) before until 2 days (48 hours) after ovulation.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 3rd ed. Philadelphia: Wolters Kluwer Health, 2017, Chapter 10: Fetal Development and Genetics, p. 336.

Bloom's Taxonomy Analyze
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction

43. A pregnant client at 34 weeks' gestation reports a burning sensation in the lower esophagus. What action would the nurse recommend to increase her comfort? Select all that apply.

Correct : A, B,C

a. Eat five to six small meals per day.
b. Do not eat fried, fatty foods.
c. Do not lie down immediately after eating.
d. Eat a large amount of carbohydrates.
e. Do not drink liquids with meals.

Difficulty93 of 100

Explanation The client is experiencing pyrosis. Eating small frequent meals, avoiding fried foods, and not laying down immediately after eating will minimize the discomfort. Large quantities of carbohydrates and not taking liquids with meals will not change the discomfort being experienced.

Reference: Chapter 12: Nursing Management During Pregnancy - Page 425

Bloom's Taxonomy Apply
Client Needs Physiological Integrity: Basic Care And Comfort
Nursing Concepts Nursing Concepts: Reproduction , Nursing Concepts: Comfort / Rest,

44. A client in the gynecological clinic as which non-hormonal birth control method can prevent pregnancy and reduce the risk of sexually transmitted diseases (STIs). Which of the following would the nurse suggest?

a. The diaphragm
b. The copper IUD
c. The female condom
d. The fertility awareness method

Explanation: The female or internal condom is a polyurethane or nitrile pouch inserted into the vagina to catch the male ejaculate. It was the first woman=controlled method that offered protection against pregnancy and some STIs if it is used properly. As with male condoms, nonlatex condoms have a higher risk of pregnancy and STIs than do latex condoms. RKC Ed 4 pp 142-143 The female condom when used properly provides protection against pregnancy and some STI's. It offers some protection against STI transmitted by skin-to-skin contact (HPV, HSV, syphilis). It is complicated to use so that increases the risks of pregnancy and STIs. It should not be used in conjunction with male condoms. ATI Ch 1 p 5.

Bloom's Taxonomy: Apply

45. A new prenatal client asks what to expect when they come in for their first prenatal appointment. What is the nurse's best response? Select all that apply.

a. A medical history including medication or drug use
b. Maternal serum alpha fetal protein (MSAFP) test
c. Blood type and Rh factor blood test
d. Complete blood count (CBC)
e. Group beta streptococcus vaginal culture

Explanation: During the first prenatal visit is a time when providers start the development of a therapeutic relationship. It involves menstrual history (which helps assess the date the baby expected to be born), prior obstetrical history, general health history, current medication or drug use including herbal supplements, and history of exposure to sexually trmitted infections.

- Prenatal labs or tests start at this visit to et baseline values:
  - Complete blood count (Hbg & Hct 5-

While ultrasounds; MSAFP, Group B Strep culturesare a part of prenatal care exams, they are done later in the pregnancy for specific reasons. RKC4 Ch 12 pp 385-394; ATI Ch 4 pp 21-22, PPT

46. A prenatal client whose blood type is 0 Rh negative is scheduled for an amniocentesis at 16 weeks gestation. Which of the following would the nurse discuss with the client regarding the amniocentesis? Select all
    a. We need you to have a full bladder for the procedure.
    b. The provider will use an ultrasound to identify where to insert the needle.
    c. This will give you immediate genetic results to tell if your baby has Downs syndrome.
    d. The prescriber will prescribe an injection of Rhogam after the procedure.
    e. This procedure can give results about the amniotic fluid as well as the gender of your baby.

Explanation: The nurse explains to the client that emptying the bladder prior to the procedure to reduce it's size will reduce the risk of inadvertent puncture of the bladder with the needle. An ultrasound is used to visualize the position of the fetus and the placenta and guide the providers placement of the needle to withdraw the amniotic fluid. The amniotic fluid that is aspirated is inspected visually for color and clarity but can then be analyzed in a lab to detect chromosomal anomalies, neural tube defects, fetal lung maturity, fetal hemolytic disease, and the gender of the fetus. It may be performed after 14 weeks of gestation. Amniocentesis is an invasive procedure so not routinely done. Because it punctures through the uterine wall and amniotic sac, there is a slight risk that there could be mixing of the fetal blood with the mother's so for women with RH negative blood types, a precaution is to have them receive Rhogam and reduce the risk of the mother's body being triggered to produce antibodies against the fetus's Rh positive blood. These results of an amniocentesis take 1-2 weeks. RKC Ch Ch 12 pp 400-401; ATI Ch6 p 35, PPT

47. A prenatal client asks about getting the diphtheria, tetanus, pertussis booster during the pregnancy. What is the best response by the nurse? Select all that apply

    a. You cannot receive any immunizations during pregnancy.
    b. You can receive only vaccines that are not live viruses during pregnancy.
    c. You can receive the DTP, influenza and hepatitis B vaccines during pregnancy.
    d. You can receive only the MMR vaccine during pregnancy.
    e. It is better if you contract the disease during pregnancy than get a vaccine.

Explanation: No evidence exists of risk from vaccinating pregnant women with inactivated virus or bacterial vaccines or toxoids. In general, live, attenuated vaccines are not recommended due to the theoretical risk of transmission to the fetus. RKC4 Ch 12 pp418-419; ATI Ch 4; PPT

48. A 25-year-old prenatal client with a BMI of 25 and who is a vegetarian asks the nurse about nutrition during pregnancy. Which of the following would the nurse include in the teaching? Select all that apply.

    a. "You need to drink 8 to 10 glasses (2.3 L) of fluid each day."
    b. "You need to increase your calcium intake to 3,000mg per day."
    c. "You should increase your intake of iron by utilizing dark leafy greens, beans, and nuts or nut butters."
    d. "You need to avoid fresh fruits and vegetables because they have bacteria on the."

e. “It is recommended that you gain between 15-25 pounds during the pregnancy.”

Explanation: There are changes in nutritional needs due to pregnancy. Health promotion related to nutrition involve increase iron and folic acid; eating a balanced diet with fresh fruits and vegetables; consuming 8 to 10 glasses of water each day; and avoiding foods like some fish and shellfish with higher levels of mercury or foods that may have Listeria. Calcium increase is not needed unless the woman is under 19 years of age. Vegetarians need to look for alternate sources of protein and iron. While some nutrients can be gotten more easily with supplements, eating an appropriate diet can provide the pregnant woman with appropriate nutrition. Weight gain recommendations in pregnancy are based on BMI i.e women with a normal or overweight BMI are recommended to gain 15-25 lbs. RKC4 Ch 11 pp364-372; ATI Ch 4 pp 21-22; PPT

49. A prenatal client is scheduled for a biophysical profile test and asks the nurse what the test results can show. What is the nurse’s best response?

a. “It will tell you the gender of the baby.”
b. “It will tell you if there are any genetic abnormalities in the infant.”
c. “It will tell you how large the baby is.”
d. “It will measure fetal breathing, fetal motion, and the amniotic flid volume.”

Explanation: Biophysical profile uses real-time ultrasound to visualize physical and physiological characteristics of the fetus and observe the biophysical responses to stimuli. It is a combination of fetal heart rate monitoring (nonstress test) and fetal ultrasound. It looks at the FHE, fetal breathing movements, gross body movements, fetal muscle tone, and the qualitative amniotic fluid volume. RKC4 Ch 12 pp404-5; ATI Ch 6 p32; PPT