N432 Unit 2 Labor and Delivery Practice
Questions with answers and rationales--Spring 2021

1. A woman in labor received an opioid close to the time of birth. The nurse would assess the newborn for which effect?

a) respiratory depression
b) urinary retention
c) abdominal distention
d) hyperreflexia

Rationale Opioids given close to the time of birth can cause central nervous system depression, including respiratory depression, in the newborn, necessitating the administration of naloxone. Urinary retention may occur in the woman who received neuraxial opioids. Abdominal distention is not associated with opioid administration. Hyporeflexia would be more commonly associated with central nervous system depression due to opioids.

2. A client comes to the emergency department reporting strong contractions that have lasted for the past 2 hours. Which assessment will indicate to the nurse that the client is in true labor?

a) progressive cervical dilatation and effacement
b) pink show
c) increased fetal activity
d) uterine contractions

Rationale True labor is defined as the onset of regular uterine contractions that cause progressive cervical dilatation and effacement. Pink show may occur 24 to 48 hours prior to birth. Increased fetal activity can occur at any stage. Thus, these are not indicators of true labor. There is no defined ratio of contractions when differentiating true from false labor.

3. A woman telephones the prenatal clinic and reports that her water just broke. Which suggestion by the nurse would be **most** appropriate?

a) "Call us back when you start having contractions."
b) Go to the labor and delivery unit for an evaluation."
c) "Drink 3 to 4 glasses of water and lie down."
d) "Come in as soon as you feel the urge to push."

Rationale When the amniotic sac ruptures, the barrier to infection is gone, and there is the danger of cord prolapse if engagement has not occurred. Therefore, the

nurse should suggest that the woman come in for an evaluation. Calling back when contractions start, drinking water, and lying down are inappropriate because of the increased risk for infection and cord prolapse. Telling the client to wait until she feels the urge to push is inappropriate because this occurs during the second stage of labor.

4. A nurse is assisting a client who is in the first stage of labor. Which principle should the nurse keep in mind to help make this client's labor and birth as natural as possible?

a) Women should be able to move about freely throughout labor.
b) The support person's access to the client should be limited to prevent the client from becoming overwhelmed.
c) Routine intravenous fluid should be implemented.
d) A woman should be allowed to assume a supine position.

Rationale Six major concepts that make labor and birth as natural as possible are as follows: 1) labor should begin on its own, not be artificially induced; 2) women should be able to move about freely throughout labor, not be confined to bed; 3) women should receive continuous support from a caring other during labor; 4) no interventions such as intravenous fluid should be used routinely; 5) women should be allowed to assume a nonsupine position such as upright and side-lying for birth; and 6) mother and baby should be housed together after the birth, with unlimited opportunity for breastfeeding.

5. Assessment of a pregnant woman reveals that the presenting part of the fetus is at the level of the maternal ischial spines. The nurse documents this as which station?

a) -2
b) -1
c) 0
d) +1

Rationale Station refers to the relationship of the presenting part to the level of the maternal pelvic ischial spines. Fetal station is measured in centimeters and is referred to as a minus or plus, depending on its location above or below the ischial spines. Zero (0) station is designated when the presenting part is at the level of the maternal ischial spines. When the presenting part is above the ischial spines, the distance is recorded as minus stations. When the presenting part is below the ischial spines, the distance is recorded as plus stations.

6. A pregnant woman comes to the labor and birth unit in labor. The woman tells the nurse, "Yesterday, I had this burst of energy and cleaned everything in sight, but I don't know why." Which response by the nurse would be **most** appropriate?

a) "You had a burst of epinephrine, which is common before labor."
b) "You were trying to get everything ready for your baby."

c) "You felt your mind telling you that you were about to go into labor."
d) "You were looking forward to the birth of your baby."

Rationale Some women report a sudden increase in energy before labor. This is sometimes referred to as nesting because many women will focus this energy toward childbirth preparation by cleaning, cooking, preparing the nursery, and spending extra time with other children in the household. The increased energy level usually occurs 24 to 48 hours before the onset of labor. It is thought to be the result of an increase in epinephrine (adrenaline) release caused by a decrease in progesterone. The burst of energy is unrelated to getting everything ready, the mind telling the woman that she will be going into labor, or looking forward to the birth.

7. The nurse is teaching a prenatal class on the difference between true and false labor contractions. The nurse determines the session is successful when the class correctly chooses which factor as an indication of true labor contraction?

a) increase even if relaxing and taking a shower
b) remain irregular with the same intensity
c) subside when walking around and use the lateral position
d) cause discomfort over the top of uterus

Rationale True labor contractions do not stop; they continue and strengthen, as well as increase in frequency. If the contractions subside while taking a shower or relaxing, then they are not labor contractions. The discomfort over the top of the uterus is normal for full term pregnancy.

8. The nurse is monitoring a client in the first stage of labor. The nurse determines the client's uterine contractions are effective and progressing well based on which finding?

a) Engagement of fetus
b) Dilation of cervix
c) Rupture of amniotic membranes
d) Bloody show

Rationale The best determination of effective contractions is dilation of the cervix. Engagement, membrane rupture, and bloody show may all occur before the cervix has dilated.

9. A nurse caring for a pregnant client in labor observes that the fetal heart rate (FHR) is below 110 beats per minute. Which interventions should the nurse perform? Select all that apply.

a) Turn the client on her left side.
b) Reduce intravenous (IV) fluid rate.
c) Administer oxygen by mask.
d) Assess client for underlying causes.
e) Ignore questions from the client.

Rationale The nurse should turn the client on her left side to increase placental perfusion, administer oxygen by mask to increase fetal oxygenation, and assess the client for any underlying contributing causes. The client's questions should not be ignored; instead, the client should be reassured that interventions are to effect FHR pattern change. A reduced IV rate would decrease intravascular volume, affecting the FHR further.

10. A nurse recommends to a client in labor to try concentrating intently on a photo of her family as a means of managing pain. The woman looks skeptical and asks, "How would that stop my pain?" Which Rationale should the nurse give?

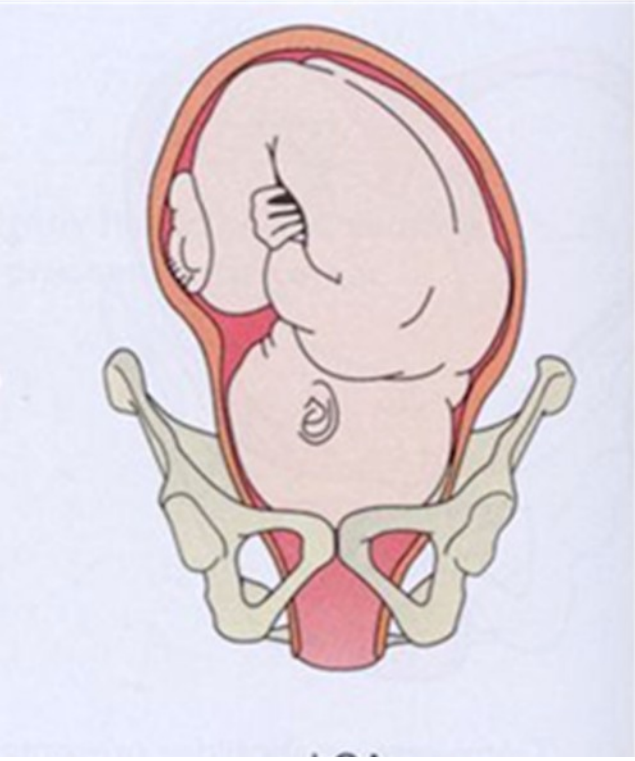
a) "It distracts your brain from the sensations of pain."
b) "It causes the release of endorphins."
c) "It blocks the transmission of nerve messages of pain at the receptors."
d) "It disrupts the nerve signal of pain via mechanical irritation of the nerves."

Rationale: Concentrating intently on an object is another method of distraction, or another method of keeping sensory input from reaching the cortex of the brain. The other answers refer to other means of pain management.

11. Which primary symptom does the nurse identify as a potentially fatal complication of epidural or intrathecal anesthesia?

a) Difficulty breathing
b) Staggering gait
c) Decreased level of consciousness
d) Intense pain

Rationale Total spinal blockade occurs when an inadvertent injection of a local anesthetic is placed into the intrathecal or epidural space. The resulting effect is that the anesthetic travels too high in the body causing paralysis of the respiratory muscles. Difficulty breathing is a sign. A decreased level of consciousness will occur later. A staggering gait or intense pain is not a primary symptom.



12. The nurse is caring for a client whose fetus is noted to be in the position shown. How would the nurse document this? (Select all that apply.)

a) Longitudinal lie
b) ROP
c) Vertex position
d) LOA
e) Transverse lie

Rationale The picture shows the fetus parallel to the maternal spine, which denotes the longitudinal lie. In the transverse lie, the fetus lies crosswise to the maternal spine. Vertex aka cephalic position or presentation means that the presenting part is the head. LOA means that the occiput of the fetus is directed towards the mother's anterior side and turned slightly to the mother's left side.

13. A nurse is providing care to a woman during the third stage of labor. Which finding would alert the nurse that the placenta is separating?

a) boggy, soft uterus
b) uterus becoming discoid shaped
c) sudden gush of dark blood from the vagina
d) shortening of the umbilical cord

Rationale Signs that the placenta is separating including a firmly contracting uterus, a change in uterine shape from discoid to globular ovoid, a sudden gush of dark blood from the vaginal opening, and lengthening of the umbilical cord protruding from the vagina.

14. A nurse is teaching a group of pregnant women about the signs that labor is approaching. When describing these signs, which sign would the nurse explain as being essential for effacement and dilation to occur?

a) Cervical ripening and softening
b) Braxton Hicks contractions
c) Bloody show
d) Lightening

Rationale The ripening and softening of the cervix which result from the effects of prostaglandins and pressure from Braxton Hicks contractions are essential for effacement and dilation of the cervix. Lightening occurs when the fetal presenting part begins to descend into the true pelvis. Bloody show occurs as the mucous plug is expelled as a result of cervical softening and increased pressure of the presenting part.

15. The nurse is determining how often contractions occur measuring from the beginning of the one contraction to the beginning of the next contraction. The nurse documents this finding as:

a) duration.
b) intensity.
c) frequency.
d) peak.

Rationale Frequency refers to how often the contractions occur and is measured from the beginning of one contraction to the beginning of the next contraction. Duration refers to how long a contraction lasts and is measured from the beginning of one contraction to the end of that same contraction. Intensity refers to the strength of the contraction determined by manual palpation or measured by an internal intrauterine pressure catheter. The peak or acme of a contraction is the highest intensity of a contraction.

16. A woman in labor is to receive continuous internal electronic fetal monitoring. The nurse prepares the client for this monitoring based on the understanding that which criterion must be present?

a) intact membranes
b) cervical dilation of 2 cm or more
c) floating presenting fetal part
d) a neonatologist to insert the electrode

Rationale For continuous internal electronic fetal monitoring, four criteria must be met: ruptured membranes, cervical dilation of at least 2 cm, fetal presenting part low enough to allow placement of the electrode, and a skilled practitioner available to insert the electrode.

17. To assess the frequency of a woman's labor contractions, the nurse would time:

a) the beginning of one contraction to the beginning of the next.
b) the end of one contraction to the beginning of the next.
c) the interval between the acme of two consecutive contractions.
d) how many contractions occur in 5 minutes.

Rationale Measuring from the beginning of one contraction to the next marks the time between contractions.

18. The laboring client who is at 3 cm dilation (dilatation) and 2 effaced is asking for analgesia. The nurse explains the analgesia usually is not administered prior to the establishment of the active phase. What is the appropriate rationale for this practice?

a) This would cause fetal depression *in utero.*
b) This may prolong labor and increase complications.
c) The effects would wear off before birth.
d) This can lead to maternal hypertension.

Rationale Administration of pharmacologic agents too early in labor can stall the labor and lengthen the entire labor. The client should be offered nonpharmacologic options at this point until she is in active labor.

19. A multigravida client admitted in active labor has progressed well and the client and fetus have remained in good condition. Which action should the nurse **prioritize** if the client suddenly shouts out, "The baby is coming!"?

a) Time the contractions.
b) Auscultate the fetal heart tones.
c) Contact the primary care provider.
d) Inspect the perineum.

Rationale The nurse needs to determine if birth is imminent by assessing the perineum and be prepared for birth. Once the nurse assesses the coming labor, the heart sounds, contraction rate, and contacting the primary care provider can all be done, if there is time.

20. A client has been in labor for 10 hours and is 6 cm dilated. She has already expressed a desire to use nonpharmacologic pain management techniques. For the past hour, she has been lying in bed with her doula rubbing her back. Now,

she has begun to moan loudly, grit her teeth, and bear down with each contraction. She rates her pain as 8 out of 10 with each contraction. What should the nurse do **first**?

a) Assess for labor progression.
b) Prepare the client for an epidural.
c) Assist the client in ambulating to the bathroom.
d) Instruct the client to do slow-paced breathing.

Rationale Performing breathing exercises, ambulating, changing position, and emptying the bladder all can help the client experience a reduction in pain. However, the best *first* step is to assess the client for labor progress before assisting her otherwise. Bearing down can be a sign that the client is 10 cm dilated.

21. A client in labor has administered an epidural anesthesia. Which assessment findings should the nurse prioritize?

a) maternal hypotension and fetal tachycardia
b) maternal hypertension and fetal bradycardia
c) maternal hypotension and fetal bradycardia
d) maternal hypertension and fetal tachycardia

Rationale Epidural anesthesia conveys the risk of hypotension, especially if the client has not received an adequate amount of fluid before the procedure is performed. A sudden drop in maternal blood pressure can cause uterine hypoperfusion, which may result in fetal bradycardia. The other choices are not an adverse effect of epidural anesthesia.

22. A pregnant client is admitted to a maternity clinic for birth. The client wishes to adopt the kneeling position during labor. The nurse knows that which to be an advantage of adopting a kneeling position during labor?

a) It helps the woman in labor to save energy.
b) It facilitates vaginal examinations.
c) It facilitates external belt adjustment.
d) It helps to rotate fetus in a posterior position.

Rationale The advantage of adopting a kneeling position during labor is that it helps to rotate the fetus in a posterior position. Facilitating vaginal examinations, facilitating external belt adjustment, and helping the woman in labor to save energy are advantages of the back-lying maternal position.

23. A client is in the third stage of labor. Which finding would alert the nurse that the placenta is separating?

a) uterus becomes globular
b) fetal head at vaginal opening

c) umbilical cord shortens
d) mucous plug is expelled

Rationale Placental separation is indicated by the uterus changing shape to globular and upward rising of the uterus. Additional signs include a sudden trickle of blood from the vaginal opening, and lengthening (not shortening) of the umbilical cord. The fetal head at the vaginal opening is termed crowning and occurs before birth of the head. Expulsion of the mucous plug is a premonitory sign of labor.

24. A nurse is required to obtain the fetal heart rate (FHR) for a pregnant client. If the presentation is cephalic, which maternal site should the nurse monitor to hear the FHR clearly?

a) lower quadrant of the maternal abdomen
b) at the level of the maternal umbilicus
c) above the level of the maternal umbilicus
d) just below the maternal umbilicus

Rationale In a cephalic presentation, the FHR is best heard in the lower quadrant of the maternal abdomen. In a breech presentation, it is heard at or above the level of the maternal umbilicus.

25. A nurse is meeting with a group of pregnant clients who are in their last trimester to teach them the signs that may indicate they are going into labor. The nurse determines the session is successful after the clients correctly choose which signs as an indication of starting labor? Select all that apply.

a) lightening
b) weight gain
c) constipation
d) bloody show
e) backache

Rationale The signs of approaching labor include lightening, bloody show, and backache. Lightening is the falling forward of the pregnant uterus due to settlement of the fetal head into the maternal pelvis. Backache associated with pelvic cramping pain, which is regular and increases in intensity, is suggestive of impending labor. Bloody show is the expulsion of the cervical mucous plug tinged with blood, and occurs due to cervical effacement and dilatation. Weight loss and diarrhea are other signs of impending labor. Weight gain and constipation are not signs of impending labor.

26. During a prenatal visit a pregnant client asks the nurse how to tell whether the contractions she is having are true contractions or Braxton Hicks contractions. Which description should the nurse mention as characteristic of true contractions?

a) begin irregularly but become regular and predictable

b) felt first in lower back and sweep around to the abdomen in a wave
c) increase in duration, frequency, and intensity
d) begin and remain irregular
e) felt first abdominally and remain confined to the abdomen and groin
f) often disappear with ambulation or sleep

Rationale True contractions begin irregularly but become regular and predictable; are felt first in the lower back and sweep around to the abdomen in a wave; continue no matter what the woman's level of activity; increase in duration, frequency, and intensity; and achieve cervical dilatation. False (Braxton Hicks) contractions begin and remain irregular; are felt first abdominally and remain confined to the abdomen and groin; often disappear with ambulation or sleep; do not increase in duration, frequency, or intensity; and do not achieve cervical dilatation.

27. Fentanyl has been administered to a client in labor. What assessment should the nurse **prioritize**?

a) Level of consciousness
b) Blood pressure
c) Maternal heart rate
d) Respiratory status

Rationale Opioids like fentanyl have significant effects on the client's respiratory status. This is the priority assessment because the other parameters are affected to a lesser degree.

28. The nurse assesses the client and tells her the baby is at +1 station. Which is the **best** response by the nurse when asked by the client what this means concerning the location of the baby?

a) 1 cm below the ischial spine.
b) 1 cm below the symphysis pubis.
c) 1 cm above the ischial spine.
d) 1 cm above the symphysis pubis.

Rationale A negative station is above the ischial spines, 0 station is at the ischial spines, and positive station is below the ischial spines. The symphysis pubis is used to determine fundal height during the pregnancy. It is also a landmark which can be used for determining urinary bladder status.

29. After describing continuous internal electronic fetal monitoring to a laboring woman and her partner, which statement by the woman would indicate the need for additional teaching?

a) “This type of monitoring is the most accurate method for our baby.”
b) “Unfortunately, I'm going to have to stay quite still in bed while it is in place.”
c) “This type of monitoring can only be used after my membranes rupture.”

d) “You'll be inserting a special electrode into my baby's scalp.”

Rationale With continuous internal electronic monitoring, maternal position changes and movement do not interfere with the quality of the tracing. Continuous internal monitoring is considered the most accurate method, but it can be used only if certain criteria are met, such as rupture of membranes. A spiral electrode is inserted into the fetal presenting part, usually the head.

30. The nurse is assisting a health care provider in inserting an epidural into a laboring mother. Completion of which nursing task helps prevent maternal hypotension?

a) Working with the mother on pattern breathing
b) Elevating the client’s legs while in bed
c) Priming tubing for initiating a fluid bolus
d) Administrating a vasopressor

Rationale Priming tubing for a fluid bolus is helpful in preventing maternal hypotension secondary to epidural placement. Introducing fluid to the vascular space elevates the circulating volume and blood pressure. Patterned breathing helps to promote relaxation but does not influence hypotension. Elevating the client’s legs assists in returning the blood to the heart. This may be helpful but not as helpful as the fluid bolus. Vasopressors are not administered during labor. Fluid is completed before medication would be introduced into the system.

31. The nurse is caring for a client who prefers resting on her back during the labor process. To facilitate client wishes, which nursing action is required?

a) Raise the head of the bed
b) Place the toco transducer low on abdomen
c) Utilize a wedge under one hip
d) Elevate the knee gatch

Rationale Changing positions frequently can help during the labor process. By placing a wedge under the client’s hip, it decreases the likelihood of hypotension and allows the nurse to protect the fetus from decreased oxygenation and meet client wishes. This option is the only one in which the staff is meeting client wishes. The head of the bed may be elevated as needed. Depending upon the location of the fetus, the toco transducer is placed where fetal heart tones are able to be heard. Rarely is the knee gatch elevated as it may slow blood flow.

32. The nurse is preparing a client for an epidural block. Which intervention is a **priority** before the epidural anesthesia is started?

a) Increase oral fluids
b) IV fluid bolus
c) Monitor temperature
d) Monitor maternal apical pulse

Rationale The client will need to have a bolus of IV fluids prior to the epidural to prevent hypotension. The hypotensive event is transitory, and increasing oral hydration is unnecessary and may lead to nausea later. Monitor the mother's body temperature as per routine. The nurse should monitor the radial pulse not the apical pulse.

33. A nurse is assigned to conduct an admission assessment on the phone for a pregnant client. Which information should the nurse obtain from the client? Select all that apply.

a) estimated due date
b) history of substance use
c) characteristics of contractions
d) appearance of vaginal blood
e) history of drug allergy

Rationale When conducting an admission assessment on the phone for a pregnant client, the nurse needs to obtain information regarding the estimated due date, characteristics of contractions, and appearance of vaginal blood to evaluate the need to admit her. History of substance use or a drug allergy is usually recorded as part of the client's medical history.

34. A client who is in the transition phase reports her pain medication last given 3 hours ago has worn off. She asks if she can have another dose of the meperidine. How should the nurse respond to the request?

a) "Since it has been over 3 hours, you should be able to have more of the medication."
b) "It is too early as the medication should be given only every 4 hours."
c) "Your phase of labor makes giving another dose unsafe."
d) "I will get permission from your health care provider."

Rationale Meperidine may cause central nervous system depression in the neonate if given too close to birth. This client is in the transition phase, thus, is within 30 minutes to 2 hours of birth. Whether it has been 3 or 4 hours since the last dose is not the determining factor; safety is the determining factor. There is no need to ask the health care provider.

35. Which nursing interventions align with the outcome of preventing maternal and fetal injury in the latent phase of the first stage of labor? Select all that apply.

1. Monitor maternal and fetal vital statistics every hour.
2. Report an elevated temperature over 38 °C (100.4 °F).

3. Answer questions and encourage verbalization of fears.
4. Have a client remain on bed rest with bathroom privileges only.
5. Position client on the left side throughout the labor process.

Rationale Consider what occurs in the latent (or early phase) of the first stage of labor, which are contractions and effacement. The nursing interventions which impact maternal and fetal injury include monitoring vital statistics, reporting temperature elevation over 38°C (100.4°F) and answering questions and encouraging client verbalization of fears. The client is often excited and talkative. The client does not need to be on bed rest or positioned on the left side unless there is a complication.

36. Which psychosocial state is anticipated when the client enters the active phase of labor?

a) The client will become more quiet and introverted.
b) The client will become angry and begin to scream.
c) The client will become more talkative and excited about the birth.
d) The client will become tired and want the process over.

Rationale The woman's psychosocial state typically changes as she enters the active phase of labor. As the contractions are increasing in amount and intensity, the woman becomes more quiet and introverted as she is focused on the work of labor. The other options may occur but are not anticipated.

37. A client is in active labor. As one of the nursing diagnoses is "Risk for trauma to the woman or fetus related to intrapartum complications or a full bladder," what would be appropriate for the nurse to do in order to achieve the goal of "no complications due to a full bladder"?

a) Limit fluid intake to 300 mL every hour
b) Insist the client use a bedpan every 2 hours
c) Palpate the area above the symphysis pubis every 2 hours.
d) Do a sterile "in and out" catheterization every 3 hours

Rationale A source of trauma that can interfere with the progress of labor is a full bladder. Every two hours the nurse should palpate the area just above the symphysis pubis feeling for a rounded area of distention, which indicates the bladder is full. This assessment must precede any proposed catheterization. Fluid limitation is unsafe. Providing a bedpan rather than the toilet does not reduce the client's risk.

38. At which time does the nurse anticipate that the woman will need the **most** pain relief measures?

a) In the latent phase of the first stage of labor
b) At the beginning of the second stage of labor

c) During the transition phase of the first stage of labor
d) In the active phase of the first stage of labor

Rationale Pain medication is given the most in the active phase of labor. Implementing general comfort measures with narcotic analgesia or epidural anesthesia is common. During the transition phase, the woman's contractions become intense and include an urge to push. A goal for this period is that the woman's pain will be manageable. Comfort measures are most important as narcotics are not given at this advanced stage. Luckily, this phase is typically the shortest. The latent phase is the early portion of labor. This is frequently completed at home with comfort measures provided by the support person. The second stage of labor begins with full dilation and ends with the birth.

39. The nurse is monitoring a pregnant client admitted to a health care center who is in the latent phase of labor. The nurse demonstrates appropriate nursing care by monitoring the fetal heart rate (FHR) with the Doppler at least how often?

a) every 15 to 30 minutes
b) every 30 minutes
c) every hour
d) continuously

Rationale During the latent phase of labor, the nurse should monitor the FHR every 30 to 60 minutes. FHR should be monitored every 30 minutes in the active phase and every 15 to 30 minutes in the transition phase of labor. Continuous monitoring is done when an electronic fetal monitor is used.

40.The nurse is teaching a group of nursing students about pharmacologic interventions for pain in labor. The teaching has been effective when the students state that complications associated with epidural and spinal anesthesia include which conditions? Select all that apply.

a) pruritis
b) maternal fever
c) hypotension
d) aspiration
e) respiratory depression

Rationale Hypotension is the most frequent side effect associated with epidural or intrathecal anesthesia. When narcotics are used in addition to anesthetics, pruritus is a common side effect. Respiratory depression is another possible side effect when narcotics are used for spinal and/or epidural anesthesia. Maternal fever occurs occasionally with an epidural. The nurse takes note and continues to assess as it can also be caused by other factors.

41. A nurse is providing care to a woman in labor. The nurse determines that the client has moved into the active phase based on which assessment findings? Select all that apply.

a) cervical dilation of 6 cm
b) contractions every 1 to 2 minutes
c) cervical effacement of 9
d) contractions lasting up to 60 seconds
e) strong desire to push

Rationale During the active phase, the cervix usually dilates from 4 to 7 cm, with 4 to 8 effacement taking place. Contractions become more frequent (every 2 to 5 minutes) and increase in duration (45 to 60 seconds). A cervical effacement of 9 and a strong desire to push signify the transition phase.

42. Palpating the client's abdomen for the fetal presenting part, fetal lie, and location of the fetal back is called?

a) Bishop's score
b) Induction of labor
c) Leopold maneuvers
d) Effleurage

Rationale Leopold maneuvers involve specific palpation of the pregnant client's abdomen and can identify the fetal presentin part, the fetal lie, and the location of the fetal back.

43. The client having contractions occurring every 4 minutes which are 40-60 seconds duration with the cervix dilated to 6 cm and 60% effaced would be in which stage of labor?

a) Second stage
b) First stage, latent phase
c) First stage, active phase
d) First stage, transitional phase

Rationale During first stage, active phase of labor contractions progress to 4-7 cm dilation,40-100% effaced, and contractions last 40-70 seconds.

44. After the client's water ruptures, what should be the first action that the nurse should do?

a) Call the provider
b) Do a vaginal exam for cervical dilation
c) Check the fetal heart rate pattern
d) document that it occurred

Rationale When the amniotic sac ruptures there is a risk that the umbilical cord can be pulled down with the amniotic fluid and

prolapse, getting caught between a presenting part and the uterus. This can decrease the oxygenation to the fetus which will be reflected in the fetal heart rate tracing, most commonly with variable decelerations.

45. The client is having contractions every 3 minutes which last 60 seconds. What is the resting interval?

a) 45 seconds
b) 2 minutes
c) 90 seconds
d) 1 minute

Rationale If the frequency is q 3 minutes then there are 3 minutes between the beginning of on contraction and the beginning of the next contraction. Subtracting the length of the contractions i.e. 60 seconds (1 minute) from 3 minutes = 2 minutes of time between the end of one contraction and the beginning of the next.

46. Decelerations that are > 15 bpm, > 2 minutes, and < 10 minutes are called?

a) variable decelerations
b) late decelerations
c) early decelerations
d) prolonged decelerations

Rationale The definition of a prolonged deceleration is that they decelerate over 15 bpm for over 2 minutes but for less than 10 minutes. If they last over 10 minutes, the baseline is considered to have changed.

47. During the 3rd stage of labor, the nurse notices a gush of blood with the umbilical cord appearing to elongate. What does this indicate to the nurse?

a) the nurse needs to palpate the fundus to see if the uterus is firm
b) the nurse needs to turn on the oxytocin infusion
c) the nurse assesses that the placenta has detached
d) the nurse calls for a hemorrhage code

Rationale

48. During the first 30 minutes of the 4th stage of labor, the nurse notices a large amount of blood on the peri pad. What would the nurse do first in response?

a) change the peri pad to a fresh one and weigh it
b) have the client get up to the bathroom to void
c) palpate the uterine fundus for firmness and location
d) notify the provider

Rationale During the immediate postpartum period (4th stage of labor), the uterus must contract in order to shut off the flow of blood

from the placenta site. A large amount of blood indicates that the uterus is most likely not contracting so the first response is to palpate the uterine fundus to check for firmness and location. Massage of the uterine fundus is then done to stimulate contractions along with the use of uterotonic medications and checking for bleeding from perineal tears or the cervix.

49. An exam by the provider which checks for cervical dilation; cervical effacement; cervical consistency; and the station of the presenting part prior to induction of labor is called?

a) A non-stress test
b) A biophysical profile
c) Leopold maneuvers
d) Bishops score

Rationale The Bishop's score is done by the provider by assessing the cervix's readiness to respond to the contractions of labor as well as to identify the location of the presenting part. This is to determine if induction of labor is likely to be successful.

50. The nurse notes decelerations that sometimes occur with a contraction and other times in between contractions but which have a rapid descent and a rapid return to baseline and short shoulders before and after. What should be the nurses first response?

a) Call the provider immediately
b) Turn the client to her side and observe to see if the decelerations resolve
c) Put an oxygen mask on the client at 5 L/min
d) Take the client's blood pressure

Rationale Variable decelerations "vary" in terms of whether they occur in conjunction with a contraction or between contractions but have a classic presentation of a rapid descent and rapid return to baseline with short 'shoulders" before and after. The have a classic V or sometimes a W appearance and are indicative of cord compression.