1. A woman at 28 weeks' gestation has been hospitalized with moderate bleeding that is now stabilizing. The licensed practical nurse (LPN) notes on routine assessment the client sleeping, lying on her side and electronic fetal heart rate monitor showing gradually increasing baseline with late decelerations. Which action should the LPN **prioritize**?

a. Administer oxygen to the client.

b. Notify the primary care provider or registered nurse.

C, Reposition the client in a semi-recumbent position on the back.

d. Decrease the rate of IV fluids.

Explanation: The fetus is showing signs of fetal distress. The immediate treatment is putting the client in a side lying position if not already in it, and alerting the RN and/or health care provider immediately. The health care provider may prescribe oxygen and also increase the rate of IV fluids based on the client's assessment; however, this is not within the scope of the LPN to administer without a prescription.

Reference: RKC 3RD ED Ch 19 p. 700.

2. A nurse is reading a journal article about cesarean births and the indications for them. Place the indications for cesarean birth below in the proper sequence from most frequent to least frequent. All options must be used.

   - a. Labor dystocia
   - b. Abnormal fetal heart rate tracing
   - c. Fetal malpresentation
   - d. Multiple gestation
   - e. Suspected macrosomia

a. 1a, 2b, 3c, 4d, 5e

b. 1b, 2c, 3a, 4e, 5d

c. 1b, 2a, 3c, 4d, 5e

d. 1b, 2a, 3c, 4e, 5d

e. 1c, 2a, 3b, 4e, 5d

f. 1a, 2d, 3c, 4b, 5e

Explanation

The most common indications for primary cesarean births include, in order of frequency: labor dystocia as the labor does not progress, abnormal fetal heart rate tracing

indicating fetal distress, fetal malpresentation making a difficult progression of labor, multiple gestation , and suspected macrosomia.

Reference: RKC 3RD ED p. 797

3. A nursing student doing a rotation in labor and birth correctly identifies which medications as **most** commonly used for tocolysis? Select all that apply.

Correct : A, B, C, D

a. magnesium sulfate
b. atosiban
c. indomethacin
d. nifedipine
e. nitroglycerin

Explanation

Medications commonly used for tocolysis include magnesium sulfate, atosiban, indomethacin, and nifedipine. These drugs are used "off label," meaning that they are effective but have not been officially tested and developed for this purpose by the Food and Drug Administration.

Reference: RKC 3RD ED Page 809

4. A pregnant client at 20 weeks' gestation arrives at the health care facility reporting excessive vaginal bleeding and no fetal movements. Which assessment finding would the nurse anticipate in this situation?

a. cervical incompetence
b. ectopic pregnancy
c. congenital malformations
d. placenta previa

Explanation

This client has reported symptoms of a spontaneous abortion or miscarriage of the second trimester. Miscarriages in the second trimester are most often related to maternal factors such as cervical incompetence, congenital or acquired anomaly of the uterine cavity, hypothyroidism, diabetes mellitus, chronic nephritis, use of crack cocaine, inherited and acquired thrombophilias, lupus, polycystic ovary syndrome, severe hypertension, and acute infection such as rubella virus, cytomegalovirus, herpes simplex virus, bacterial vaginosis, and toxoplasmosis. Cervical incompetence is a condition where there is painless cervical dilatation and results in second trimester fetal loss or can progress to preterm premature rupture of membranes. Ectopic pregnancy, congenital malformations, and placenta previa are not involved in causing second trimester fetal loss. Ectopic pregnancy usually leads to first trimester fetal loss. Placenta previa is a condition in which there is implantation of the placenta to the lower uterine segment. Congenital malformations result in first trimester fetal loss.

Reference: RKC 3RD ED Page 688

5. A client reports bright red, painless vaginal bleeding during her 32nd week of pregnancy. A sonogram reveals that the placenta has implanted low in the uterus and is partially covering the cervical os. Which immediate care measures are initiated? Select all that apply.

Correct : B, C, E

a. Place the woman on bedrest maintaining the supine position.
b. Determine the time the bleeding began and about how much blood has been lost.
c. Obtain baseline vital signs and compare to those vital signs previously obtained.
d. Assist the client in stirrups and perform a pelvic examination.
e. Attach external monitoring equipment to record fetal heart sounds and kick counts.

Explanation

Assessment is a priority in the immediate care period. Determining the extent of the blood loss, obtaining vital signs and monitoring the fetus provides data. With the exception of performing a pelvic examination and placing the client in the supine position, all of the answers are appropriate immediate care measures. The nurse should never attempt a pelvic or rectal examination with painless bleeding late in pregnancy because any agitation of the cervix might tear the placenta further and initiate massive hemorrhage, which is possibly fatal to both mother and child. The nurse should not place the client in the supine position for extended periods due to the possibility of supine hypotension. Left side lying is suggested.

Reference: RKC 3RD ED Page 699-700

6. A woman in active labor has just had her membranes ruptured to speed up labor. The nurse is concerned the woman is experiencing a prolapse of the umbilical cord when the nurse notices which pattern on the fetal heart monitor?

a. variable deceleration pattern
b. fetal heart rate (FHR) increase to 200 beats/min
c. early deceleration with each contraction
d. late deceleration with late recovery following contraction

Explanation

Umbilical cord prolapse can be seen after the membranes have ruptured, when the FHR is displaying a sudden variable deceleration FHR pattern on a fetal monitor. It is not uncommon for FHR to increase following a procedure. Early deceleration with each contraction is seen when the fetal head is being compressed through the pelvic opening. Late deceleration with late recovery following contraction is associated with uteroplacental insufficiency (UPI).

Reference: RKC 3RD ED Page 824

7. When caring for a client with premature rupture of membranes (PROM), the nurse observes an increase in the client's pulse. What should the nurse do **next**?

a. Assess the client's temperature.
b. Monitor the client for preterm labor.
c. Assess for cord compression.
d. Monitor the fetus for respiratory distress.

Explanation

A temperature elevation or an increase in the pulse of a client with PROM would indicate infection. Increase in the pulse does not indicate preterm labor or cord compression. The nurse should monitor FHR patterns continuously, reporting any variable decelerations suggesting cord compression. Respiratory distress syndrome is one of the perinatal risks associated with PROM.

Reference: RKC 3RD ED Page 722

8. A pregnant woman is being evaluated for HELLP. The nurse reviews the client's diagnostic test results. An elevation in which result would the nurse interpret as helping to confirm this diagnosis?

a. LDH
b. white blood cells
c. hematocrit
d. platelet count

Explanation

HELLP (hemolysis, elevated liver enzymes, low platelet count) syndrome is a variant of the preeclampsia/eclampsia syndrome. The diagnosis is based on laboratory test results, including: low hematocrit, elevated liver enzymes (elevated LDH, elevated AST, elevated ALT, elevated BUN, elevated bilirubin level), elevated uric acid and creatinine levels, and low platelet count. White blood cell counts are not used to evaluate for HELLP.

Reference: RKC 3RD ED Page 717

9. A nursing student correctly identifies the causes of labor dysfunction to include which factors? Select all that apply.

Correct : A, C

a. problems with the uterus
b. problems with the mother's diet
c. problems with the fetus
d. problems with access to health care
e. problems with finances

Explanation

Labor dysfunction can occur because of problems with the uterus or fetus. Although the others might affect the type of prenatal care a woman receives, they do not directly affect her process of labor.

Reference: RKC 3RD ED Page 798

10. A nurse suspects that a pregnant client may be experiencing a placental abruption based on assessment of which finding? Select all that apply.

Correct : A, D, E

a. dark red vaginal bleeding
b. insidious onset
c. absence of pain
d. rigid uterus
e. absent fetal heart tones

Explanation

Assessment findings associated with a placental abruption include a sudden onset with concealed or visible dark red bleeding, constant pain or uterine tenderness on palpation, firm to rigid uterine tone, and fetal distress or absent fetal heart tones.

Reference: RKC 3RD ED Page 701

11. The nurse is preparing discharge instructions for a client at 32 weeks' gestation who was admitted for PROM. What is the **best** response from the nurse when the client asks when she can have intercourse with her husband again?

a. "You will not be able to have intercourse again until 6 weeks after you give birth."
b. "The need to keep the infant safe should be of more concern than when to have sex."
c. "That is a question to ask your health care provider; at this point you are on pelvic rest to try and stop any further labor."
d. "Intercourse has nothing to do with preterm labor; you can have sex with your husband."

Explanation

The client needs to be on pelvic rest until the health care provider says otherwise. The intercourse can cause excitability in the uterus and encourage cervical softening and should be avoided unless the provider says it is safe. The nurse should be professional in all communications and not talk down to the client.

Reference: RKC 3RD ED Page 814

12. A laboring woman is receiving oxytocin IV to augment her labor and 2 hours later begins having contractions every 2 minutes lasting 60 to 90 seconds each with little, if any, rest time in between the contractions. At this time, which interventions would be the **priority** for the nurse caring for this client? Select all that apply.

Correct : C, D, E

a. Administer betamethasone to mature the fetal lungs.
b. Ask the woman to drink 32 ounces (1 L) of water.
c. Discontinue the oxytocin infusion.
d. Administer an IV bolus of fluids.
e. Administer oxygen by mask at 8 to 10L

The danger of hyperstimulation is that a fetus needs 60 to 90 seconds between contractions in order to receive adequate oxygenation from placenta blood vessels. Hyperstimulation is usually defined as five or more contractions in a 10-minute period or contractions lasting more than 2 minutes in duration or occurring within 60 seconds of each other. Several interventions such as asking the woman to turn onto her left side to improve blood flow to the uterus, administering an IV fluid bolus to dilute the level of oxytocin in the maternal blood stream, and administering oxygen by mask at 8 to 10 L are all helpful interventions for hyperstimulation. The surest method to relieve hyperstimulation is to immediately discontinue the oxytocin infusion. The lungs should be mature if a woman is undergoing induction. Drinking water takes too long to be absorbed and dilute the blood stream, so IV fluids are best.

Reference: RKC 3RD ED Page 819

13. Which change in insulin is **most** likely to occur in a woman during pregnancy?

a. enhanced secretion from normal
b. not released because of pressure on the pancreas
c. unavailable because it is used by the fetus
d. less effective than normal

Explanation

Somatotropin released by the placenta makes insulin less effective. This is a safeguard against hypoglycemia.

Reference: RKC 3RD ED Page 735

14. A G2P1 woman with type 1 diabetes is determined to be at 8 weeks' gestation by her health care provider. The nurse should point out which factor will help the client maintain glycemic control?

a. Vitamin supplements
b. Oral hypoglycemic agents
c. Exercise
d. Plenty of rest

Explanation

The three main facets to glycemic control for the woman with pregestational diabetes are diet, exercise, and insulin. An individual with type 1 diabetes uses insulin and not oral hypoglycemic agents. Vitamin supplements may assist with helping to keep the woman healthy but not necessarily through glycemic control. It will be important for the woman to get enough rest throughout the pregnancy but this will not assist with glycemic control.

Reference: RKC 3RD ED Page 741

15. At 31 weeks' gestation, a 37-year-old woman with a history of preterm birth reports cramps, vaginal pain, and low, dull backache accompanied by vaginal discharge and bleeding. Assessment reveals cervix 2.1 cm long; fetal fibronectin

in cervical secretions, and cervix dilated 3 to 4 cm. Which interactions should the nurse prepare to assist with?

a. Bed rest and hydration at home
b. Hospitalization, tocolytic, and corticosteroids
c. An emergency cesarean birth
d. Careful monitoring of fetal kick counts

Explanation

At 31 weeks' gestation, the goal would be to maintain the pregnancy as long as possible if the mother and fetus are tolerating continuation of the pregnancy. Stopping the contractions and placing the client in the hospital allow for monitoring in a safe place if the woman continues and gives birth. Administration of corticosteroids may help to develop the lungs and prepare for early preterm birth. Sending the woman home is contraindicated in the scenario described. An emergency cesarean birth is not indicated at this time. Monitoring fetal kick counts is typically done with a post-term pregnancy.

Reference: RKC 3RD ED Page 809

16. A client in preterm labor is receiving magnesium sulfate IV and appears to be responding well. Which finding on assessment should the nurse **prioritize**?look into changing

a. Depressed deep tendon reflexes
b. Tachypnea
c. Bradycardia
d. Elevated blood glucose

Explanation

The nurse should assess the woman at least once hourly and report any dyspnea (not tachypnea), tachycardia (not bradycardia), productive cough, adventitious breath sounds, and absent or decreased deep tendon reflexes in a client receiving magnesium sulfate; these are all signs of possible magnesium toxicity. Elevated blood glucose is a potential adverse reaction if the woman is receiving terbutaline.

Reference: RKC 3RD ED Page 810

17. The nurse encourages a woman with gestational diabetes to maintain an active exercise period during pregnancy. Prior to this exercise period, the nurse would advise her to take which action?

a. Inject a bolus of insulin.
b. Eat a high-carbohydrate snack.
c. Eat a sustaining-carbohydrate snack.
d. Add a bolus of long-acting insulin.

Explanation

Because exercise uses up glucose, women with diabetes should take a sustaining-carbohydrate snack before hard exercise to prevent hypoglycemia.

Reference: Page 741

18. Assessment of a pregnant woman and her fetus reveals tachycardia and hypertension. There is also evidence suggesting vasoconstriction. The nurse would question the woman about use of which substance?

a. marijuana
b. alcohol
c. heroin
d. cocaine

Explanation

Cocaine use produces vasoconstriction, tachycardia, and hypertension in both the mother and fetus. The effects of marijuana are not yet fully understood. Alcohol ingestion would lead to cognitive and behavioral problems in the newborn. Heroin is a central nervous system depressant.

Reference: RKC 3RD ED Page 779

19. The nurse is caring for an Rh-negative nonimmunized client at 14 weeks' gestation. What information would the nurse provide to the client?

a. Obtain Rho(D) immune globulin at 28 weeks' gestation.
b. Consume a well-balanced, nutritional diet.
c. Avoid sexual activity until after 28 weeks.
d. Undergo periodic transvaginal ultrasounds.

Explanation

The current recommendation is that every Rh-negative nonimmunized woman receives Rho(D) immune globulin at 28 weeks' gestation and again within 72 hours after giving birth. Consuming a well-balanced nutritional diet and avoiding sexual activity until after 28 weeks will not help to prevent complications of blood incompatibility. Transvaginal ultrasound helps to validate the position of the placenta and will not help to prevent complications of blood incompatibility.

Reference: RKC 3RD ED p. 717.

20. Which would a client with preeclampsia be higher risk for:

a. Placenta previa
b. Gestational hypertension
c. Abruptio placentae
d. Hyperemesis gravidarium

One of the effects and symptoms of preeclampsia is hypertension which is vaso constriction. This puts the client at higher risk for abruptio placentae

21. Would the nurse do a vaginal/cervical exam on a client with diagnosed full placenta previa who comes into labor and delivery because they think they are in labor?

22. How often are pulse, respirations, blood pressure and neurological status i.e. deep tendon reflexes done during labor on a patient with severe preeclampsia?