

1. 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.

2. 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.

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 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

- a) 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.

- b) 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) Administering 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.

- c) 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.

- d) 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.
- a) Monitor maternal and fetal vital statistics every hour.
 - b) Report an elevated temperature over 38 °C (100.4 °F).
 - c) Answer questions and encourage verbalization of fears.
 - d) Have a client remain on bed rest with bathroom privileges only.
 - e) 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.

- e) 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.

- f) 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.

20. 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.