N432 Practice Quiz 4 DAN & CHA

1. A nurse is preparing a couple and their newborn for discharge. Which instructions would be **most** appropriate for the nurse to include in discharge teaching?

    a. introducing solid foods immediately to increase sleep cycle
    b. demonstrating comfort measures to quiet a crying infant
    c. encouraging daily outings to the shopping mall with the newborn
    d. allowing the infant to cry for at least an hour before picking him or her up

Difficulty3 of 100

Explanation

Discharge teaching typically would focus on several techniques to comfort a crying newborn. The nurse needs to emphasize the importance of responding to the newborn's cues, not allowing the infant to cry for an hour before being comforted. Information about solid foods is inappropriate for a newborn because solid foods are not introduced at this time. The mother and newborn need rest periods. Therefore, daily outings to a shopping mall would be inappropriate. Information about newborn sleep–wake cycles and measures for sensory enrichment and stimulation would be more appropriate.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021 , p. 542.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education ,Nursing Concepts: Comfort / Rest ;Nursing Concepts: Therapeutic Communication

2. When giving a postpartum client self-care instructions in preparation for discharge, the nurse instructs her to report heavy or excessive bleeding. How should the nurse describe “heavy bleeding?”
    a. saturating 1 pad in 3 hours
    b. saturating 1 pad in 1 hour
    c. saturating 1 pad in 6 hours
    d. saturating 1 pad in 8 hours

Difficulty5 of 100

Explanation

Bleeding is considered heavy when a woman saturates a sanitary pad in 1 hour. Excessive bleeding occurs when a postpartum client saturates 1 pad in

15 minutes. Moderate bleeding occurs when the bleeding saturates less than 15 cm of a pad in 1 hour.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 562.

_Bloom's Taxonomy 3. Apply

Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Reproduction Nursing Concepts: Caring

3. Two weeks after a vaginal birth, a client presents with low-grade fever. The client also reports a loss of appetite and low energy levels. The health care provider suspects an infection of the episiotomy. What sign or symptom is **most** indicative of an episiotomy infection?
   a. foul-smelling vaginal discharge
   b. sudden onset of shortness of breath
   c. pain in the lower leg
   d. apprehension and diaphoresis

Difficulty8 of 100

Explanation

The nurse should monitor for foul-smelling vaginal discharge to verify the presence of an episiotomy infection. Sudden onset of shortness of breath, and apprehension and diaphoresis are signs of pulmonary embolism and do not indicate episiotomy infection. Pain in the lower leg is indicative of a thrombosis.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 824.

_Bloom's Taxonomy 3. Apply

Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Infection Nursing Concepts: Caring Interventions Nursing Concepts: Evidence-Based Practice

4. The nurse is conducting discharge teaching with a postpartum woman. What would be an important instruction for this client?
   a. Call her caregiver if amount of lochia decreases.
   b. Call her caregiver if lochia moves from serosa to alba.
   c. Call her caregiver if lochia moves from serosa to rubra.
   d. Call her caregiver if lochia moves from rubra to serosa.

Difficulty10 of 100

Explanation

Most cases of late postpartum hemorrhage occur after the woman leaves the health care or birthing facility. Therefore, client education before discharge about expected changes and danger signs and symptoms is crucial. Instruct the woman to call her primary care provider if she experiences any signs of infection, such as fever greater than 100.4°F (38°C), chills, or foul-smelling lochia. She should also report lochia that increases (versus decreasing) in amount, or reversal of the pattern of lochia (i.e., moves from serosa back to rubra).

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 542.

Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Clotting

5. A mother is postpartum 2 hours after a cesarean birth with epidural anesthesia. The nurse notes the urine output in the Foley bedside drainage bag is 50 mL. What should the nurse do **first**?

    a. Check the catheter tubing for kinks or obstruction.
    b. Call the obstetric provider.
    c. Increase IV fluids.
    d. Remove the catheter and get the mother up to bathroom.

Difficulty11 of 100

Explanation

The nurse should always assess the situation before attempting an intervention. If the catheter tubing is kinked or obstructed urine may not be draining adequately; therefore, this should be the priority. Because the mother's epidural anesthesia may not totally be worn off the nurse should not ambulate the mother. The mother may also not be ready to void when the Foley is removed. The mother may need additional IV fluids but the obstetric provider would first need to be notified.

Reference:

Ricci, S. S., Kyle, T., & Carman, S., *Maternity and Pediatric Nursing*, 4th ed., Philadelphia, Wolters Kluwer, 2021, , p. 520.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Basic Care And Comfort

Nursing Concepts Nursing Concepts: Clinical Decision Making / Clinical Judgment

6. A client who gave birth to twins 6 hours ago becomes restless and nervous. Her blood pressure falls from 130/80 mm Hg to 96/50 mm Hg. Her pulse drops from 80 to 56 bpm. She was induced earlier in the day and experienced abruptio placentae. Based on this information, what postpartum complication would the nurse expect is happening?
   a. infection
   b. hemorrhage
   c. fluid volume overload
   d. pulmonary emboli

Difficulty11 of 100

Explanation

Some risk factors for developing hemorrhage after birth include precipitous labor, uterine atony, placenta previa and abruptio placentae, labor induction, operative procedures, retained placenta fragments, prolonged third stage of labor, multiparity, and uterine overdistention.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 809-813.

_Bloom's Taxonomy 3. Apply

Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Medical Emergencies

7. A postpartum client with a history of deep vein thrombosis is being discharged on anticoagulant therapy. The nurse teaches the client about the therapy and measures to reduce her risk for bleeding. Which statement by the client indicates the need for additional teaching?
   a. "If my lochia increases, I need to call my health care provider."
   b. "I should brush my teeth vigorously to stimulate the gums."
   c. "I need to avoid using any aspirin-containing products."
   d. "If I get a cut, I need to apply direct pressure for about 5 minutes or more."

Difficulty11 of 100

Explanation

The client is at risk for bleeding and as such should gently brush her teeth with a soft toothbrush to prevent injury. An increase in lochia warrants notification of the health care provider. Aspirin and aspirin-containing products should be avoided. If the client experiences a cut that bleeds, she should apply direct pressure to the site for 5 to 10 minutes.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 821.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Pharmacological And Parenteral Therapies
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Clotting Nursing Concepts: Pharmacology

8. A client gave birth 2 days ago and is preparing for discharge. The nurse assesses respirations to be 26 rpm and labored, and the client was short of breath ambulating from the bathroom this morning. Lung sounds are clear. The nurse alerts the primary care provider and the nurse-midwife to her concern that the client may be experiencing:
   a. mitral valve collapse.
   b. thrombophlebitis.
   c. pulmonary embolism.
   d. upper respiratory infection.

Difficulty11 of 100

Explanation These symptoms suggest a pulmonary embolism. Mitral valve collapse and thrombophlebitis would not present with these symptoms; infection would have a febrile response with changes in lung sounds.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 819.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Medical Emergencies Nursing Concepts: Critical Thinking

9. A nurse is developing a program to help reduce the risk of late postpartum hemorrhage in clients in the labor and birth unit. Which measure would the nurse emphasize as part of this program?
   a. administering broad-spectrum antibiotics
   b. inspecting the placenta after delivery for intactness
   c. manually removing the placenta at birth
   d. applying pressure to the umbilical cord to remove the placenta

Difficulty11 of 100

Explanation After the placenta is expelled, a thorough inspection is necessary to confirm its intactness because tears or fragments left inside may indicate an accessory lobe or placenta accreta. These can lead to profuse hemorrhage because the uterus is unable to contract fully.

Administering antibiotics would be appropriate for preventing infection, not postpartum hemorrhage. Manual removal of the placenta or excessive traction on the umbilical cord can lead to uterine inversion, which in turn would result in hemorrhage.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 817.

Bloom's Taxonomy 3. Apply
Client Needs Safe And Effective Care Environment: Management Of Care
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Reproduction Nursing Concepts: Nursing Process

10. When completing the morning postpartum data collection, the nurse notices the client's perineal pad is completely saturated. Which action should be the nurse's **first** response?
    a. Vigorously massage the fundus.
    b. Immediately call the primary care provider.
    c. Have the charge nurse review the assessment.
    d. Ask the client when she last changed her perineal pad.

Difficulty12 of 100

Explanation If the morning assessment is done relatively early, it is possible that the client has not yet been to the bathroom, in which case her perineal pad may have been in place all night. Secondly, her lochia may have pooled during the night, resulting in a heavy flow in the morning. Vigorous massage of the fundus, which is indicated for a boggy uterus, would not be recommended as a first response until the client had gone to the bathroom, changed her perineal pad, and emptied her bladder. The nurse would not want to call the primary care provider unnecessarily. If the nurse were uncertain, it would be appropriate to have another qualified individual check the client but only after a complete assessment of the client's status.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 540.

Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Therapeutic Communication Nursing Concepts: Assessment

11. A nurse is teaching a postpartum client how to do muscle-clenching exercises for the perineum. The client asks the nurse, "Why do I need to do these exercises?" Which reason would the nurse **most** likely incorporate into the response?
    a. reduces lochia
    b. promotes uterine involution

c. improves pelvic floor tone
d. alleviates perineal pain

Difficulty12 of 100

Explanation

Muscle clenching perineal exercises help to improve pelvic floor tone, strengthen perineal muscles, and promote healing, ultimately helping to prevent urinary incontinence later in life. Kegel exercises have no effect on lochia, involution, or pain.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 15: Postpartum Adaptations, p. 518.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Health Promotion Nursing Concepts: Patient-Centered Care

12. The nurse recognizes that the postpartum period is a time of rapid changes for each client. What is believed to be the cause of postpartum affective disorders?
    a. drop in estrogen and progesterone levels after birth
    b. lack of social support from family or friends
    c. medications used during labor and birth
    d. preexisting conditions in the client

Difficulty13 of 100

Explanation

Plummeting levels of estrogen and progesterone immediately after birth can contribute to postpartum mood disorders. It is believed that the greater the change in these hormone levels between pregnancy and postpartum, the greater the change for developing a mood disorder. Lack of support, medications, and preexisting conditions may contribute but are not the main etiology.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 528 & 827-828.

_**Taxonomy** 2. Understand

Client Needs Psychosocial Integrity: Psychosocial Integrity
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Mood & Affect / Mental Health Concepts

13. After teaching a woman with a postpartum infection about care after discharge, which client statement indicates the need for additional teaching?

a. “I need to call my doctor if my temperature goes above 100.4° F (38° C).”
b. “When I put on a new pad, I'll start at the back and go forward.”
c. “If I have chills or my discharge has a strange odor, I'll call my doctor.”
d. “I'll point the spray of the peri-bottle so it the water flows front to back.”

Difficulty13 of 100

Explanation

The woman needs additional teaching when she states that she should apply the perineal pad starting at the back and going forward. The pad should be applied using a front-to-back motion. Notifying the health care provider of a temperature above 100.4° F (38° C), aiming the peri-bottle spray so that the flow goes from front to back, and reporting danger signs such as chills or lochia with a strange odor indicate effective teaching.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 821-22.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Infection Nursing Concepts: Health Promotion

14. A client who has a breastfeeding newborn reports sore nipples. Which intervention can the nurse suggest to alleviate the client’s condition?

a. Recommend a moisturizing soap to clean the nipples.
b. Encourage use of breast pads with plastic liners.
c. Offer suggestions based on observation to correct positioning or latching.
d. Fasten nursing bra flaps immediately after feeding.

Difficulty13 of 100

Explanation

The nurse should observe positioning and latching-on technique while breastfeeding so that she may offer suggestions based on observation to correct positioning/latching. This will help minimize trauma to the breast. The client should use only water, not soap, to clean the nipples to prevent dryness. Breast pads with plastic liners should be avoided. Leaving the nursing bra flaps down after feeding allows nipples to air dry.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 559-60 & 822.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Caring Interventions Nursing Concepts: Sensory Perception Nursing Concepts: Nutrition

15.Which nursing intervention is appropriate for prevention of a urinary tract infection (UTI) in the postpartum woman?

a. increasing oral fluid intake
b. increasing intravenous fluids
c. screening for bacteriuria in the urine
d. encouraging the woman to empty her bladder completely every 2 to 4 hours

Difficulty14 of 100

Explanation

The nurse should advise the woman to urinate every 2 to 4 hours while awake to prevent overdistention and trauma to the bladder. Maintaining a good fluid intake is also important, but it is not necessary to increase fluids if the woman is consuming enough. Screening for bacteria in the urine would require a primary care provider's order and is not necessary as a prevention measure.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021,, p. 554.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Infection Nursing Concepts: Health Promotion Nursing Concepts: Elimination

16. On a routine home visit, the nurse is asking the new mother about her breastfeeding and personal eating habits. How many additional calories should the nurse encourage the new mother to eat daily?

a. 500 additional calories per day
b. 1,000 additional calories per day
c. 250 additional calories per day
d. 750 additional calories per day

Difficulty16 of 100

Explanation

The breast-feeding mother's nutritional needs are higher than they were during pregnancy. The mother's diet and nutritional status influence the quantity and quality of breast milk. To meet the needs for milk production, the woman should eat an additional 500 calories per day, 20 grams of protein per day, 400 mg of calcium per day, and 2 to 3 quarts of fluid per day.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 557.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Nutrition Nursing Concepts: Wellness

17. A postpartum woman is prescribed oxytocin to stimulate the uterus to contract. Which action would be **most** important for the nurse to do?

a. Administer the drug as an IV bolus injection.
b. Give as a vaginal or rectal suppository.
c. Piggyback the IV infusion into a primary line.
d. Withhold the drug if the woman is hypertensive.

Difficulty16 of 100

Explanation

When giving oxytocin, it should be diluted in a liter of IV solution and the infusion set up to be piggy-backed into a primary line to ensure that the medication can be discontinued readily if hyperstimulation or adverse effects occur. It should never be given as an IV bolus injection. Oxytocin may be given if the woman is hypertensive. Oxytocin is not available as a vaginal or rectal suppository.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 815-816.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Pharmacological And Parenteral Therapies
Nursing Concepts Nursing Concepts: Technical Skills Nursing Concepts: Clinical Decision Making / Clinical Judgment Nursing Concepts: Critical Thinking

18. Which intervention would be helpful to a client who is bottle feeding her infant and experiencing hard, engorged breasts?

a. applying ice
b. restricting fluids
c. applying warm compresses
d. administering bromocriptine

Difficulty18 of 100

Explanation

Women who do not breastfeed often experience moderate to severe engorgement and breast pain when no treatment is applied. Ice promotes comfort by decreasing blood flow (vasoconstriction), numbing the area, and discouraging further letdown of milk. Restricting fluids does not reduce engorgement and should not be encouraged. Warm compresses will promote blood flow and hence, milk production, worsening the problem of engorgement. Bromocriptine has been removed from the market for lactation suppression.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 561.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Basic Care And Comfort
Nursing Concepts Nursing Concepts: Comfort / Rest Nursing Concepts: Health Promotion Nursing Concepts: Caring Interventions

19. A nurse is applying ice packs to the perineal area of a client who has had a vaginal birth. Which intervention should the nurse perform to ensure that the client gets the optimum benefits of the procedure?

a. Apply ice packs directly to the perineal area.
b. Apply ice packs for 40 minutes continuously.
c. Ensure ice pack is changed frequently.
d. Use ice packs for a week after birth.

Difficulty18 of 100

Explanation

The nurse should ensure that the ice pack is changed frequently to promote good hygiene and to allow for periodic assessments. Ice packs are wrapped in a disposable covering or clean washcloth and then applied to the perineal area, not directly. The nurse should apply the ice pack for 20 minutes, not 40 minutes. Ice packs should be used for the first 24 hours, not for a week after birth.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 549.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Basic Care And Comfort
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Health Promotion

20. Seven hours ago, a multigravida woman gave birth to a male infant weighing 4,133 g. She has voided once and calls for a nurse to check because she states that she feels “really wet” now. Upon examination, her perineal pad is saturated.

a. inspect the perineum for lacerations.
b. increase the flow of an IV.
c. assess and massage the fundus.
d. call the primary care provider or the nurse-midwife.

Difficulty19 of 100

Explanation This woman is a multigravida who gave birth to a large baby and is at risk for hemorrhage. The other actions are to be done after the initial fundal massage.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 542.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting
Nursing Concepts: Technical Skills
Nrsing Concepts: Clinical Decision Making / Clinical Judgment

21. A nurse is developing a plan of care for a woman who is at risk for thromboembolism. Which measure would the nurse include as the **most** cost-effective method for prevention?

a. prophylactic heparin administration
b. compression stockings
c. early ambulation
d. warm compresses

Difficulty19 of 100

Explanation Although compression stockings and prophylactic heparin administration may be appropriate, the most cost-effective preventive method is early ambulation. It is also the easiest method. Warm compresses are used to treat superficial venous thrombosis.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 819.

Bloom's Taxonomy 3. Apply
Client Needs Safe And Effective Care Environment: Management Of Care
Nursing Concepts Nursing Concepts: Clotting
Nursing Concepts: Nursing Process
Nursing Concepts: Mobility

22. A postpartum client who had a cesarean birth reports right calf pain to the nurse. The nurse observes that the client has nonpitting edema from her right knee to her foot. The nurse knows to prepare the client for which test **first**?

a. venous duplex ultrasound of the right leg
b. transthoracic echocardiogram
c. venogram of the right leg
d. noninvasive arterial studies of the right leg

Difficulty20 of 100

Explanation Right calf pain and nonpitting edema may indicate deep vein thrombosis (DVT). Postpartum clients and clients who have had abdominal surgery are at increased risk for DVT. Venous duplex ultrasound is a noninvasive test that visualizes the veins and assesses blood flow patterns. A venogram is an invasive test that utilizes dye and radiation to create images of the veins and would not be the first choice. Transthoracic echocardiography looks at cardiac structures and is not indicated at this time. Right calf pain and edema are symptoms of venous outflow obstruction, not arterial insufficiency.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 544.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Clotting
Nursing Concepts: Perfusion
Nursing Concepts: Technical Skills

23. A postpartum woman who developed deep vein thrombosis is being discharged on anticoagulant therapy. After teaching the woman about this treatment, the nurse determines that additional teaching is needed when the woman makes which statement?

a. “I will use a soft toothbrush to brush my teeth.”
b. “I can take ibuprofen if I have any pain.”
c. “I need to avoid drinking any alcohol.”

d. “I will call my health care provider if my stools are black and tarry.”

Difficulty22 of 100

Explanation Individuals receiving anticoagulant therapy need to avoid use of any over-the-counter products containing aspirin or aspirin-like derivatives such as NSAIDs (ibuprofen) to reduce the risk for bleeding. Using a soft toothbrush and avoiding alcohol are appropriate measures to reduce the risk for bleeding. Black, tarry stools should be reported to the health care provider.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 821.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Pharmacological And Parenteral Therapies
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Clotting Nursing Concepts: Pharmacology

24. When teaching the new mother about breastfeeding, the nurse is correct when providing what instructions? Select all that apply.

Correct : B, C, E

a. Give newborns water and other foods to balance nutritional needs.
b. Help the mother initiate breastfeeding within 30 minutes of birth.
c. Encourage breastfeeding of the newborn infant on demand.
d. Provide breastfeeding newborns with pacifiers.
e. Place baby in uninterrupted skin-to-skin contact with the mother.

Difficulty23 of 100

25. The nurse should show mothers how to initiate breastfeeding within 30 minutes of birth. To ensure bonding, place the baby in uninterrupted skin-to-skin contact with the mother. Breastfeeding on demand should be encouraged. Pacifiers do not help fulfill nutritional requirements and are not a part of breastfeeding instruction. The nurse should also ensure that no food or drink other than breast milk is given to newborns.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , pp. 558-559.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Nutrition Nursing Concepts: Psychosocial Well-Being Nursing Concepts: Interpersonal Relationships

26. A primipara client who is bottle feeding her baby begins to experience breast engorgement on her third postpartum day. Which instruction by the nurse would be **most** appropriate to aid in relieving her discomfort?

a. “Express some milk from your breasts every so often to relieve the distention.”
b. “Remove your bra to relieve the pressure on your sensitive nipples and breasts.”
c. “Apply ice packs to your breasts to reduce the amount of milk being produced.”
d. “Take several warm showers daily to stimulate the milk let-down reflex.”

Difficulty28 of 100

ExplanationFor the woman with breast engorgement who is bottle feeding her newborn, encourage the use of ice packs to decrease pain and swelling. Expressing milk from the breasts and taking warm showers would be appropriate for the woman who was breastfeeding. Wearing a supportive bra 24 hours a day also is helpful for the woman with engorgement who is bottle feeding.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 561.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Reproduction Nursing Concepts: Tissue Integrity

27. The nurse administers Rho(D) immune globulin to an Rh-negative client after birth of an Rh-positive newborn based on the understanding that this drug will prevent her from:

a. becoming Rh positive.
b. developing Rh sensitivity.
c. developing AB antigens in her blood.
d. becoming pregnant with an Rh-positive fetus.

Difficulty31 of 100

Explanation
The woman who is Rh-negative and whose infant is Rh-positive should be given Rho(D) immune globulin within 72 hours after birth to prevent sensitization.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 565.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Pharmacology Nursing Concepts: Immunity Nursing Concepts: Health Promotion

28. A woman who is breastfeeding her newborn says, "He doesn't seem to want to nurse. I must be doing something wrong." After teaching the woman about breastfeeding and offering suggestions, which statement by the mother indicates the need for additional teaching?

a. "Breastfeeding takes time and practice."
b. "Some women just can't breastfeed. Maybe I'm one of these women."
c. "Some babies latch on and catch on quickly; others take a little more time."
d. "Maybe a lactation specialist can help me work through this."

Difficulty31 of 100

Explanation The statement about some women not being able to breastfeed is incorrect and displays a negative attitude, indicating that the woman is at fault for the current situation. Breastfeeding takes time and practice and is a learned response. Support and practical suggestions can be helpful. Understanding that some babies need more time helps to reduce any frustration and uncertainty about her ability to breastfeed. A lactation consultant can provide the woman with additional support and teaching to foster empowerment in this situation.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 558-559.

Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Interpersonal Relationships

29. A client who gave birth by cesarean birth 3 days ago is bottle-feeding her neonate. While collecting data the nurse notes that vital signs are stable, the fundus is four fingerbreadths below the umbilicus, lochia are small and red, and the client reports discomfort in her breasts, which are hard and warm to touch. The **best** nursing intervention based on this data would be:

a. encouraging the client to wear a supportive bra.
b. having the client stand facing in a warm shower.
c. informing the primary care provider that the client is showing early signs of breast infection.
d. using a breast pump to facilitate removal of stagnant breast milk.

Difficulty32 of 100

Explanation

These assessment findings are normal for the third postpartum day. Hard, warm breasts indicate engorgement, which occurs approximately 3 days after birth. Vital signs are stable and do not indicate signs of infection. The client should be encouraged to wear a supportive bra, which will help minimize engorgement and decrease nipple stimulation. Ice packs can reduce vasocongestion and relieve discomfort. Warm water and a breast pump will stimulate milk production.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 561.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance
Nursing Concepts Nursing Concepts: Caring Interventions Nursing Concepts: Nursing Process Nursing Concepts: Patient-Centered Care

30. A woman arrives at the office for her 4-week postpartum visit. Her uterus is still enlarged and soft, and lochial discharge is still present. Which nursing diagnosis is **most** likely for this client?

a. Risk for fatigue related to chronic bleeding due to subinvolution
b. Risk for infection related to microorganism invasion of episiotomy
c. Risk for impaired breastfeeding related to development of mastitis
d. Ineffective peripheral tissue perfusion related to interference with circulation secondary to development of thrombophlebitis

Difficulty33 of 100

Explanation

Subinvolution is incomplete return of the uterus to its prepregnant size and shape. With subinvolution, at a 4- or 6-week postpartal visit, the uterus is still enlarged and soft. Lochial discharge usually is still present. The symptoms in the scenario are closest to those of subinvolution.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 810-811.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting
Nursing Concepts: Nursing Process Nursing Concepts: Evidence-Based Practice

31. A nurse is assessing a client with postpartal hemorrhage; the client is presently on IV oxytocin. Which interventions should the nurse

perform to evaluate the efficacy of the drug treatment? Select all that apply.

Correct : A, B, D

a. Assess the client’s uterine tone.
b. Monitor the client’s vital signs.
c. Assess the client’s skin turgor.
d. Get a pad count.
e. Assess deep tendon reflexes.

Difficulty33 of 100

Explanation A nurse should evaluate the efficacy of IV oxytocin therapy by assessing the uterine tone, monitoring vital signs, and getting a pad count. Assessing the skin turgor and assessing deep tendon reflexes are not interventions applicable to administration of oxytocin.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 815-816.

_Bloom's Taxonomy 2. Understand

Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Assessment Nursing Concepts: Pharmacology Nursing Concepts: Caring Interventions

32. A postpartum woman is having difficulty voiding for the first time after giving birth. Which action would be **least** effective in helping to stimulate voiding?
a. pouring warm water over her perineal area
b. having her hear the sound of water running nearby
c. placing her hand in a basin of cool water
d. standing her in the shower with the warm water on

Difficulty34 of 100

ExplanationHelpful measures to stimulate voiding include placing her hand in a basin of warm water, pouring warm water over her perineal area, hearing the sound of running water nearby, blowing bubbles through a straw, standing in the shower with the warm water turned on, and drinking fluids.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 551.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Basic Care And Comfort

Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Comfort / Rest Nursing Concepts: Elimination

33. A woman who is 2 weeks postpartum calls the clinic and says, “My left breast hurts.” After further assessment on the phone, the nurse suspects the woman has mastitis. In addition to pain, the nurse would question the woman about which symptom?

a. an inverted nipple on the affected breast
b. no breast milk in the affected breast
c. an ecchymotic area on the affected breast
d. hardening of an area in the affected breast

Difficulty35 of 100

Explanation Mastitis is characterized by a tender, hot, red, painful area on the affected breast. An inverted nipple is not associated with mastitis. With mastitis, the breast is distended with milk, the area is inflamed (not ecchymotic), and there is breast tenderness.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 822.

_**Bloom's Taxonomy** 3. Apply

Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Clinical Decision Making / Clinical Judgment Nursing Concepts: Infection

34. A new mother talking to a friend states, "I wish my baby was more like yours. You are so lucky. My baby has not slept straight through the night even once. It seems like all she wants to do is breastfeed. I am so tired of her." This is an example of which behavior?

a. positive bonding
b. negative bonding
c. positive attachment
d. negative attachment

Difficulty37 of 100

ExplanationExpressing disappointment or displeasure in the infant, failing to explore the infant visually or physically, and failing to claim the infant as part of the family are just a few examples of negative attachment behaviors.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 546

Bloom's Taxonomy 3. Apply
Client Needs Psychosocial Integrity: Psychosocial Integrity
Nursing Concepts Nursing Concepts: Interpersonal Relationships Nursing Concepts: Psychosocial Well-Being Nursing Concepts: Stress & Coping

35. A woman who gave birth to an infant 3 days ago has developed a uterine infection. She will be on antibiotics for 2 weeks. What is the **priority** education for this client?

a. Encourage an oral intake of 2 to 3 liters per day.
b. Keep the environment quiet to encourage rest.
c. Change her perineal pads frequently.
d. Take analgesics for uterine pain.

Difficulty37 of 100

Explanation

Many antibiotics are nephrotoxic, so the nurse would encourage liberal fluid intake each day to support a urinary output of at least 30 mL/hr. The other three actions are important but not the highest priority for this client.

Reference: Ricci, S. S., Kyle, T., & Carman, S., *Maternity and Pediatric Nursing*, 4th ed., Philadelphia, Wolters Kluwer, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 814-815.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Pharmacological And Parenteral Therapies
Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Pharmacology

36. The nurse notes that a client’s uterus, which was firm after the fundal massage, has become boggy again. Which intervention would the nurse do **next**?

a. Perform vigorous fundal massage for the client.
b. Check for bladder distention, while encouraging the client to void.
c. Use semi-Fowler position to encourage uterine drainage.
d. Offer analgesics prescribed by health care provider.

Difficulty39 of 100

Explanation

If the nurse finds a previously firm fundus to be relaxed, displaced, and boggy, the nurse should assess for bladder distention and encourage the woman to void or initiate catheterization as indicated. Emptying a full bladder facilitates uterine contraction and decreased bleeding. The nurse should not perform vigorous fundal massage. Excessive massage leads to

overstimulation of uterine muscle, resulting in excessive bleeding. The nurse should place the client in a semi-Fowler position to encourage uterine drainage in the client with postpartum endometritis. The nurse should offer analgesics as prescribed by the health care provider to minimize perineal discomfort in clients experiencing postpartum lacerations.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 814-815 **Bloom's Taxonomy** 3. Apply

Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Assessment Nursing Concepts: Elimination Nursing Concepts: Time Management/Organization

37. A nurse is providing care to a postpartum woman. The woman gave birth vaginally at 2 a.m. The nurse would anticipate the need to catheterize the client if she does not void by which time?

a. 3:30 a.m.
b. 5:15 a.m.
c. 7:45 a.m
d. 9:00 a.m.

Difficulty40 of 100

Explanation If a woman has not voided within 4 to 6 hours after giving birth, catheterization may be needed because a full bladder interferes with uterine contraction and may lead to hemorrhage. Not voiding by 9 a.m. exceeds the 4 to 6 hour time frame.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. **Bloom's Taxonomy** 4. Analyze p811

Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Elimination

38. While assessing a postpartum client who gave birth about 12 hours ago, the nurse evaluates the client's bladder and voiding. The nurse determines that the client may be experiencing bladder distention based on which finding? Select all that apply.

Correct : B, C, D

a. moderate lochia rubra
b. rounded mass over symphysis pubis
c. dullness on percussion over symphysis pubis
d. fundus boggy to the right of the umbilicus
e. elevated oral temperature

Difficulty45 of 100

Explanation If the bladder is distended, the nurse would most likely palpate a rounded mass at the the area of the symphysis pubis and note dullness on percussion. In addition, a boggy uterus that is displaced from midline to the right suggests bladder distention. If the bladder is full, lochia drainage would be more than normal because the uterus cannot contract to suppress the bleeding. An elevated temperature during the first 24 hours may be normal, however, if the elevated temperature is greater than 100.4 degrees F (38 degrees C), infection is suggested.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 541.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Assessment Nursing Concepts: Reproduction Nursing Concepts: Elimination

39. A client has been discharged from the hospital after a cesarean birth. Which instruction should the nurse include in the discharge teaching?

a. "Followup with your healthcare provider within 3 weeks of being discharged."
b. “Notify the healthcare provider if your temperature is greater than 99° F (37.2° C)."
c. "You should be seen by your healthcare provider if you have blurred vision."
d. "Call your healthcare provider if you saturate a peri-pad in less than 4 hours."

Difficulty46 of 100

Explanation The client needs to notify the healthcare provider for blurred vision as this can indicate preeclampsia in the postpartum period. The client should also notify the healthcare provider for a temperature great than 100.4° F (38° C) or if a peri-pad is saturated in less than 1 hour. The nurse should ensure that the follow-up appointment is fixed for within 2 weeks after hospital discharge.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 539.

Bloom's Taxonomy 3. Apply
Client Needs Health Promotion And Maintenance: Health Promotion And Maintenance

Nursing Concepts Nursing Concepts: Teaching & Learning / Patient Education Nursing Concepts: Perfusion

40. As part of an in-service program to a group of home health care nurses who care for postpartum women, a nurse is describing postpartum depression. The nurse determines that the teaching was successful when the group identifies that this condition becomes evident at which time after birth of the newborn?

a. in the first week
b. within the first 2 weeks
c. in approximately 1 month
d. within the first 6 weeks

Difficulty46 of 100

Explanation PPD usually has a gradual onset and becomes evident within the first 6 weeks postpartum. Postpartum blues typically manifests in the first week postpartum. Postpartum psychosis usually appears about 3 months after birth of the newborn.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 828-829.

Bloom's Taxonomy 4. Analyze
Client Needs Psychosocial Integrity: Psychosocial Integrity
Nursing Concepts Nursing Concepts: Psychosocial Well-Being Nursing Concepts: Stress & Coping Nursing Concepts: Mood & Affect / Mental Health Concepts

41. During the fourth stage of labor, the nurse assesses the client's fundal height and tone. When completing this assessment, the nurse performs which action to prevent prolapse or inversion of the uterus?

a. places index and middle fingers across the muscle
b. palpates the abdomen while feeling the uterine fundus
c. massages the fundus carefully to expel any blood clots
d. places a gloved hand just above the symphysis pubis

Difficulty47 of 100

Explanation The nurse can prevent prolapse or inversion of the uterus by placing a gloved hand just above the symphysis pubis that guards the uterus and prevents any downward displacement that may result in prolapse or inversion. To assess the client's rectus muscle, the nurse places the index and middle fingers across the muscle. Palpating the abdomen and feeling the

uterine fundus or massaging the fundus carefully to expel any blood clots would be of no benefit in preventing prolapse or inversion of the uterus.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 540-541.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Caring Interventions Nursing Concepts: Collaboration / Teamwork & Collaboration Nursing Concepts: Technical Skills

42. A nurse finds that a client is bleeding excessively after a vaginal birth. Which assessment finding would indicate retained placental fragments as a cause of bleeding?

a. soft and boggy uterus that deviates from the midline
b. firm uterus with trickle of bright red blood in perineum
c. firm uterus with a steady stream of bright red blood
d. Large uterus with painless dark red blood mixed with clots

Difficulty48 of 100

ExplanationThe presence of a large uterus with painless dark red blood mixed with clots indicates retained placental fragments in the uterus. This cause of hemorrhage can be prevented by carefully inspecting the placenta for intactness. A firm uterus with a trickle or steady stream of bright red blood in the perineum indicates bleeding from trauma. A soft and boggy uterus that deviates from the midline indicates a full bladder, interfering with uterine involution.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 810 & 817.

Bloom's Taxonomy 2. Understand
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Assessment Nursing Concepts: Reproduction Nursing Concepts: Clotting

43. The nurse is reviewing the medical record of a postpartum client. The nurse determines that the client is at risk for thromboembolism based on which factors from her history? Select all that apply.

Correct : A, D, E

a. previous oral contraceptive use
b. first pregnancy
c. age 30 years

d. severe varicose veins
e. preeclampsia

Difficulty50 of 100

ExplanationRisk factors associated with thromboembolism include oral contraceptive use, multiparity, age over 35 years, severe varicose veins, and preeclampsia.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 520 & 544.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Perfusion

44. Hypercoagulability during pregnancy protects the mother against excessive blood loss during birth. It also can increase a woman's risk of developing a blood clot. It does this by which means? Select all that apply.

Correct : A, B, D

a. stasis
b. altered coagulation
c. decline in HGB
d. localized vascular damage
e. decline in WBCs

Difficulty50 of 100

ExplanationThree factors predispose women to thromboembolic disorders during pregnancy: stasis (compression of the large veins because of gravid uterus), altered coagulation (state of pregnancy), and localized vascular damage (may occur during birthing process). All these increase the risk of clot formation.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 543.

Bloom's Taxonomy 2. Understand
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Clotting Nursing Concepts: Health, Wellness & Illness Nursing Concepts: Perfusion

45. Which assessment finding 1 hour after birth should be reported to the health care provider?

a. Fundus of uterus is palpable at the level of the umbilicus.
b. Fundus is displaced to the right, and bladder is hard.
c. Large, bruised hemorrhoids are protruding from the anal opening.
d. Lochia rubra is saturating a pad every 45 to 60 minutes.

Difficulty50 of 100

ExplanationThe nurse should ask the woman to turn over so her buttocks can be inspected in order to ensure that blood is not pooling beneath her. If the nurse observes a constant trickle of vaginal flow or the woman is soaking through a pad every 60 minutes, she is losing more than the average amount of blood. She needs to be examined by her health care provider to be certain there is no cervical or vaginal tear, or that poor uterine contraction is not causing excessive bleeding. Following perineal assessment, the nurse should assess the rectal area for the presence of hemorrhoids. If any are present, the nurse should document their number, appearance, and size in centimeters. Fundus of uterus palpable at the level of the umbilicus is a normal finding immediately after birth. When the fundus is displaced to right and bladder is hard to palpation, the bladder is full, and the nurse needs to assist the client in emptying the bladder. The health care provider should be notified if a catheter needs to be inserted and there are no standing prescriptions for an in-and-out cath following birth.
Reference: Ricci, S. S., Kyle, T., & Carman, S., *Maternity and Pediatric Nursing*, 4th ed., Philadelphia, Wolters Kluwer, 2021, Chapter 15: Postpartum Adaptations, p. 542 & 813-815.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Clinical Decision Making / Clinical Judgment Nursing Concepts: Perfusion

46. A nurse is reviewing the policies of a facility related to bonding and attachment with newborns. Which practice would the nurse identify as needing to be changed?
a. allowing unlimited visiting hours on maternity units
b. offering round-the-clock nursery care for all infants
c. promoting rooming-in
d. encouraging infant contact immediately after birth

Difficulty50 of 100

Explanation
Factors that can affect attachment include separation of the infant and parents for long times during the day, such as if the infant was being cared for in the nursery throughout the day. Unlimited visiting hours, rooming-in, and infant contact immediately after birth promote bonding and attachment.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 544-545.

Bloom's Taxonomy 3. Apply
Client Needs Safe And Effective Care Environment: Management Of Care
Nursing Concepts Nursing Concepts: Interpersonal Relationships Nursing Concepts: Health Care Systems / Health Care Organizations Nursing Concepts: Quality Improvement

47. A nurse is caring for a postpartum client who has been treated for deep vein thrombosis (DVT). Which prescription would the nurse question?
a. Wear compression stockings.
b. Plan long rest periods throughout the day.
c. Take aspirin as needed
d. Take an oral contraceptive daily.

Difficulty50 of 100

Explanation

When caring for a client with DVT, the nurse should instruct the client to avoid using oral contraceptives. Cigarette smoking, use of oral contraceptives, sedentary lifestyle, and obesity increase the risk for developing DVT. The nurse should encourage the client with DVT to wear compression stockings. The nurse should instruct the client to avoid using products containing aspirin when caring for clients with bleeding, but not for clients with DVT. Prolonged rest periods should be avoided. Prolonged rest involves staying motionless; this could lead to venous stasis, which needs to be avoided in cases of DVT.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, Chapter 22: Nursing Management of the Postpartum Woman at Risk, p. 821.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Pharmacology Nursing Concepts: Clotting Nursing Concepts: Therapeutic Communication

48. A woman gave birth vaginally approximately 12 hours ago, and her temperature is now 100.8° F (38.2° C). Which action would be **most** appropriate for the nurse to take?
a. Continue monitoring the woman's temperature every 4 hours; this finding is normal.
b. Notify the health care provider about this elevation; this finding reflects possible infection.

c. Obtain a urine culture; the woman most likely has a urinary tract infection.
d. Inspect the perineum for hematoma formation.

Difficulty52 of 100

Explanation

A temperature above 100.4° F (38° C) at any time or an abnormal temperature after the first 24 hours may indicate infection and must be reported. Abnormal temperature readings warrant continued monitoring until an infection can be ruled out through cultures or blood studies. A hematoma would not necessarily be a cause for an elevated temperature. Cultures may be warranted after notifying the health care provider. A temperature of 100.4° F or less during the first 24 hours postpartum is normal and may be the result of dehydration due to fluid loss during labor.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 539.

Bloom's Taxonomy 4. Analyze
Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Reproduction Nursing Concepts: Clinical Decision Making / Clinical Judgment Nursing Concepts: Infection

49. Review of a woman's labor and birth record reveals a laceration that extends through the anal sphincter muscle. The nurse identifies this laceration as which type?
a. first-degree laceration
b. second-degree laceration
c. third-degree laceration
d. fourth-degree laceration

Difficulty52 of 100

Explanation

A third-degree laceration extends through the anal sphincter muscle. A first-degree laceration involves only skin and superficial structures above the muscle. A second-degree laceration extends through the perineal muscles. A fourth-degree laceration continues through the anterior rectal wall.

Reference:

- Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 543.

Bloom's Taxonomy 3. Apply

Client Needs Physiological Integrity: Physiological Adaptation
Nursing Concepts Nursing Concepts: Assessment Nursing Concepts: Reproduction Nursing Concepts: Tissue Integrity

48. A nurse working on the postpartum floor is mentoring a new graduate and instructs the new nurse to make sure that clients empty their bladders. A full bladder can lead to which complication?

a. permanent urinary incontinence
b. increased lochia drainage
c. fluid volume overload
d. ruptured bladder

Difficulty54 of 100

Explanation If the bladder is full in a postpartum mother, lochia drainage will be more than normal because the uterus cannot contract to suppress the bleeding. The other options do not happen if a woman has a distended bladder.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, p. 541.

Bloom's Taxonomy 3. Apply
Client Needs Physiological Integrity: Reduction Of Risk Potential
Nursing Concepts Nursing Concepts: Health Promotion Nursing Concepts: Elimination Nursing Concepts: Clotting

49. A mother who just given birth has difficulty sleeping despite her exhaustion from labor. What are the causes of this inability to rest? Select all that apply.

Correct : A, B, C, E

a. crying baby
b. inability to get adequate pain relief
c. frequent trips to the bathroom due to diuresis
d. bottle feeding
e. excess fatigue and overstimulation by visitors

Difficulty54 of 100

Explanation The period before labor and birth can be uncomfortable for the mother, thus preventing adequate rest and creating a sleep hunger. The early postpartum period involves many adjustments that can take a toll on the mother’s sleep.

Reference: Ricci, S. S., Kyle, T., Carman, S. *Maternity and Pediatric Nursing*, 4th ed. Philadelphia: Wolters Kluwer Health, 2021, , p. 537.

Bloom's Taxonomy 6. Create
Client Needs Physiological Integrity: Basic Care And Comfort
Nursing Concepts Nursing Concepts: Elimination Nursing Concepts: Psychosocial Well-Being Nursing Concepts: Sleep