1. The nurse is counseling the client who is trying to become pregnant. To promote fetal health when the client is unaware of a pregnancy, the nurse should stress the inclusion of which nutrient in daily food intake?

A. Potassium
B. Calcium
C. Folic acid
D. Sodium

ANSWER: C

A. Potassium is important in preventing leg cramps during pregnancy, but this is usually not an issue during the first four weeks of gestation.
B. Calcium is important for fetal development of bones, teeth, heart, nerves, and muscles, but the fetus will take calcium from the mother. Calcium is more important to maternal health than fetal development.
C. The nurse should educate the client about the need for adequate folic acid intake. Folic acid is important in preventing neural tube defects, especially during the first four weeks of fetal development.
D. Sodium is important for maintaining optimal electrolyte balance but is typically ingested in more than adequate amounts in a typical diet.

2. The nurse is reviewing the medication history of the client during preconception counseling. The client reports taking isotretinoin for acne. Which is the nurse's best response?

A. "Stop taking isotretinoin now! It can cause serious birth defects if you become pregnant."
B. "You need to be on some type of birth control right now. Getting pregnant is not an option."
C. "Talk with your HCP about changing isotretinoin before you consider becoming pregnant."
D. "Once you are off of isotretinoin for treating acne, you can then safely become pregnant."

ANSWER: C

A. Responding to the client emphatically can create anxiety and fear.
B. Telling the client that getting pregnant is not an option is a paternal response and does not facilitate open communication.
C. The best response is to have the client consult her HCP so another medication can be prescribed. This response indicates that isotretinoin (Accutane) is not safe but that alternative medications can be prescribed.

D. Clients must wait one month after cessation of isotretinoin before becoming pregnant.

3. The nurse is counseling the client who has SLE. The client tells the nurse that she plans to become pregnant in the next year. Which response by the nurse is correct?

A. “It is best to plan for your pregnancy when you have been in remission for 6 months.”
B. “Having systemic lupus erythematosus will not impact your pregnancy in any way.”
C. “Your chances of having an infant with congenital malformations are increased with SLE.”
D. “You will need to be scheduled for a cesarean delivery to prevent disease transmission.”

ANSWER: A

A. Planning for pregnancy with SLE when in remission for 6 months is correct. Pregnancy planned during periods of inactive or stable disease often results in giving birth to a healthy full-term baby without increased risks of pregnancy complications.
B. Exacerbations of SLE can occur during pregnancy and impact pregnancy outcomes.
C. There is no risk of congenital malformations associated with maternal SLE. However, the risk for spontaneous abortion, preterm labor and birth, and neonatal death is increased.
D. SLE is not a transmissible disease, and there is no reason for a cesarean delivery.

4. The 22-year-old client tells the clinic nurse that her last menstrual period was 3 months ago, which began on November 21. She has a positive urine pregnancy test. Using Naegele’s rule, which date should the nurse calculate to be the client’s estimated date of confinement (EDC)?

A. August 28
B. January 28
C. August 15
D. January 15

ANSWER: A

A. Naegele’s rule is a common method to determine the EDC. To calculate the EDC, subtract 3 months and add 7 days. This makes the EDC August 28.

B. An EDC of January 28 was calculated by adding 2 months and 7 days.
C. An EDC of August 15 was calculated by subtracting 3 months and 6 days.
D. An EDC of January 15 was calculated by adding 2 months and subtracting 6 days.

5. The client, who is Chinese American and pregnant, is receiving nutritional counseling about the need for increased amounts of calcium in her diet. Which response by the nurse is most helpful when the client states she does not consume any dairy products?

A. "Tell me how you perceive dairy products in your culture."
B. "Try having a glass of soy milk at each meal and at bedtime."
C. "Tell me about your intake of fortified tom and leafy green vegetables."
D. "Rice milk fortified with calcium and nettle tea are good calcium choices."

ANSWER: C

A. Although asking about the client's perception of dairy products shows cultural sensitivity, the client has already stated she does not consume these. This statement is not the most helpful regarding helping the client to increase calcium intake in her diet.
B. The nurse is making a recommendation without further assessing the client's dietary preferences. Soy milk should be calcium fortified; yet, according to research the calcium content can be as much as 85 percent less than the amount indicated on the product label.
C. Assessing the client's intake of calcium-rich foods is the best response. Both fortified tofu and leafy green vegetables are high in calcium and are common foods conSumed in the Chinese American diet.
D. Both rice milk fortified with calcium and nettle tea are sources of calcium; however, the nurse is making an assumption that the client consumes these beverages.

6 . The client tells the nurse, "Most days, I am so happy I am pregnant, but other days, I am not sure that I am ready to have a baby." Which is the most accurate response from the nurse?

A. "This is such a happy time in your life. You need to be optimistic to feel happy."
B. "How does your spouse feel about the pregnancy? I hope he is happy about the baby."
C. "Feeling differently from day to day is normal. How do you feel today?"
D. "Why do you feel this way? Is there something I can do to make it better for you?"

ANSWER: C

A. Not all clients consider pregnancy a happy time in their lives, and the nurse should never tell the client how to feel.
B. The nurse should not divert the client's concerns away from self by bringing up the father's adaptation to the pregnancy, even though paternal adaptation is related to maternal adaptation.
C. It is most therapeutic to acknowledge the client's feelings and probe for more information on her thoughts and feelings about the pregnancy.
D. The client may not be able to identify why she has the feelings she is experiencing or how the nurse can make her feel better. This response does not provide an avenue for further exploration of the client's concerns.

7. The nurse is teaching the pregnant client during her first trimester. The nurse identifies that which decision is most important for her to make first?

A. Bottle versus breastfeeding
B. Labor and delivery location
C. Pain management during labor
D. Method for delivery of the baby

ANSWER: B

A. The decision on feeding the newborn can be made up to the time of the first feeding.
B. A decision regarding labor and delivery location is the priority for the client in order to properly plan for a home birth versus a hospital birth, HCP availability at the location, and type of labor and delivery settings available at the location.
C. The decision on pain management can be made early but can be changed up through the early stages of labor.
D. The decision of delivery method should be made early but cannot be determined until the decision is made on labor and delivery location.

8. The pregnant client is experiencing low back pain. After determining that the client is not in labor, the nurse instructs the client to perform which exercises to increase comfort and decrease the incidence of the low back pain? Select all that apply.

A. Kegel exercises
B. Pelvic tilt exercises
C. Leg raises

D. Back stretch
E. Stepping

ANSWER: B, C, D

A. Kegel exercises strengthen the pubococcygeal muscle, decreasing urinary leakage, but do not relieve back pain.
B. Pelvic tilt exercises strengthen and stretch the abdominal and back muscles to relieve pain.
C. Leg raises strengthen and stretch leg and abdominal muscles to relieve pain.
D. Back stretch relieves pain from the back muscles caused by lordosis.
E. Stepping provides aerobic exercise, which is good for circulation but is not recommended to decrease low back pain.

9. The nurse's assessment findings of the pregnant Client include darkening of areola and nipple, presence of Goodell's sign, leukorrhea, HR 124 bpm, dysuria, and heartburn. Of these findings, how many require further evaluation? _ findings (Record your answer as a whole number.)

ANSWER: 3

There are three abnormal findings that require further evaluation. Leukorrhea needs to be distinguished from a vaginal infection, such as Candida albicans or a sexually transmitted infection. Heart rate can increase by 10 to 15 bpm during pregnancy, but an increase to 124 bpm is too high. Dysuria may be a sign of a UTI.

10. The pregnant client and her significant other are attending childbirth classes. The client asks for guidance on preparing her school-aged child for the new baby's birth. Which strategies might the nurse suggest that the client use with her child? Select all that apply.

A. Read books about bringing home a new baby.
B. Think of unique names for the new baby.
C. Help pack a bag for bringing the new baby home.
D. Explain how pregnancy occurred, if asked.
E. Help the child buy presents for the new baby.

ANSWER: A, B, C, E

A. Engaging the child in activities such as reading books about bringing the new baby home helps the child to feel a part of the experience.

B. Engaging the child in activities such as naming the new baby helps the child to feel a part of the experience.
C. Engaging the child in activities such as packing a bag for the new baby's coming home helps the child to feel a part of the experience.
D. Children younger than adolescents do not fully understand conception and pregnancy due to preoperational and concrete operational thinking. They are not usually asking for an explanation of sex during this time.
E. Engaging the child in activities such as buying presents for the new baby helps the child to feel a part of the experience.

11. The nurse is counseling the client who is pregnant. The nurse should teach that which assessment finding requires follow-up with the HCP?

A. Dependent edema
B. Edema in the hands
C. Generalized edema
D. Edema occurring every evening

ANSWER: C

A. Dependent edema is typical during pregnancy, resulting from relaxation of the blood vessels in the legs and decreased venous blood return.
B. Edema in the hands is typical during pregnancy, particularly when a high-sodium diet is consumed.
C. The nurse needs to teach the client that generalized edema is a sign of preeclampsia and requires follow-up by an HCP for further evaluation.
D. Edema that occurs every evening is a normal finding associated with decreased venous return and pelvic congestion from daily activity.

12. The client expresses concerns related to nausea in the first trimester of pregnancy. Which recommendation should the nurse make?

A. Eat crackers while still in bed in the morning.
B. Lie down and rest whenever nausea occurs.
C. Eat more frequently throughout the day.
D. Avoid food items containing ginger.

ANSWER: A

A. The nurse should instruct the client to eat dry crackers before rising from bed. This typically relieves some of the nausea.

B. Lying down when the nausea occurs may increase heartburn and reflux, thereby increasing nausea.
C. Eating frequently may increase heartburn and reflux, thereby increasing nausea.
D. Food items with ginger may help to alleviate nausea and are recommended (rather than avoided), including ginger tea.

13. The nurse is providing nutrition counseling to the client during her first prenatal clinical visit. Which statement, if made by the client, indicates that the client has an understanding of some of the nutritional requirements during pregnancy?

A. "I can eat cheese as an alternative to milk, as I don't care for milk."
B. "I should be eating more at each meal because I'm eating for two."
C. "I will need to limit my calories because I am already overweight."
D. "I should limit myself to eating only three healthy meals per day."

ANSWER: A

A. Cheese is a milk product and is an alternative to milk. This statement indicates understanding of nutritional requirements regarding milk and milk products.
B. Caloric intake needs to increase by 300 kcal per day during pregnancy to meet increased metabolic needs. However, "I'm eating for two" is a common misconception and leads to caloric intake greater than necessary.
C. Caloric intake needs to increase by 300 kcal per day and should not be limited during pregnancy.
D. Nutritional snacks throughout the day can provide for steady blood glucose levels and decrease the nausea associated with pregnancy. A limit of only three meals per day may not provide the client with enough calories to meet increased metabolic needs or may cause the client to eat more at each meal and increase nausea and bloating.

14. The nurse is providing nutrition counseling to a primigravida who is 10 weeks pregnant. Which meal choice stated by the client indicates she needs additional information?

A. Black beans, wild rice, collard greens
B. Dry cereal, milk, dried cranberries
C. Tuna, broccoli, baked potato
D. Beef strips, lentils, red peppers

ANSWER: C

A. Black beans provide a good source of calcium, iron, and protein. Black beans, wild rice, and collard greens provide fiber. Collard greens provide a good source of calcium and folic acid.
B. Dry cereal provides a good source of vitamin D, milk provides a good source of calcium, and dried cranberries provide a good source of calcium and iron.
C. Tuna contains mercury and should be limited in pregnancy due to risk of mercury poisoning. The nurse should provide this additional information.
D. Beef provides a good source of protein and iron, lentils provide a good source of iron, and red peppers provide a good source of vitamin C.

15. The nurse evaluates the pregnant client with sickle cell disease during her second trimester. The nurse should identify which manifestation as being related to sickle cell disease and not the pregnancy?

A. Hand and lower extremities edema
B. 2- Elevated serum blood glucose level
C. Decreased oxygen saturation level
D. Elevated blood pressure

ANSWER: C

A. Edema is a normal finding related to pregnancy. A decrease in osmotic pressure causes a shift of body fluids into interstitial spaces, leading to edema.
B. Elevated serrrm blood glucose levels after a meal help ensure that there is a sustained supply of glucose available for the fetus. Sustained elevation may be associated with pregnancy-related diabetes, not sickle cell disease.
C. Decreased oxygen saturation level is a clinical manifestation of sickle cell disease. Dehydration and anemia during pregnancy can result in vaso-occlusive crisis, which causes damage to RBCs and decreased oxygenation. The decrease in oxygenation manifests in decreased oxygen saturation levels.
D. Elevated BP is associated with essential hypertension or preeclampsia.

16 . The nurse is assessing the client who is 34 weeks' gestation. Place an X where the nurse should place the Doppler first to assess the FHR when the fetus is thought to be left occiput anterior ('LOA).





FHT are best heard in the lower left quadrant of the client's abdomen when the fetus is LOA.

17. The client who is 32 weeks pregnant asks how the nurse will monitor the baby's growth and determine if the baby is "really okay." Which assessments should the nurse identify for evaluating the fetus for adequate growth and viability? Select all that apply.

A. Auscultate maternal heart tones.
B. Measure the height of the fundus.
C. Measure the client's abdominal girth.
D. Complete a third-trimester ultrasound.
E. Auscultate the fetal heart tones (F HT).

ANSWER: B, E

A. The presence of fetal (not maternal) heart tones is a standard to assess fetal grth and viability.
B. Adequate fetal growth is evaluated by measuring the fundal height.
C. The abdominal circumference does not provide information about fetal growth. The increase in abdominal girth could be due to weight gain or fluid retention, not just growth of the baby.
D. Third-trimester ultrasound is neither routine nor advised for routine prenatal care because of the added cost and potential risk to the fetus.

E. Auscultating the FHT assesses fetal viability.

18. The client tells the nurse that she is using cocoa butter on her abdomen to prevent stretch marks. Which is the most accurate response from the nurse?

A. “That is wonderfull. If you continue to use cocoa butter daily, you should have no stretch marks after delivery.”
B. “The cocoa butter will not prevent stretch marks completely, but it will help to reduce their number.”
C. “The cocoa butter will not prevent stretch marks but Will decrease the appearance of the linea nigra.”
D. “Cocoa butter does not prevent stretch marks, but it soothes itching that occurs as your abdomen enlarges.”

ANSWER: D

A. Cocoa butter does not prevent striae gravidarum.
B. Cocoa butter does not decrease the incidence of striae gravidarum.
C. Cocoa butter does not prevent the appearance of linea nigra.
D. Cocoa butter is an emollient and provides moisture to the skin, thereby decreasing the itching associated with stretching of the skin as the abdomen enlarges.

19. The nurse is caring for the 24-year-old client whose pregnancy history is as follows: elective termination age 18 years, spontaneous abortion age 21 years, term vaginal delivery at 22 years old, and currently pregnant again. Which documentation by the nurse of the client’s gravidity and parity is correct?

A. G4P1
B. G4P2
C. G3Pl
D. G2P1

ANSWER: A

A. The client has been pregnant four times in all (gravidity). This client has delivered once (parity) and is currently pregnant, so the parity is 1.
B. Although the client has been pregnant four times in all (gravidity), she would have had to deliver two fetuses over 20 weeks old, regardless of whether either fetus survived.
C. The client has been pregnant four times in all, not three (gravidity). Parity of 1 is correct.

D. The client has been pregnant four times in all, not two times (gravidity). Parity of 1 is correct.

20. The nurse is caring for the pregnant client at 20 weeks' gestation. At what level should the clinic nurse expect to palpate the client's uterine height?

A. Two finger-breadths above the symphysis pubis
B. Halfway between the symphysis pubis and the umbilicus
C. At the level of the umbilicus
D. Two finger-breadths above the umbilicus

ANSWER: C

A. The uterine height is too low for 20 weeks' gestation. At 13 weeks, the uterus would be approximately two finger-breadths above the symphysis pubis.
B. The uterine height is too low for 20 weeks' gestation. At 16 weeks, the uterus would be approximately halfway between the umbilicus and symphysis pubis
C. At 20 gestational weeks, the uterus should be at the level of the umbilicus.
D. The uterine height is too high for 20 weeks' gestation. At 22 weeks, the uterus would be two finger-breadths above the umbilicus.

21. The nurse assesses the fundal height for multiple pregnant clients. For which client should the nurse conclude that a fundal height measurement is most accurate?

A. The pregnant client with uterine fibroids
B. The pregnant client who is obese
C. The pregnant client with polyhydramnios
D. The pregnant client experiencing fetal movement

ANSWER: D

A. Fibroids can increase fundal height and give a false measurement.
B. Obesity can increase fundal height and give a false meaSur'ernent.
C. Polyhydramnios can increase fundal height and give a false measurement.
D. Excessive fetal movement may make it difficult to measure the client's fundal height; however, it should not cause an inaccuracy in the measurement.

22. The nurse is conducting a physical assessment of the pregnant client. Which physiological cervical changes associated with pregnancy should the nurse expect to find? Select all that apply.

A. Formation of mucus plug
B. Chadwick's sign
C. Presence of colostrum
D. Goodell's sign
E. Cullen's sign

ANSWER: A, B, D

A. Cervical changes associated with pregnancy include the formation of the mucus plug. Endocervical glands secrete a thick, tenacious mucus, which accumulates and thickens to form the mucus plug that seals the endocervical canal and prevents the ascent of bacteria or other substances into the uterus. This plug is expelled when cervical dilatation begins.
B. Cervical changes associated with pregnancy include a bluish-purple discoloration of the cervix (Chadwick's sign) from increased vascularization.
C. Colostrum does occur with pregnancy but is a physiological change associated with the breasts and not with a cervical change.
D. Cervical changes associated with pregnancy include the softening of the cervix (Goodell's sign) from increased vascularization and hypertrophy and engorgement of the vessels below the growing uterus.
E. Cullen's sign is a bluish discoloration of the periumbilical skin caused by intraperitoneal hemorrhage. It can occur with a ruptured ectopic pregnancy or acute pancreatitis.

23. The nurse is assessing pregnant clients. During which time frames should the nurse expect clients to report frequent urination throughout the night? Select all that apply.

A. Before the first missed menstrual period
B. During the first trimester
C. During the second trimester
D. During the third trimester
E. One week following delivery

ANSWER: B, D

A. Women do not typically experience urinary changes before the first missed menstrual period.

B. Urinary frequency is most likely to occur in the first and third trimesters. First-trimester urinary frequency occurs as the uterus enlarges in the pelvis and begins to put pressure on the bladder.
C. During the second trimester, the uterus moves into the abdominal cavity, putting less pressure on the bladder.
D. In the third trimester, urinary frequency returns due to the increased size of the fetus and uterus placing pressure on the bladder.
E. Nocturnal frequency occurring a week after delivery may be a Sign of a UTI.

24. The pregnant client asks the nurse, who is teaching a prepared childbirth class, when she should expect to feel fetal movement. The nurse responds that fetal movement usually can first be felt during which time frame?

A. 8 to 12 weeks of pregnancy
B. 12 to 16 weeks of pregnancy
C. 18 to 20 weeks of pregnancy
D. 22 to 26 weeks of pregnancy

ANSWER: C

A. Eight to 12 weeks of pregnancy is too early to expect the first fetal movement to be felt.
B. Twelve to 16 weeks of pregnancy is too early to expect the first fetal movement to be felt.
C. Subtle fetal movement (quickening) can be felt as early as 18 to 20 weeks of gestation, and it gradually increases in intensity.
D. Twenty-two to 26 weeks of pregnancy is later than expected to feel the first fetal movement.

25. The nurse is caring for the pregnant client at the initial prenatal visit. Which universal screenings should the nurse complete? Select all that apply.

A. Taking the client's blood pressure
B. Doing a urine dipstick test for protein
C. Doing a urine dipstick test for glucose
D. Asking questions about domestic Violence
E. Asking questions about use of tobacco

ANSWER: A, D, E

A. BP screening should be performed at the initial prenatal visit to establish a baseline and to evaluate for actual or potential problems.

B. The use of routine urine dip assessments is unreliable in detecting proteinuria and is not always considered accurate. A urine sample should be collected and a UA completed to check for a UTI.
C. The urine dipstick test is of insufficient sensitivity to be used as a screening tool for glycosuria and is not always considered accurate. A urine sample should be collected and a UA completed to check for the presence of glucose.
D. Domestic violence screening should be performed at the initial prenatal visit to determine fetal and maternal risk for harm.
E. Screening for tobacco use should be performed at the initial prenatal visit to determine fetal and maternal risk. Smoking is associated with an increased risk for spontaneous abortion, preterm labor, and low birth weight.

26 . While assessing the prenatal client, the nurse found a number of concerning problems. Place the conceming problems in the sequence that they should be addressed by the nurse.

A. Currently bleeding and cramping
B. Previous varicella infection
C. Currently using tobacco
D. Has intense pelvic pain

ANSWER: D, A , C , B

D. Has intense pelvic pain is most concerning and should be addressed first by the nurse. It could be a symptom of a serious medical condition, such as a miscarriage, ectopic pregnancy, or appendicitis. This symptom represents a possible pathology that could warrant immediate surgical intervention.

A. Currently bleeding and cramping should be addressed next. It could be associated with the pelvic pain and could be a symptom of a serious medical condition, such as a miscarriage or ectopic pregnancy.

C. Currently using tobacco can put the client at risk for multiple adverse outcomes and should be addressed, although it is not an immediately concerning factor.

B. Previous varicella infection is important to document but poses no risk to the client or the fetus, so it is the least important to address.

27. The nurse is reviewing the laboratory report from the first prenatal visit of the pregnant client. Which laboratory result should the nurse most definitely discuss with the HCP?

A. Hemoglobin 11 gdL; hematocrit 33%
B. White blood cell (WBC) count: 7000/mm3
C. Pap smear: human papilloma virus changes
D. Urine pH: 7 .4; specific gravity 1.015

ANSWER: C

A. A normal Hgb is 12—15 g/dL; nutritional counseling should be initiated when the Hgb is less than 12 g/dL. An Hct of 33% is also low (normal Hct value = 38% to 47%; this decreases by 4% to 7% in pregnancy), but increasing the Hgb with iron-rich foods should also raise the Hot.
B. A WBC count of 7000/mm3 is within the normal range of 5000 to 12,000/mm3.
C. A Pap smear with HPV changes reflects an abnormal result. HPV changes are a risk factor for cervical cancer. The nurse should discuss the result with the HCP because it requires further assessment and follow-up.
D. A urine pH of 7.4 is within the normal range of 4.6 to 8.0; the specific gravity is within the normal range of 1-010 to 1.0.25.

28. The nurse is taking the health history of the 40-year-old pregnant client. Which identified medical conditions increase the client's risk for complications during her pregnancy? Select all that apply.

A. Diabetes mellitus type 2
B. Previous full-term pregnancy
C. Controlled chronic hypertension
D. New onset of iron-deficiency anemia
E. Hemorrhage with a previous pregnancy

ANSWER: A, C , D , E

A. DM is a risk factor for complications such as preeclampsia, eclampsia, dystocia, fetal macrosomia, recurrent monilial vaginitis and UTIs, ketoacidosis, congenital abnormalities, and others.
B. Having a previous fitll-term pregnancy is not a risk factor for a current pregnancy.
C. Controlled chronic hypertension may become uncontrolled during pregnancy due to water retention and other factors related to pregnancy. It is a risk factor for complications such as preeclampsia, placental abruption, and fetal hypoxia.

D. Iron-deficiency anemia is associated with an increased incidence of preterm birth, low-birth- weight infants, and maternal and infant mortality.
E. Previous pregnancy complications are a risk factor for complications.

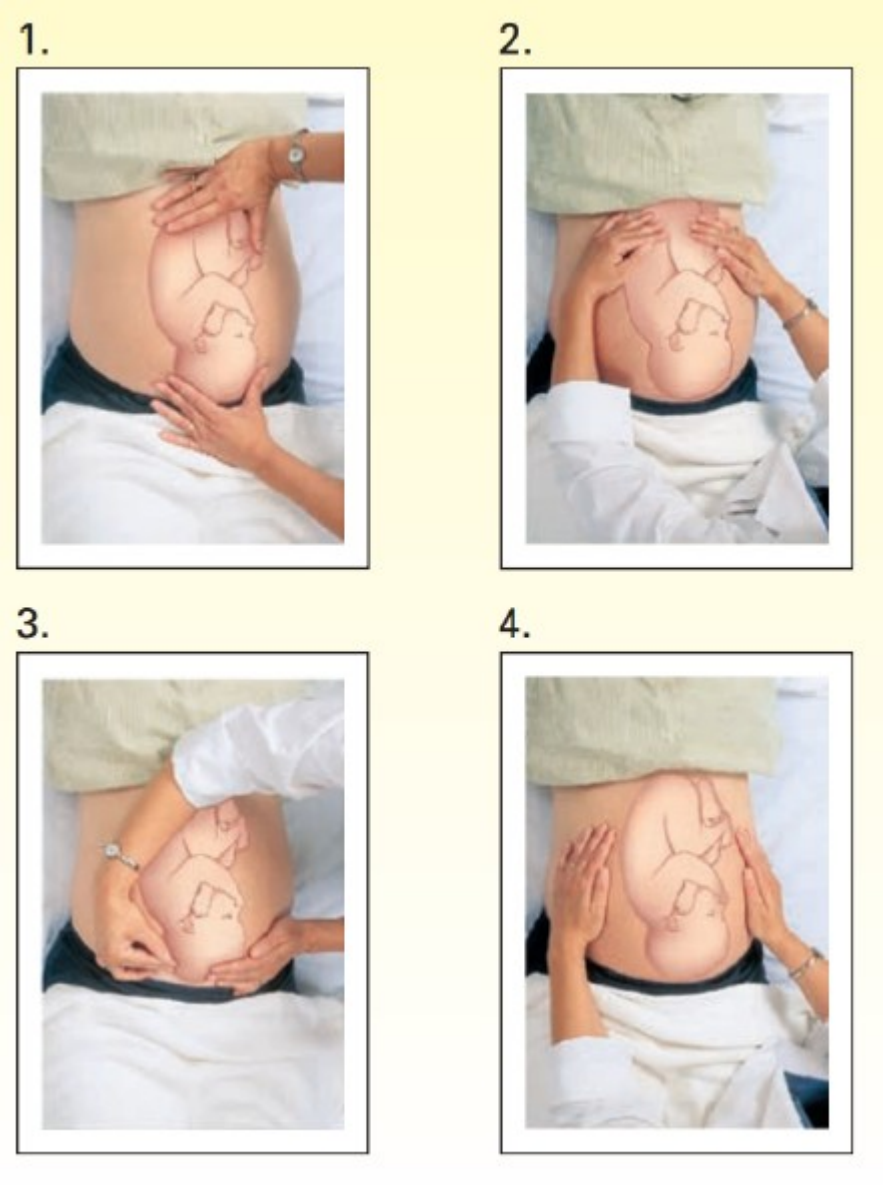
29. Multiple women are being seen in a clinic for various conditions. From which clients should the nurse prepare to obtain a group beta streptococcus (GBS) culture? Select all that apply.

A. The client who is having symptoms of preterm labor
B. The women who had a neonatal death 1 year ago
C. All pregnant women coming to the clinic for care
D. The women who had a spontaneous abortion 1 week ago
E. The women who had an abortion for an unwanted Pregnancy

ANSWER: A, C

A. The client in preterm labor should be screened for GBS infection. Between 10% and 30% of all women are colonized for GBS.
B. There is no indication that the client with a previous neonatal death is pregnant.
C. All pregnant women, regardless of risk status, should be screened for GBS infection. Between 10% and 30% of all women are colonized for GBS.
D. The client would not be screened for GBS solely because of a history of spontaneous abortion.
E. The client would not be screened for GBS solely because of an elective abortion.

30. The experienced nurse is observing the new nurse determine the fetal position of the pregnant client using Leopold maneuver. The experienced nurse determines that the new nurse correctly identifies the first Leopold maneuver when placing the hands in which position illustrated first?



ANSWER: B

A. This illustration shows the fourth Leopold maneuver. The nurse's fingertips are used to determine the location of the cephalic prominence.
B. This illustration shows the first step of Leopold's maneuver. The nurse palpates the fundus to determine which fetal body part (e.g., head or buttocks) occupies the uterine fundus.
C. This illustration shows the third Leopold maneuver ("Pawlik maneuver"). During this maneuver the fetal part in the fundal region is

compared with the part in the lower uterine segment. It is completed primarily to confirm that the fetus is in a cephalic (head) presentation.

D. This illustration shows the second Leopold maneuver. The second maneuver determines the location of the fetal back or spine.

31. The pregnant client has an abnormal l-hour glucose screen and completes a 3-hour, 1OO-g oral glucose tolerance test (OGTT). Which test results should the nurse interpret as being abnormal?

A. Fasting blood glucose = 104 mg/dL
B. 1-hour = 179 mg/dL
C. 2-hour = 146 mg/dL
D. 3-hour = 129 mg/dL

ANSWER: A

A. The fasting blood glucose of 104 mg/dL is abnormal for the OGTT; normal is 95 mg/Dl or lower.
B. A l-hour OGTT value of 179 mg/dL is normal; normal is 180 mg/dL or lower.
C. The 2-hour OGTT value of 146 mg/dL is normal; an abnormal value is 155 mg/dL or higher.
D. The 3-hour OGTT value of 129 mg/dL is normal; an abnormal value is 140 mg/dL or higher.

32. The nurse is reviewing the laboratory test results of the pregnant client. Which laboratory test findings would require further follow-up from the nurse?

Laboratory Test	Result
Hgb	10.6 g/dL
Indirect Coombs' test	Negative
50-g 1-hour glucose test	137
Glucosuria	Negative
Proteinuria	Trace
Group beta streptococcus (GBS)	Negative

A. Hemoglobin

B. 50-g, l-hour glucose test
C. Glucosuria
D. Proteinuria

ANSWER: A

A. The normal Hgb level should be 12—16 g/dL in the pregnant client. The nurse should encourage iron—rich foods.
B. The 50-g l-hour glucose test should be less than 140. Values over 140 warrant a 3-hour glucose screen to determine if the client has gestational diabetes.
C. The presence of glucose in the urine (glucosuria) is negative, which is a normal finding.
D. Proteinuria in trace amounts is connnon in pregnant women. although higher protein concentrations should be evaluated.

33. The nurse assesses the 34-week pregnant client (G2Pl). Place the assessment findings in the sequence that they should be addressed by the nurse from the most significant to the least significant.

A. Pedal edema at +3
B. BP 144/94 mm Hg
C. Positive group beta streptococcus vaginal culture
D. Fundal height increase of 4.5 cm in 1 week

ANSWER: B, D, A, C

B. BP 144/94 mm Hg warrants immediate evaluation. It could indicate preeclampsia, a condition that can progress to serious complications.

D. Fundal height increase of 4.5 cm in 1 week is abnormal and requires further follow-up. Normal fundal height increase is l to 2 cm per week. An increase in fundal size can be related to gestational diabetes, large-for-gestational—age fetus, fetal anomalies, or polyhydramnios.

A. Pedal edema at +3 may be a normal physiological process if it is an isolated finding. Pedal edema warrants further assessment because it can be a symptom of preeclampsia.

C. Positive group beta streptococcus vaginal culture warrants antibiotic treatment in labor but does not warrant intervention during the pregnancy.

34. The pregnant client tells the nurse that she thinks she is carrying twins. In reviewing the client's history and medical records, the nurse should determine that which factors are associated with a multiple gestation? Select all that apply.

A. Elevated serum alpha-fetoprotein
B. Use of reproductive technology
C. Maternal age greater than 40
D. History of twins in the family
E. Elevated hemoglobin levels

ANSWER: A, B, D

A. An elevated serum alpha-fetoprotein level (an oncofetal protein normally produced by the fetal liver and yolk sac) is associated with a multiple gestation.
B. The use of reproductive technology such as artificial insemination or fertility drugs is associated with a multiple gestation.
C. Maternal age greater than 40 is not associated with multiple gestation.
D. History of twins in the family is associated with a multiple gestation.
E. An elevated Hgb is not associated with multiple Gestation.

35. The 22—year-old client, who is experiencing vaginal bleeding in the first trimester of pregnancy, fears that she has lost her baby at 8 weeks. Which definitive test result should indicate to the nurse that the client's fetus has been lost?

A. Falling beta human chorionic gonadotropin (BHCG) measurement
B. Low progesterone measurement
C. Ultrasound showing a lack of fetal cardiac activity
D. Ultrasound determining crown—rump length

ANSWER: C

A. Falling BHCG levels do not conclusively diagnose fetal demise.
B. Low progesterone levels do not conclusively diagnose fetal demise.
C. Ultrasound is used to determine if the fetus has died. The lack of fetal heart activity in a pregnancy over 6 weeks determines a fetal loss.
D. Crown—rump length determines only the fetal gestational age.

36 . The pregnant client (GlPO) in the first trimester tells the nurse that she is anxious about losing her baby, prenatal care, and her labor and birth. Which teaching need should the nurse identify as priority?

A. Sexual relations with her spouse

B. Fetal growth and development
C. Options for labor and delivery
D. Preparing needed items for the baby

ANSWER: B

A. There is no indication that sexual relations are a concern for the client. Sexual relations, including intercourse, are safe during the first trimester.
B. Information about fetal growth and development is priority and important to address during the first trimester, especially when the client expresses concerns about losing her baby.
C. Labor and delivery options for the baby are priorities in the third trimester.
D. The completion of preparations for the baby is a priority in the third trimester.

37. The nurse is teaching the client who is wishing to travel by airplane during the first 36 weeks of her pregnancy. Which is the primary risk of air travel for this client that the nurse should address?

A. Risk of preterm labor
B. Deep vein thrombosis
C. Spontaneous abortion
D. Nausea and vomiting

ANSWER: B

A. Preterm labor is not associated with air travel.
B. The primary risk with air travel during pregnancy is DVT. Pregnancy increases the risk of blood coagulation, and prolonged sitting produces venous stasis.
C. The threat of spontaneous abortion diminishes during the second trimester. Spontaneous abortion is not associated with air travel.
D. Although nausea and vomiting can occur, they are not dangerous.

38. The first=trimester pregnant client asks the nurse if the activities in which she participates are safe in the first trimester. Which activity should the nurse verify as a safe activity during the client's first trimester?

A. Hair coloring
B. Hot tub use
C. Pesticide use
D. Sexual activity

ANSWER: D

A. Hair coloring should be avoided in the first trimester because the chemicals can be absorbed and pose a risk to the developing fetus.
B. Hot tub use should be avoided because it increases the client's body temperature. Maternal hyperthermia during the first trimester raises concerns about possible spontaneous abortion, CNS defects, and failure of neural tube closure.
C. Exposure to pesticides during pregnancy increases the risk for preterm birth, intrauterine growth restriction, childhood developmental delays, and infertility later in adulthood.
D. Sexual activity is not contraindicated in pregnancy unless a specific risk factor is identified.

39. The nurse is counseling the pregnant client who has painful hemorrhoids. Which initial recommendation should be made by the nurse?

A. Apply steroid-based creams.
B. Modify the diet to include more fiber.
C. Treat these surgically before delivery.
D. Increase intake of foods with flavonoids.

ANSWER: B

A. Steroid-based creams are frequently used for hemorrhoids, although evidence does not support their effectiveness.
B. An initial recommendation should be a high-fiber diet because high-fiber foods increase intestinal bulk and make passage of stool easier.
C. Surgical intervention to remove hemorrhoids is not recommended in pregnancy because hemorrhoids frequently resolve after pregnancy.
D. Flavonoids aid in symptom relief, although they are not recommended as the first line of t reatment.

40. The client presents with vaginal bleeding at 7 weeks. Which action should be taken by the nurse first?

A. Take the client's vital signs
B. Prepare examination equipment
C. Give 2 liters oxygen per nasal cannula
D. Assess the client's response to the situation

ANSWER: A

A. Assessing the client's VS should be completed first. Bleeding can cause hypotension.

B. Although preparing examination equipment is important, the nurse should first focus on the client.
C. Having oxygen available is important, but there is no indication that the client needs oxygen at this time.
D. Assessing the client's response is important, but assessment of physiological problems should occur first.

41. The client who is actively bleeding due to a spontaneous abortion asks the nurse why this is happening. The nurse advises the client that the majority of first-trimester losses are related to which problem?

A. Cervical incompetence
B. Chronic maternal disease
C. Poor implantation
D. Chromosomal abnormalities

ANSWER: D

A. Cervical incompetence can result in spontaneous abortion but does not account for the majority.
B. Chronic maternal disease can result in spontaneous abortion but does not account for the majority.
C. Poor implantation can result in spontaneous abortion but does not account for the majority.
D. Chromosomal abnormalities account for the majority of first-trimester spontaneous abortions.

42. The pregnant client presents with vaginal bleeding and increasing cramping. Her exam reveals that the cervical os is open. Which term should the nurse expect to see in the client's chart notation to most accurately describe the client' condition?

A. Ectopic pregnancy
B. Complete abortion
C. Imminent abortion
D. Incomplete abortion

ANSWER: C

A. In ectopic pregnancy, the pregnancy is outside of the uterus, and intervention is indicated to resolve the pregnancy.
B. A complete abortion indicates that the contents of the pregnancy have been passed.

C. In imminent abortion, the client's bleeding and cramping increase and the cervix is open, which indicates that abortion is imminent or inevitable.
D. In an incomplete abortion, a portion of the pregnancy has been expelled, and a portion remains in the uterus.

43. Interventions have been prescribed by the HCP for the client with decreased fetal movement at 35 weeks' gestation. Place the prescribed interventions in the sequence that they should be performed by the nurse.

A. Prepare for a nonstress test
B. Prepare for a biophysical profile
C. Palpate for fetal movement
D. Apply and explain the external fetal monitor

ANSWER: C, D, A, B

C. Palpate for fetal movement should be performed first. Assessment should be first to verify fetal movement.

D. Apply and explain the external fetal monitor should be next. The fetus should be monitored for heart rate changes.

A. Prepare for an NST. The NST is performed to determine fetal well-being.

B. Prepare for a biophysical profile (BPP). The BPP is an assessment of five fetal biophysical variables: FHR acceleration, fetal breathing, fetal movements, fetal tone, and amniotic fluid volume. The first criterion is assessed with the NST. The other variables are assessed by ultrasound scanning.

44. The nurse is screening prenatal clients who may be caniers for potential genetic abnormalities. Which ethnic group should the nurse identify as having the lowest risk for hemoglobinopathies, such as sickle cell disease and thalassemia?

A. African descent
B. Southeast Asian descent
C. Scandinavian descent
D. Mediterranean descent

ANSWER: C

A. Individuals of African descent are at risk for hemoglobinopathies and should be offered carrier screening.

B. Individuals of Southeast Asian descent are at risk for hemoglobinopathies and should be offered carrier screening.
C. Individuals of Scandinavian descent are not an identified risk group for hemoglobinopathies.
D. Individuals of Mediterranean descent are at risk for hemoglobinopathies and should be offered carrier screening.

45. The pregnant client tells the nurse that she smokes two packs per day (PPD) of cigarettes, has smoked in other pregnancies, and has never had any problems. What is the nurse's best response?

A. "I'm glad that your other pregnancies went well. Smoking can cause both maternal and fetal problems, and it is best if you could quit smoking."
B. "You need to stop smoking for the baby's sake. You could have a spontaneous abortion with this pregnancy if you continue to smoke."
C. "Smoking can lead to having a large baby, which can make delivery difficult. You may even need a cesarean section."
D. "Smoking less would eliminate the risk for your baby, and you would feel healthier during your pregnancy."

ANSWER: A

A. The nurse is acknowledging that the client did not experience problems with her other pregnancies but is also informing the client that smoking can cause maternal and fetal problems during pregnancy.
B. Telling the client to stop smoking for the baby's sake is confrontational, making the client less likely to listen to the nurse's teaching. Although spontaneous abortion is associated with tobacco use during pregnancy, the nurse is using a scare tactic rather than therapeutic communication.
C. Smoking can lead to a fetus that is small for gestational age, not a large baby.
D. Decreasing her smoking intake should be suggested; however, it does not eliminate the risk to the baby completely.

46 . The 28-year-old pregnant client (G3P2) has just been diagnosed with gestational diabetes at 30 weeks. The client asks what types of complications may occur with this diagnosis. Which complications should the nurse identify as being associated with gestational diabetes? Select all that apply.

A. Seizures
B. Large-for—gestational-age infant

C. Low—birth-weight infant
D. Congenital anomalies
E. Preterm labor

ANSWER: B, D

A. Seizures do not occur as a result of diabetes but can be associated with preeclampsia, another pregnancy complication.
B. Infants of diabetic mothers can be large as a result of excess glucose to the fetus.
C. Infants of diabetic mothers are usually large for gestational age and do not have a low birth weight.
D. Congenital anomalies are more common in diabetic pregnancies.
E. Preterm labor is not typically associated with maternal diabetes.

47. The client is diagnosed with pregnancy—related diabetes at 28 weeks' gestation. In teaching the client, the nurse includes which information for man- aging her blood glucose levels? Select all that apply.

A. Drawing glycosylated hemoglobin A1c levels
B. Performing home blood glucose monitoring
C. Developing a weight management plan
D. Engaging in appropriate daily exercise
E. Taking oral diabetic agents in the am.

ANSWER: A,B , C, D

A. Hgb A1c will be drawn and monitored throughout the pregnancy, with a goal of reaching a level of less than 7%.
B. Home blood glucose monitoring will help the client identify when her blood glucose is outside normal parameters.
C. Excessive weight gain worsens control of glucose levels.
D. Exercise adapted for the pregnant body is important to glucose control.
E. Oral diabetic agents are contraindicated in pregnant clients.

48. The nurse informs the pregnant client that her laboratory test indicates she has iron-deficiency anemia. Based on this diagnosis, the nurse should monitor this client for which problems? Select all that apply.

A. Susceptibility to infection
B. Easily fatigued
C. Increased risk for preeclampsia
D. Increased risk of diabetes
E. Congenital defects

ANSWER: A, B, C

A. Iron-deficiency anemia is associated with susceptibility to infection because oxygen is not transported effectively.
B. Iron-deficiency anemia is associated with fatigue because oxygen is not transported effectively.
C. Iron-deficiency anemia is associated with risk ofpreeclampsia because oxygen is not transported effectively.
D. Iron-deficiency anemia is not associated with an increased risk of diabetes.
E. Iron-deficiency anemia is not associated with an increased risk of congenital defects.

49. The pregnant client presents to a clinic with ongoing nausea, vomiting, and anorexia at 29 weeks' gestation. Her Hgb level is 5 g/dL, and a blood smear reveals that newly formed RBCs are macrocytic. Which condition should the nurse further explore?

A. Sickle cell anemia
B. Folic acid deficiency anemia
C. Beta-thalassemia. minor
D. Beta-thalassemia major

ANSWER: B

A. Sickle cell anemia is an inherited disorder in which the Hgb is abnormally formed. The chief symptom among individuals with sickle cell anemia is pain.
B. With the client's symptoms and laboratory findings, the nurse should further explore folic acid deficiency. It is usually seen in the third trimester and coexists with iron-deficiency anemia.
C. Beta-thalassemia minor is an inherited hematological disorder. There is a defect in the synthesis of the beta chain within the Hgb molecule. Beta- thalassemia minor typically results in mild anemia.
D. Beta-thalassemia major is an inherited hematological disorder. There is a defect in the synthesis of the beta chain within the Hgb molecule, but it is more severe than beta-thalassemia minor. Pregnancy in individuals with beta-thalassemia major is rare. Symptoms are usually severe anemia that warrants transfusion therapy.

50. The nurse is caring for the client admitted to the antepartum unit at 32 weeks' gestation with possible pretemr labor. The nurse is perfonning a fetal fibronectin (fFN) test. Which event, if it occurred, would require the nurse to reacollect the specimen?

A. The specimen is collected before a vaginal examination.
B. A lubricant was used to facilitate insertion of the swab.
C. The client reports that she has not had intercourse for 3 days.
D. The specimen is collected before other specimens are collected.

ANSWER: B

A. The specimen needs to be collected before a vaginal examination in order to ensure that the fluids are not contaminated.
B. When collecting a fetal fibronectin test swab, the nurse must not use lubricant, as it will interfere with the collection of the specimen and contaminate the specimen. If this occurs, the test will need to be repeated.
C. The client must not have had sexual intercourse within 24 hours of the specimen collection, as semen will contaminate the specimen.
D. The specimen must be collected before other specimens are collected to maintain the integrity of the specimen.

51. The client admitted in preterm labor is told that an amniocentesis needs to be performed. The client asks the nurse why this is necessary when the HCP has been performing ultrasounds throughout the pregnancy. Which is an appropriate response by the nurse?

A. "Your baby is older now, and an amniocentesis provides us with more information on how your baby is doing."
B. "An amniocentesis could not be performed before 32 weeks, so you will be having this test from now until delivery."
C. "Your doctor wants to make sure that there are no problems with the baby that an ultrasound might not be able to identify."
D. "With your preterm labor your doctor needs to know your baby's lung maturity; this is best identified by amniocentesis."

ANSWER: D

A. While an amniocentesis can provide fetal information that an ultrasound cannot, the rationale for the amniocentesis is to determine lung maturity. Stating additional information is too broad.

B. An amniocentesis can be performed as early as 12 weeks' gestation, not after 32 weeks.
C. The amniocentesis is not being performed to identify fetal anomalies.
D. The amniocentesis is being performed to determine fetal lung maturity. Once fetal lung maturity is determined, appropriate care can be planned, including administration of betamethasone, administration of tocolytics, or delivery of the baby.

52. The 42-year-old client who had a partial hydatidiform molar pregnancy 3 months ago asks the nurse whether she and her husband can try conceiving again. Which response by the nurse is incorrect and warrants follow-up action by the observing nurse manager?

A. "You will need serial levels of beta human chorionic gonadotropin (BHCG) drawn."
B. "You cannot conceive ever again because of your risk of choriocarcinoma."
C. "You should not become pregnant yet for 6 to 12 months."
D. "Your risk of another hydatidiform molar pregnancy is low."

ANSWER: B

A. Because of the risk of choriocarcinoma, serial serum BHCG testing is completed after a hydatidiform molar pregnancy.
B. Women who have had a molar pregnancy can conceive again once their BHCG levels are normal and remain normal for a certain time period, usually 6 to 12 months. This response by the nurse is incorrect and should be followed 11p by the observing nurse manager.
C. Because the client will undergo serial serum BHCG testing alter a hydatidiform molar pregnancy, she should not get pregnant for 6 to 12 months until testing is completed and it is confimied that she does not have a malignancy.
D. Couples with a past history of molar pregnancy have the same statistical chance of conceiving again and having a normal pregnancy as those without.

53. The pregnant client presents to the ED with a large amount of painless, bright red bleeding. She looks to be about 30 to 34 weeks pregnant based on her uterine size. She speaks limited English and is unable to communicate with the staff. Which actions should be taken by the nurse? Select all that apply.

A. Call for an interpreter for this client.
B. Establish an intravenous access.
C. Auscultate for fetal heart tones.

D. Place the client into a lithotomy position.
E. Perform a digital pelvic examination.

ANSWER: A , B , C

A. The nurse should call for an interpreter so that the client is able to communicate.
B. An 1V access should be performed by the nurse to administer any needed medications.
C. Auscultating F HT will provide information about fetal well-being.
D. Positioning the client in a lithotomy position can cause abdominal pain, and there is no indication that birth is imminent.
E. The pregnant client who presents in later pregnancy should never have a digital pelvic examination because this could cause additional bleeding, especially if she has placenta previa.

54. The nurse assesses the client in her third trimester with suspected placenta previa. Which finding should the nurse associate with placenta previa?

A. Cervix is 100% effaced
B. Painless vaginal bleeding
C. 3- The fetal lie is transverse
D. Absence of fetal movement

ANSWER: B

A. The nurse should not perform a vaginal examination to determine etfacement on the client with suspected placenta previa.
B. In placenta previa, the abnormal location of the placenta causes painless, bright red vaginal bleeding as the lower uterine segment stretches and thins.
C. The lie of the fetus is not associated with placenta previa.
D. An absence of fetal movement is always cause for concern but is not a primary symptom of placenta previa.

55. The client at 32 weeks' gestation presents to a hospital with a severe headache. Her admission BP is 184/104 mm Hg. Based on the assessment and findings of the serum laboratory report, which most severe complication warrants the nurse's further assessment?

Serum Laboratory Test	Client Results
Serum bilirubin	2.1 mg/dL
LDH	782 units/L
AST (SGOT)	84 units/L
ALT (SGPT)	51 units/L
Plt	99,000/mm^3
Hgb	12.1 g/dL
Hct	36.3%

A. Renal failure
B. Liver failure
C. Preeclampsia
D. HELLP syndrome

ANSWER: D

A. The laboratory results do not show the serum creatinine level, so no inferences can be made about renal failure.
B. Although liver enzymes are elevated, HELLP syndrome is a more severe complication associated with pregnancy.
C. Preeclampsia commonly coexists with HELLP syndrome; however, these laboratory findings show worsening symptoms that are associated with HELLP syndrome.
D. It is most important for the nurse to further assess for HELLP syndrome, a variation of pregnancy—induced hypertension characterized by hemolysis (elevated bilirubin), elevated liver enzymes, and low platelets.

56 . The 29-weeks-pregnant client presents to triage with decreased fetal movement. Her initial BP is 140/90 mm Hg. She states she "doesn't feel well" and her Vision is "blurry." Additional assessment findings include: normal reflexes, +2 proteinuria , trace pedal edema, and puffy face and hands. What is the most important information that the nurse should obtain from the client's prenatal record?

A. Depressed liver enzymes
B. BP at her first prenatal visit
C. Urine dipstick from last visit
D. The pattern of weight gain

ANSWER: B

A. Generalized vasospasm in preeclampsia would result in reduced blood flow to the liver and elevated, not depressed, liver enzymes.
B. The pregnant client with a BP that is greater than 140/90 mm Hg with the presence of proteinuria may have preeclampsia. New-onset hypertension is associated with preeclampsia.
C. The urine clip from the last visit should be reviewed but is not the most important to review because the significant information is the client's elevated BP.
D. The weight gain pattern should be reviewed but is not the most important to review because the significant information is the client's elevated BP.

57. The client at 31 weeks' gestation is diagnosed with mild preeclampsia and placed on home management. What information should the nurse include when providing home management instructions? Select all that apply.

A. "Plan for hospitalization when nearing 36 weeks' gestation."
B. "Weigh daily and inform the HCP of a sudden increase in weight."
C. "Home care will be consulted to take your blood pressure (BP) daily."
D. "Perform stretching and range-of-motion exercises twice daily."
E. "Rest as much as possible, especially in the lateral recumbent position."

ANSWER: B, D, E

A. A diagnosis of mild preeclampsia does not require hospitalization during the antepartum period unless home management fails to reduce the client's BP, or other complications occur.
B. A sudden weight gain could indicate that the mild preeclampsia is uncontrolled and the client is retaining fluid. The HCP should be consulted.
C. BP monitoring every 4 to 6 hours is recommended for the client with mild preeclampsia, but the BP can be taken by the client and does not require a consult with home care.
D. Stretching and ROM exercises can help prevent thrombophlebitis and venous stasis.
E. The lateral recumbent position improves uteroplacental blood flow, reduces maternal BP, and promotes diuresis.

58. The nurse is caring for the client with mild preeclampsia. The nurse should monitor for which complications associated with mild preeclampsia? Select all that apply.

A. Placental abruption

B. Hyperbilirubinemia
C. Nonreassuring fetal status
D. Severe preeclampsia
E. Gestational diabetes

ANSWER: A, B, C, D

A. Placental abruption can occur as a complication of preeclampsia due to hypoperfusion of the placenta and endothelial injury.
B. Hyperbilirubinemia can occur as a complication of preeclampsia due to hypoperfusion t0 the liver.
C. Nonreassuring fetal status can occur as a complication of preeclampsia due to hypoperfusion to the placenta.
D. Severe preeclampsia can occur as a complication of preeclampsia if the BP remains uncontrolled.
E. Gestational diabetes is not associated with preeclampsia.

59. The nurse is caring for the client who is Rh negative at 13 weeks' gestation. The client is having cramping and has moderate vaginal bleeding. Which HCP order should the nurse question?

A. Administer Rho(D) imnmne globulin (RhoGAM).
B. Obtain a beta human chorionic gonadotropin level (BHCG).
C. Schedule for an immediate ultrasound.
D. Place on continuous external fetal monitoring.

ANSWER: B

A. RhoGAM is indicated for any pregnant client with bleeding who is Rh negative.
B. Obtaining the BHCG level is not indicated at 13 weeks' gestation. BHCG levels are followed in early pregnancy before a fetal heartbeat can be confirmed.
C. An ultrasound can identify the cause of bleeding and confirm fetal viability.
D. Continuous external fetal monitoring can be used to confirm a fetal heartbeat, fetal viability, and fetal risk.

60. The nurse is caring for the client with a grade 3 placental abruption. Prioritize the prescribed interventions that the nurse should implement.

A. Obtain serum blood draw for clotting disorders
B. Administer 1 unit whole blood
C. Start oxygen at 2—4 liters per nasal cannula

D. Administer lactated Ringer's at 200 mL/hr
E. Prepare for cesarean delivery if fetal distress
F. Continuous external fetal monitoring

ANSWER: C, D, F, A, B , E

C. Start oxygen at 2—4 liters per nasal cannula is priority to maximize fetal oxygenation.

D. Administer lactated Ringer's at 200 mL/hr to treat hypovolemia, increase blood flow, and maximize oxygenation.

F. Continuous external fetal monitoring should be performed to identify fetal distress early.

A. Obtain serum blood draw for clotting disorders, specifically DIC.

B. Administer] unit whole blood is next and will depend on the amount of blood loss.

E. Prepare for cesarean delivery if fetal distress would be last because it would depend on the client and fetal status.

61. The nurse is caring for the pregnant client. The nurse identifies that the use of which street drug places the client at risk for placental abruption?

A. Heroin
B. Marijuana
C. Oxycodone
D. Cocaine

ANSWER: D

A. Heroin use during pregnancy is associated with intrauterine growth restriction, spontaneous abortion, preterm labor and birth, and stillbirth.
B. Marijuana use during pregnancy is primarily associated with intrauterine growth restriction.
C. Oxycodone (OxyContin) is synthetic morphine, and its use during pregnancy is associated with intrauterine growth restriction, spontaneous abortion, preterm labor and birth, and stillbirth.
D. The most commonly used drug that places the pregnant client at risk for placental abruption is cocaine. Stillbirth, preterm labor and birth, and small for gestational age are also associated with cocaine use during pregnancy.

62. The nurse is caring for the antepartum client with a velamentous cord insertion. The client asks what symptom she would most likely experience first if one of the vessels should tear. The nurse should respond that she would most likely experience which symptom first?

A. Vaginal bleeding
B. Abdominal cramping
C. Uterine contractions
D. Placental abruption

ANSWER: A

1. In a velamentous cord insertion, vessels of the cord divide some distance from the placenta in the placental membrane. Thus, the most likely first symptom would be vaginal bleeding.

2. Abdominal cramping is unlikely to occur; velamentous cord insertion is not related to uterine activity.

3. Contractions are unlikely to occur; velamentous cord insertion is not related to uterine activity.

4. An abruption, when the placenta comes off the uterine wall, results in severe abdominal pain.

63. The 38-year-old pregnant client at 22 weeks' gestation has just been told she has hydramnios after undergoing a sonogram for size greater than dates. The nurse should further assess for which conditions associated with hydramnios? Select all that apply.

A. A congenital anomaly
B. Gestational diabetes
C. Chronic hypertension
D. TORCH infections
E. Preeclampsia

ANSWER: A, B, D

1. In cases of anencephaly, the fetus is thought to urinate excessively because of overstimulation of the cerebrospinal centers, resulting in hydramnios.

2. The nurse should further assess for gestational diabetes. Hydramnios is thought to occur from excessive fetal urination due to fetal hyperglycemia.

3. Chronic hypertension is not associated with excess amniotic fluid.

4. Infants with mothers infected with toxoplasmosis, rubella, CMV, or herpes simplex virus infections (TORCH) are more likely to have hydramnios due to the inflammatory response and fluid accumulation.

5. Preeclampsia is not associated with excess amniotic fluid.

64. The client is hospitalized at 30 weeks' gestation in preterm labor. A test is performed to determine the lecithin to sphingomyelin (L/S) ratio, with results indicating a ratio less than 2:1. The nurse planning care for the client should expect to implement which interventions? Select all that apply.

A. Administering hydralazine
B. Maintaining the client on bedrest
C. Preparing the client for a nonstress test
D. Giving betamethasone
E. Administering metronidazole

ANSWER: B, C, D

A. Hydralazine (Apresoline) is an antihypertensive agent and is administered to clients experiencing preeclampsia, not preterm labor.
B. Bed rest will maximize placental oxygenation while fetal lung maturity continues.
C. The client should be prepared for a nonstress test. This is used to monitor for uterine contractions and labor. Labor needs to be stopped until the fetal lungs are more fully developed.
D. Betamethasone (Celestone Soluspan) is a corticosteroid and is given to stimulate fetal lung maturity.
E. Metronidazole (F lagyl) is an antiprotozoal and antibacterial agent used to treat a vaginal infection; there is no indication that the client has a vaginal infection

65. The client had a D&C for treating an incomplete spontaneous abortion. Which statements should the nurse include when preparing the client for discharge the same day? Select all that apply.

A. "Return for a blood transfusion if bleeding continues to be dark red."
B. "Intravenous antibiotics will be prescribed every 8 hours for two days."

C. “I can make a referral to a pregnancy loss support group if you like.”
D. “You need to use contraceptives to avoid getting pregnant for one year.”
E. “Someone should remain with you at home for the first 12 to 24 hours.”

ANSWER: C, E

A. Dark red blood does not necessarily indicate the need for a blood transfiision; it could be old blood. The client should notify the HCP if experiencing heavy bleeding following the D&C.
B. A D&C for treating incomplete spontaneous abortion does not require the routine administration of IV antibiotics.
C. The client who had an incomplete spontaneous abortion may experience grief and loss. The nurse should offer to do a referral to a pregnancy loss support group to provide ongoing support after hospital discharge.
D. There is no medical need for the client who had a spontaneous abortion to avoid pregnancy for one year.
E. A D&C is usually performed on an outpatient basis if there are no complications, and the client can return home a few hours after the procedure. Someone should remain with the client to ensure that she is safe and no complications develop.