N432 Practice Questions Unit 4

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

2. When giving a postpartum client self-care instruction 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

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

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.

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.

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

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."

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.
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

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.

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

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

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.”

14. A client who has a breastfeeding newborn report 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.

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

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

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.

18. Which intervention would be helpful to a client who is bottle feeding her infant and experiencing hard, engorged breasts?
a. Apply ice
b. Restricting fluids
c. Applying warm compresses
d. Administering bromocriptine

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.

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.

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

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

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.”

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

25. 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.”

26. 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.

27. 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."

28. 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.

29. 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

30. 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.
    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.

31. 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

32. 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

33. 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

34. 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.

35. 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.

36. 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.

37. 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.
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

38. 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."

39. 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

40. 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

41. 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

42. 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.
    a. previous oral contraceptive use
    b. first pregnancy
    c. age 30 years
    d. severe varicose veins
    e. preeclampsia

43. 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.
    a. stasis
    b. altered coagulation
    c. decline in HGB
    d. localized vascular damage
    e. decline in WBCs

44. 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.

45. 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

46. 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.

47. 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.

48. 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

49. 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

50. 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.

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