

1 . The nurse assesses the pregnant client who comes to the triage unit and determines that she is at 4/50/—1 and that the fetal HR is 148. What priority information should the nurse collect before proceeding?

- A. Time and amount of last meal
- B. Number of weeks' gestation
- C. Who is attending the delivery
- D. History of previous illnesses

ANSWER: B

- A. The time and amount of last meal is important to know, but number of weeks' gestation is more important. This client is dilated at 4 cm and in active labor.
- B. Knowing the weeks of gestation is most important because if she is in premature labor, she may need to be given tocolytics to stop the process and to ensure adequate fetal lung maturity. If she is full term, the labor process could continue.
- C. Who will attend the delivery should be identified during admission to the labor unit, but it is not the most important when being evaluated in triage.
- D. History of previous illnesses should be collected during admission to the labor unit, but it is not the most important when being evaluated in triage.

2. The nurse, admitting a 40-week primigravida to the labor unit, just documented the results of a recent vaginal exam: 3/100/—2, RSP. How should the oncoming shift nurse interpret this documentation?

- A. The fetus is approximately 2 cm below maternal ischial spines.
- B. The cervix is totally dilated and effaced, with fetal engagement.
- C. The fetus is breech and posterior to the client's pelvis.
- D. The fetal lie is transverse, and the fetal attitude is flexion.

ANSWER: C

- A. At —2, the fetus is 2 cm above, not below, the maternal ischial spines. Two centimeters below the ischial spines would be recorded as +2.
- B. The cervix is 3 cm, not totally dilated. Total dilation would be documented as 10 for the first number. Also, the cervix is 100% effaced, which is total effacement (shortening and thinning out).
- C. The nurse should interpret 3/100/—2, RSP as the cervix is 3 cm dilated, 100% effaced, and the fetus is 2 cm above the maternal ischial spines. RSP means that the fetus is to the right of the mother's pelvis (R), with the sacrum as the specific presenting part (S), which is a breech position. This fetus is also posterior (P).

- D. Fetal lie (relationship of long axis or spine of fetus to long axis of mother) is longitudinal, not transverse. The documentation does not specify if the fetal attitude is flexion.

3. The nurse is caring for the low-risk laboring client during the first stage of labor. When should the nurse assess the FHR pattern? Select all that apply.

- A. Before administering medications
- B. At least every fifteen minutes
- C. After vaginal examinations
- D. During a hard contraction
- E. When giving oxytocin

ANSWERS: A, C

- A. The FHR may be affected by medications given to the mother. Therefore, a baseline FHR should be determined before giving any medication to the laboring client and then assessed again after giving the medication.
- B. The FHR should be assessed every 30 minutes (not 15 minutes) during the first stage of labor if the client is categorized as low risk. The FHR should be assessed every 15 minutes during the second stage of labor.
- C. The FHR should be assessed after each vaginal examination because the fetus could change positions, or be stressed by the intrusion of the examiner's fingers, or intact membranes could have ruptured.
- D. Although the FHR could be listened to during a contraction, it may be difficult due to muffling of the sounds and maternal movement. It is most important to listen before and after the contraction to more accurately detect FHR decelerations.
- E. If the client is classified as low risk, she should not be receiving oxytocin (Pitocin) for labor augmentation or induction.

4. After performing Leopold's maneuvers and determining that the fetus is in the RSA position, the nurse plans to assess the FHR. Place an X 011 the area of the client's abdomen where the nurse would best be able to listen to and count the FHR.



The right upper quadrant of the client's abdomen is the best area to listen to and count the FHR when the fetus is in the RSA (right sacrum anterior) position. When the fetus is in RSA position, the fetal back faces the client's right side. The fetal presentation is breech, and the fetal head is in the upper segment of the client's abdomen. The FHR is heard most clearly through the fetal back. This is designated as the area of maximal intensity or loudness, providing clarity of fetal heart sounds.

5. The laboring client in the first stage of labor is talking and laughing with her husband. The nurse should conclude that the client is probably in what phase?

- A. Transition
- B. Active
- C. Active pushing
- D. Latent

ANSWER: D

- A. During the transition phase (8—10 cm), the client is usually more restless, irritable, and more likely to lose control.
- B. During the active phase (4—7 cm), the client may become more anxious and fatigued and needs to concentrate on breathing techniques to cope with the increasingly stronger contractions.
- C. The client who is actively pushing is focusing on how effective she is in the descent of the fetus and concentrating on how she is coping with contractions. She is usually not expressing happiness or laughter, and is not talkative.
- D. During the latent phase (1—3 cm), the client is usually happy and talkative.

6. The nurse just administered butorphanol tartrate as prescribed to the client in active labor. Following administration of butorphanol tartrate, what is the nurse's most important action to help prevent side effects?

- A. Assess the client's bladder for distention
- B. Place the client on seizure precautions
- C. Assess the client's body for itchy rash
- D. Evaluate her vital signs and pulse oximetry

ANSWER: D

- A. Although bladder distention is a possible side effect of butorphanol tartrate, it is not common and is not the most important assessment.
- B. Seizures are not a potential side effect of butorphanol tartrate.
- C. An itchy rash is not a potential side effect of butorphanol tartrate.
- D. Evaluating maternal VS and pulse oximetry would determine changes in respiratory and cardiac status. Respiratory depression in both the mother and fetus can occur with butorphanol tartrate (Stadol).

7. The nurse is caring for the Muslim client in labor. What should the nurse be most aware of as a possible belief of the client?

- A. Male health care providers should enter the room after receiving permission from her husband.
- B. The client may prefer to eat only "hot" foods and to drink only special tea and warm water.
- C. Fathers, rather than female relatives, are usually present to provide support during the labor.
- D. She will be more likely to moan, scream, or cry out in pain during each labor contraction.

ANSWER: A

- A. Some Muslim women are not comfortable with male HCPs and may prefer to have their husband in the room if a male is involved in care.
- B. Eating “hot” foods and drinking special tea and warm water are preferences of Hmong women from Laos and not those of Muslim women.
- C. The Muslim client may choose to have her husband, a male relative, or a female friend or relative provide support during childbirth, rather than her father.
- D. Muslim women are more likely to be silent and stoic during labor contractions, and not cry out in pain.

8. The laboring client is at 5/100/0, RCA, and having difficulty coping with her contractions. She does not want an epidural analgesia or medications. How can the nurse best assist the client and her partner at this time?

- A. Apply counter pressure to sacral area with a firm object.
- B. Implement effleurage (light massage) of the abdomen.
- C. Provide a quiet, calm, and relaxed labor environment.
- D. Re-emphasize modified-paced breathing techniques.

ANSWER: D

- A. Counter pressure can be helpful to cope with internal pressure sensations and pain in the lower back when the fetus is in posterior position. The fetus is ROA or right occiput anterior position.
- B. Effleurage can distract from contraction pain during the latent phase of the first stage of labor. This client is in active labor, and as labor progresses, hyperesthesia occurs, increasing the likelihood that effleurage will be uncomfortable and less effective.
- C. Providing a quiet, calm, and relaxed labor environment should be part of the nursing responsibilities to help the client cope with contractions, but this is not the best option.
- D. Breathing techniques provide distraction, reduce pain perception, and help the client maintain control during labor. The modified-paced breathing technique is usually more effective during active labor (4—7 cm). The client is at 5 cm. The modified-paced technique is performed at about twice the normal breathing rate and requires that the client remain alert and concentrate fully on her breathing.

9. The labor nurse observes a sinusoidal FHR pattern on the monitor tracing. How should the nurse interpret this pattern?

- A. The fetus may be in a sleep state.
- B. Congenital anomalies are possible.
- C. This may indicate severe fetal anemia.
- D. This predicts normal fetal well-being.

ANSWER: C

- A. An FHR pattern having minimal variability (not a sinusoidal pattern) might indicate that the fetus is in a sleep state.
- B. Absent or minimal variability, not a sinusoidal F HR pattern, could indicate possible congenital anomalies.
- C. A sinusoidal pattern, which is regular, smooth, undulating, and uncommon, classically occurs with severe fetal anemia as a result of abnormal perinatal conditions.
- D. Moderate variability of the FHR (not a sinusoidal pattern) reflects normal fetal well-being.

10. The continuous electronic FHR monitor tracing on the laboring client is no longer recording. How should the nurse immediately respond?

- A. Conclude that there is a problem with the baby and call for help.
- B. Check that there is adequate gel under the transducer and reposition.
- C. Give the client oxygen via facemask at 8 to 10 liters per minute.
- D. Auscultate fetal heart rate by fetoscope and assess maternal vital signs.

ANSWER: B

- A. Assessing for adequate gel under the transducer and repositioning should be done before assuming there is a problem with the baby's HR.
- B. When the FHR monitor tracing is no longer recording, the nurse should first check for adequate gel under the transducer. There needs to be adequate gel under the transducer for good conduction, and adding gel frequently corrects the problem.
- C. There is no indication to give oxygen to the client.
- D. Auscultating FHR by fetoscope and assessing maternal VS could be completed, but not until the transducer has been checked.

11 . The nurse is caring for the client in labor. Which assessment finding would help the nurse determine whether the client is in the third stage of labor?

- A. Lengthening of fetal cord
- B. Increased bloody show
- C. A strong urge to push
- D. More frequent contractions

ANSWER: A

- A. The third stage of labor lasts from the birth of the baby until the placenta is expelled. Lengthening of the fetal cord is one of several signs indicating placental separation.

- B. Bloody show is pink and mucoid in nature and occurs during the first and second stages of labor. During the third stage, there may be increased vaginal bleeding that is bright or dark red.
- C. A strong urge to push may occur during the first and second stages of labor.
- D. More frequent contractions occur during the first and second stages of labor.

12. The client in labor tells the nurse that it feels like her membranes just ruptured. Which assessment finding of the amniotic fluid would indicate that it is normal?

- A. Cloudy in color
- B. Has a strong odor
- C. Meconium stained
- D. Has apH of 7.1

ANSWER: D

- A. Normal amniotic fluid should be clear. Cloudiness could indicate the presence of meconium or an intrauterine infection.
- B. Amniotic fluid should have no odor. Any odor may indicate the presence of infection.
- C. Amniotic fluid should be clear. Meconium stained could indicate fetal distress.
- D. The pH of amniotic fluid is usually between 6.5 and 7.5, which is more alkaline than urine or purulent material.

13. The laboring multigravida client's last vaginal examination was 8/90/+1. The client now states feeling rectal pressure. Which action should the nurse perform first?

- A. Encourage the client to push.
- B. Notify the obstetrician or midwife.
- C. Help the client to the bathroom.
- D. Complete another vaginal exam.

ANSWER: D

- A. The client needs to be fully dilated (10 cm, not 8 cm) and fully effaced (100%, not 90%) before being encouraged to push. Pushing too early may cause cervical edema and lacerations and may slow the labor process.
- B. Rectal pressure may indicate that the client has progressed since the last vaginal exam- Another vaginal exam should be performed before contacting the obstetrician or midwife.
- C. During labor, rectal pressure is usually not due to the need for a bowel movement because intestinal motility decreases.
- D. The nurse should first evaluate labor progress by performing another vaginal exam. Previously the client was almost fully effaced (90%), and fetal station

was 1 cm below the ischial spines (+1). Rectal pressure is often due to pressure exerted during descent of the fetal presenting part.

14. The laboring client's amniotic membranes have just ruptured. Which nursing action should be priority?

- A. Monitor maternal temperature.
- B. Inspect characteristics of the fluid.
- C. Perform a sterile vaginal examination.
- D. Assess the fetal heart rate pattern.

ANSWER: D

- A. The maternal temperature should be monitored during labor and at least every two hours after the membranes rupture to assess for possible infection. However, this is not the priority nursing action.
- B. Characteristics of the fluid (color, odor, and estimated amount) should be assessed and documented after rupture, but this is not the priority at this time.
- C. A vaginal exam that assesses the progress of labor does need to be performed right after membrane rupture, but it is not the priority.
- D. The priority nursing action is to assess the FHR pattern for several minutes immediately after membrane rupture to determine fetal well being. The umbilical cord may prolapse as a result of the rupture, causing life-threatening changes in the FHR.

15. The client in labor received an epidural anesthesia 20 minutes ago. The nurse assesses that the client's BP is 98/62 mm Hg and that the client is lying supine. What should the nurse do next?

- A. Increase the lactated Ringer's infusion rate.
- B. Elevate the client's legs for 2 to 3 minutes.
- C. Place the bed in 10- to 20-degree Trendelenburg.
- D. Position the client in a left side-lying position.

ANSWER: D

- A. Increasing the infusion rate may be implemented if repositioning the client does not correct the hypotension.
- B. Elevating the client's legs for 2 to 3 minutes is done with severe or prolonged hypertension to increase blood return from the extremities. It may be implemented after repositioning to left side, increasing the IV rate, and placing in Trendelenburg position.

- C. Placing in 10- to 20-degree Trendelenburg position is usually implemented if the BP does not increase within 1 to 2 minutes after repositioning to left side and increasing the IV flow rate.
- D. The first action is to place the client in a left side-lying position. This displaces the uterus and alleviates aortocaval compression.

16. The nurse explained the process of cervical effacement to the client in early labor. Which statement by the client indicates that she understands the information?

- A. "The cervix will widen from less than 1 cm to about 10 cm."
- B. "The cervix will pull or draw up and become paper-thin."
- C. "The cervical changes will cause my membranes to rupture."
- D. "The cervical changes will help my baby to change position."

ANSWER: B

- A. Widening of the cervix describes cervical dilation, not effacement.
- B. In cervical effacement, the cervix progressively changes from a thick and long structure, to paper thin. This statement indicates that the client understands the information.
- C. Cervical changes will not cause membranes to rupture. The power of contractions causes cervical changes (effacement and dilation) and, possibly, membrane rupture.
- D. Cervical changes will not help the fetus to change position. Fetal descent is thought to occur from the pressure of contractions, especially from the fundus, and from the pressure of the amniotic fluid. Fetal position changes also occur from the fetal head and body adjusting to the maternal pelvis as they descend.

17. The nurse observes on the monitor tracing of the client in the transition phase of labor that the baseline FHR is 160 and that there is moderate variability with V-shaped decelerations unrelated to contractions. What should the nurse do first?

- A. Prepare for delivery.
- B. Notify the obstetrician.
- C. Apply oxygen nasally.
- D. Reposition the client.

ANSWER: D

- A. The fetus has a normal baseline HR and good variability. There is no indication that immediate delivery is necessary. Other measures could correct the V-shaped (variable) decelerations.

- B. Other nursing measures are used to correct the V-shaped (variable) decelerations prior to contacting the obstetrician (or midwife).
- C. Repositioning the client should be implemented prior to giving her oxygen.
- D. Repositioning the client to her side or to knee-chest should be done first to take the pressure off the umbilical cord. Variable decelerations usually result from cord compression and stretching during fetal descent.

18. The nurse is caring for the pregnant client. Which assessment findings help the nurse determine that she may be in true labor? Select all that apply.

- A. Progressive cervical dilation and effacement
- B. Walking usually increases contraction intensity
- C. Warm tub baths and rest lessen contractions
- D. Discomfort is usually in the client's abdomen
- E. Contractions increase in duration and intensity

ANSWERS: A, B, E

- A. Progressive cervical dilation and effacement indicate true labor. In false labor, the contractions may occur for several hours, but there is no cervical change.
- B. In true labor, walking usually increases the intensity of contractions. In false labor, walking usually has little or no effect on contractions and may sometimes decrease the frequency, intensity, and duration of contractions.
- C. Warm tub baths and rest lessen contractions during false labor. In true labor, contractions do not decrease with warm tub baths or rest.
- D. Discomfort is usually in the client's abdomen during false labor. Discomfort begins in the back and radiates around to the abdomen during true labor.
- E. Contractions increase in duration and intensity during true labor, while there is usually no change in contractions during false labor.

19. The nurse is assessing the laboring client who is morbidly obese. The nurse is unable to determine the fetal position. Which action should be performed by the nurse to obtain the most accurate method of determining fetal position in this client?

- A. Inspect the client's abdomen.
- B. Palpate the client's abdomen.
- C. Perform a vaginal examination.
- D. Perform transabdominal ultrasound.

ANSWER: D

- A. Inspection of the abdomen can be used to determine fetal position, but because the client is obese, this is not the most accurate method.
- B. Palpation of the abdomen can be used to determine fetal position, but because the client is obese, this is not the most accurate method.
- C. Vaginal examination can be used to determine fetal position, but because the client is obese, this is not the most accurate method.
- D. Real-time transabdominal ultrasound (US) is the most accurate assessment measure to determine the fetal position and is frequently available in the birthing setting. US images may be used to assess fetal lie, presentation, and position in the morbidly obese client.

20. The nurse is caring for multiple clients. The nurse determines that which client would be a candidate for intermittent fetal monitoring during labor?

- A. The client with a previous cesarean birth
- B. The primigravida client at 41 weeks
- C. The client with preeclampsia
- D. The client with gestational diabetes

ANSWER: B

- A. Women with a previous cesarean birth are at an increased risk for uterine rupture.
- B. The client who is overdue by 7 days but has a reassuring FHR pattern is able to have intermittent fetal monitoring.
- C. Women with preeclampsia are at an increased risk for placental insufficiency and need continuous monitoring during labor.
- D. Women with gestational diabetes are at an increased risk for placental insufficiency and need continuous monitoring during labor.

21 . The nurse is caring for the client in preterm labor who has gestational diabetes. The nurse determines that the client has a reactive NST when which findings are noted?

- A. Two fetal heart rate (FHR) accelerations of 15 beats per minute (bpm) above baseline for at least 15 seconds in a 20-minute period
- B. An FHR acceleration of 15 bpm above baseline for at least 10 seconds in the 40-minute time period for the NST
- C. Two FHR accelerations of 20 bpm above baseline when the mother changes position during the 20-minute NST
- D. The occurrence of at least three mild repetitive variable decelerations in the 20-minute time period for the NST

ANSWER: A

- A. The FHR is monitored by the placement of an electronic fetal monitor that has an ultrasound transducer to record the FHR and a tocody-namometer to detect uterine or fetal movement. The client is given a handheld marker to indicate when she feels fetal movement. Fetal movement is accompanied by an increase in the FHR in the healthy fetus. The criterion for a reactive (normal) NST is the presence of two FHR accelerations of 15 bpm above baseline lasting 15 seconds or longer in a 20-minute period.
- B. One FHR acceleration during a 40-minute period is insufficient and indicates a nonreactive (abnormal) NST.
- C. Maternal movement can cause an inconsistency in the FHR on the monitor strip and should be avoided during an NST.
- D. The occurrence of at least three mild repetitive variable decelerations in a 20-minute period describes a nonreactive (abnormal) NST and fetal intolerance.

22. The 39-year-old client with type 1 DM presents at 36 weeks' gestation with regular contractions. An HCP decides to do an amniocentesis. Which statement best supports why the nurse and NA should prepare the client for an amniocentesis now?

- A. Diabetic women have a higher incidence of birth defects, and the HCP wants to determine if a birth defect is present.
- B. The client is over 35, at 36 weeks' gestation with regular contractions, and is at risk for chromosomal disorders.
- C. An amniocentesis performed at 36 weeks' gestation is being completed to determine if the fetal lungs have matured.
- D. The amniocentesis is more accurate than the fetal fibronectin test in determining if delivery is imminent.

ANSWER: C

- A. In mid pregnancy, the cells in amniotic fluid can be studied for genetic abnormalities such as Down's syndrome and birth defects, but amniocentesis would not be performed for this purpose when the client is in preterm labor.
- B. Many women over the age of 35 have amniocentesis completed to test for chromosomal disorders, but not this late in the pregnancy.
- C. Infants of diabetic mothers are less likely to have mature lung capacity at 36 weeks; knowing lung maturity can influence whether delivery should proceed.
- D. Fetal fibronectin testing is used to determine if a preterm birth is likely, but it cannot be used to determine lung maturity.

23. The laboring client is experiencing dyspnea, diaphoresis, tachycardia, and hypotension while lying on her back. Which intervention should the nurse implement immediately?

- A. Turn the client onto her left side-
- B. Turn the client onto her right side.

- C. Notify the attending obstetrician.
- D. Apply oxygen by nasal cannula.

ANSWER: A

- A. When the laboring client lies flat on her back, the gravid uterus completely occludes the inferior vena cava and laterally displaces the subrenal aorta. This aortocaval compression reduces maternal cardiac output, producing dyspnea, diaphoresis, tachycardia, and hypotension. Other symptoms include air hunger, nausea, and weakness. A left side-lying position decreases aortocaval compression.
- B. Lying on the right side increases aortocaval compression.
- C. Notifying the obstetrician is not the first intervention. The obstetrician would be notified if symptoms are not relieved by a left side-lying position.
- D. Applying oxygen may be needed, but first the client should be placed left side-lying.

24. The nurse notifies the HCP after feeling a pulsating mass during the vaginal examination of a newly admitted full-term pregnant client. Which HCP order should the nurse question?

- A. Prepare for possible cesarean section.
- B. Place the client in a knee-chest position.
- C. Initiate a low-dose oxytocin IV infusion.
- D. Give terbutaline 0.25 mg subcutaneously-

ANSWER: C

- A. The pulsating mass indicates umbilical cord prolapse, which is a medical emergency. If vaginal birth is not imminent, a cesarean section is preferred in order to prevent lypoxic acidosis.
- B. Placing the client in a knee—chest position relieves pressure on the umbilical cord.
- C. The nurse should question the administration of oxytocin (Pitocin). Oxytocin is used for stimulating contraction of the uterus. Uterine contractions can cause further umbilical cord compression.
- D. Terbutaline (Brethine) is a tocolytic agent used to reduce contractions.

25. The primigravida client has been pushing for 2 hours when the infant's head emerges. The infant fails to deliver, and the obstetrician states that the turtle sign has occurred. Which should be the nurse's interpretation of this information?

- A. There is cephalopelvic disproportion.
- B. The infant has a shoulder dystocia.
- C. The infant's position is occiput posterior.

D. The infant's umbilical cord is prolapsed.

ANSWER: B

- A. Cephalopelvic disproportion occurs when the head is too large to fit through the client's pelvis. Fetal descent ceases, and infant's head would not emerge.
- B. The "turtle sign" occurs when the infant's head suddenly retracts back against the mother's perineum after emerging from the vagina, resembling a turtle pulling its head back into its shell. This head retraction is caused by the infant's anterior shoulder being caught on the back of the maternal pubic bone (shoulder dystocia), preventing delivery of the remainder of the infant.
- C. Persistent occiput posterior results in prolonged pushing; however, once the head is born, the remainder of the birth occurs without difficulty.
- D. A cord prolapse occurs when the umbilical cord enters the cervix before the fetal presenting part and is considered a medical emergency.

26. The nurse is caring for the client who is being evaluated for a suspected malpresentation. The fetus's long axis is lying across the maternal abdomen, and the contour of the abdomen is elongated. Which should be the nurse's documentation of the lie of the fetus?

- A. Vertex
- B. Breech
- C. Transverse
- D. Brow

ANSWER: C

- A. Vertex presentations result in the he's being vertical.
- B. Breech presentations result in the he's being vertical.
- C. A transverse lie occurs in 1 in 300 births and is marked by the fetus's lying in a side-lying position across the abdomen.
- D. A brow presentation is also a vertical lie.

27. The nurse is caring for the client who has been in the second stage of labor for the last 12 hours. The nurse should monitor for which cardiovascular change that occurs during this stage of labor?

- A. An increase in maternal heart rate
- B. A decrease in the cardiac output
- C. An increase in the white blood cell (WBC) count
- D. A decreased intravascular volume during contractions

ANSWER: A

- A. Maternal HR is normally increased due to pain resulting from increased catecholamine secretion, fear, anxiety, and increased blood volume.
- B. When the laboring client holds her breath and pushes against a closed glottis, intrathoracic pressure rises. Blood in the lungs is forced into the left atrium, leading to a transient increase (not decrease) in cardiac output.
- C. Although the WBCS increase to 25,000/mm³ to 30,000/mm³ during labor and early postpartum as a physiological response to stress, this is not a cardiovascular change.
- D. During the second stage of labor, the maternal intravascular volume is increased (not decreased) by 300 to 500 mL of blood from the contracting uterus.

28. The pregnant client presents with regular contractions that she describes as strong in intensity. Her cervical exam indicates that she is dilated to 3 cm. Which conclusion should the nurse make based on this information?

- A. The client is experiencing early labor.
- B. The client is experiencing false labor.
- C. The client has experienced cervical ripening.
- D. The client has experienced lightening.

ANSWER: A

- A. Early labor is a pattern of labor that occurs when contractions become regular and the cervix dilates to 3 cm.
- B. False labor occurs when Braxton—Hicks contractions are strong enough for the client to believe she is in actual labor. The contractions are infrequent or do not have a definite pattern. The lack of cervical change is also consistent with false labor. The latent phase is characterized by regular contractions, although fetal descent may not occur.
- C. Cervical ripening (softening, effacement, and increased distensibility) begins about 4 weeks before birth. There is no information in the stem about cervical ripening.
- D. Lightening is settling or lowering of the fetus into the pelvis. Lightening can occur a few weeks or a few hours before labor. There is no information in the stem about lightening.

29. The nurse is reviewing laboratory results of the client in labor prior to her receiving epidural anesthesia. Which result is most important to report to the HCP prior to the initiation of the epidural?

- A. White blood cells: 24,000/mm³
- B. Glucose: 78 grams/dL

- C. Hemoglobin: 10.2 g/dL
- D. Platelets: 100,000/mm³

ANSWER: D

- A. The WBC count in labor is normally increased due to the stress of labor and can be as high as 25,000/mm³ to 30,000/mm³.
- B. The glucose level normally falls during labor because of an expenditure of energy in labor.
- C. Anemia or a reduction in the Hgb and Het is common in pregnancy. Hgb levels less than 10 g/dL are considered abnormal in pregnancy.
- D. The nurse should report the low platelet count of 100,000/mm³ (normal is 150,000 to 450,000/mm³). A low count can contribute to bleeding and affect the use of epidural anesthesia.

30. The nurse's laboring client presents with ruptured membranes, frequent contractions, and bloody show. She reports a greenish discharge for 2 days. Place the nurse's actions in the order that they should be completed.

- A. Perform a sterile vaginal exam
- B. Assess the client thoroughly
- C. Obtain fetal heart tones
- D. Notify the health care provider

ANSWER: C, A, B, D

C. Obtain FHT should be first. The client has ruptured membranes with greenish fluid, and the fetus could be experiencing nonreassuring fetal status.

A. Perform a sterile vaginal exam to determine labor progression.

B. Assess the client thoroughly. This needs to be completed prior to notifying the HCP with the information.

D. Notify the HCP is last of the options. Assessment findings would need to be reported to the HCP. The client should then be moved into an inpatient room.

31 . The nurse is about to auscultate an F HR on the client in triage. What information should the nurse determine first in order to find the correct placement for auscultation?

- A. Position of the fetus
- B. Position of the placenta
- C. Presence of contractions
- D. Where to apply the ultrasonic gel

ANSWER: A

- A. The nurse should first perform Leopold's maneuvers to determine the fetal position. This will enable proper placement of the Doppler device over the location of the FHR.
- B. The position of the placenta can provide important information. However, if the Doppler device is placed over the placenta, the nurse will hear a swishing sound and not the FHR.
- C. The FHR is still assessed regardless of the presence of contractions. The nurse who has difficulty obtaining an FHR because of a contraction can listen again once the contraction has concluded.
- D. Ultrasonic gel is used with any ultrasound device and allows for the conduction of sound and continuous contact of the device with the maternal abdomen. In order to apply the gel to the correct location, the position of the fetus must be known.

32. The nurse is assessing the Hispanic client who is in the active stage of labor. Which is the most crucial information that the nurse should assess related to the client's ethnicity and stage of labor?

- A. Choice of pain control measures
- B. Desire for hot or cold fluids
- C. Persons to be in the room during labor and birth
- D. Desire for circumcision if a male infant is born

ANSWER: A

- A. Because cultural variations exist in pain control measures used and pain tolerance, the most crucial assessment in the active stage of labor is the client's choice of pain control measures.
- B. A desire for hot or cold fluids is an important aspect that should be determined during the early stage of labor.
- C. Determination of support persons is an important aspect that should be made during the early stage of labor.
- D. The desire for circumcision is an important consideration, but it is not the primary need during the active stage of labor.

33. The laboring client is experiencing problems, and the nurse is concerned about possible side effects from the epidural anesthetic just administered. Which problems should the nurse attribute to the epidural anesthetic? Select all that apply.

- A. Has breakthrough sharp pain
- B. Blood pressure is increased
- C. Has a pounding headache
- D. Unable to feel a full bladder

- E. Has an elevated temperature

ANSWER: A, C, D, E

- A. Breakthrough pain can occur when the continuous infusion rate of the anesthetic agent is below the recommended rate for a therapeutic dose. Breakthrough pain can also occur when the client has a full bladder or when the cervix is completely dilated.
- B. Hypertension is a contraindication for epidural anesthesia. A major side effect of epidural anesthesia is hypotension (not hypertension) caused by a spinal blockade, which lowers peripheral resistance, decreases venous return to the heart, and subsequently lessens cardiac output and lowers BP.
- C. A spinal headache can be a complication of epidural anesthesia and occurs when the dura is accidentally punctured during epidural placement.
- D. A sensory level of T10 is usually maintained during epidural anesthesia; most women are unable to feel a full bladder or to void after receiving an epidural anesthetic.
- E. Maternal temperature may be elevated to 100.1°F (37.8°C) or higher with an epidural. Sympathetic blockade may decrease sweat production and diminish heat loss.

34. The client in labor is requesting water therapy (hydrotherapy) to help provide pain relief and relaxation. Her recent vaginal exam was 2/50/–2. How should the nurse respond to the client's request?

- A. "Usually we initiate hydrotherapy during active labor."
- B. "You will not need to change positions quite as much."
- C. "We will not be able to monitor fetal heart rate as easily."
- D. "You can use hydrotherapy for up to 60 minutes at a time."

ANSWER: A

- A. Hydrotherapy is usually initiated when the client is in active labor, at approximately 4 or 5 cm. This timing will help reduce the risk of prolonged labor and provide a welcome change when the contractions are becoming stronger and closer together.
- B. Changing position takes less effort while immersed in water, so women are encouraged to change positions more frequently to help facilitate the process of labor.
- C. FHR monitoring can be done just as easily during hydrotherapy, using a wireless external monitor, Doppler, or fetoscope. Internal electrodes can be placed during most types of hydrotherapy but is contraindicated during jet hydrotherapy.
- D. There is no time limit for laboring women to use hydrotherapy; they may stay as long as desired, unless complications develop during the labor process.

35. The nurse practitioner informs the new nurse that the laboring client's monitor is showing prolonged decelerations. Which interpretation by the new nurse is correct?

- A. The monitor pattern is U or V shaped, with a decrease in FHR to less than 70 beats/minute (bpm), lasting more than 60 seconds.
- B. The FHR shows an episodic or periodic acceleration that lasts 2 minutes or more but less than 10 minutes in duration.
- C. There is an FHR decrease of 15 bpm or more below baseline occurring for at least 2 but not more than 10 minutes.
- D. The mother's heart rate is exhibiting intermittent or transient deviations or changes from the baseline heart rate.

ANSWER: C

- A. A U- or V-shaped pattern with abrupt decrease in the FHR to less than 70 bpm, lasting more than 60 seconds, describes variable (not prolonged) deceleration typically associated with cord compression.
- B. Any episodic or periodic acceleration of FHR that lasts 2 minutes or more but less than 10 minutes in duration describes prolonged acceleration, not deceleration.
- C. A prolonged deceleration occurs when the FHR decreases 15 bpm or more below baseline for at least 2 but not more than 10 minutes. The prolonged deceleration may resolve spontaneously or with the aid of interventions.
- D. The fetal heart monitor is monitoring the FHR and not the mother's heart rate.

36. The nurse's laboring client is being electronically monitored during her labor. The baseline FHR throughout the labor has been in the 130s. In the last 2 hours, the baseline has decreased to the 100s- How should the nurse document this FHR?

- A. Tachycardia
- B. Bradycardia
- C. Late deceleration
- D. Within normal limits

ANSWER: B

- A. Tachycardia occurs when the baseline is greater than 160 bpm.
- B. An FHR baseline less than 110 is classified as bradycardia.
- C. A prolonged deceleration is defined as a change from the baseline FHR that occurs for 2 to 10 minutes before returning to baseline. A late deceleration is a gradual decrease and return of the FHR to baseline, associated with a uterine contraction.

- D. A decrease to the 1003 is not within the normal range. The normal FHR is 120 to 160 bpm.

37. The nurse is caring for the pregnant client whose F HR tracing reveals a reduction in variability over the last 40 minutes. The client has had occasional decelerations after the onset of a contraction that did not resolve until the contraction was over. The client suddenly has a prolonged deceleration that does not resolve, and the nurse immediately intervenes by calling for assistance. Place the nurse's interventions in the sequence that they should occur.

- A. Administer oxygen via facemask
- B. Have the HCP paged if the prolonged decelerations have not resolved.
- C. Place an indwelling urinary catheter in anticipation of emergency cesarean birth if the heart rate remains low.
- D. Increase the rate of the intravenous (IV) fluids
- E. Assist the client into a different position
- F. Prepare for a vaginal examination and fetal scalp stimulation

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

E. Assist the client into a different position should be first. Repositioning is an attempt to increase the F HR in case of cord obstruction.

A. Administer oxygen via facemask is next to increase oxygenation to the fetus.

D. Increase the rate of the IV fluids next to treat possible hypotension, the most common cause of fetal bradycardia.

B. Have the HCP paged if the prolonged decelerations have not resolved. The immediate focus should be on attempting to relieve the prolonged decelerations.

F. Prepare for a vaginal examination and fetal scalp stimulation. This is performed to rule out cord prolapse and to provide stimulation to the fetal head.

C. Place an indwelling urinary catheter in anticipation of emergency cesarean birth if the HR remains low.

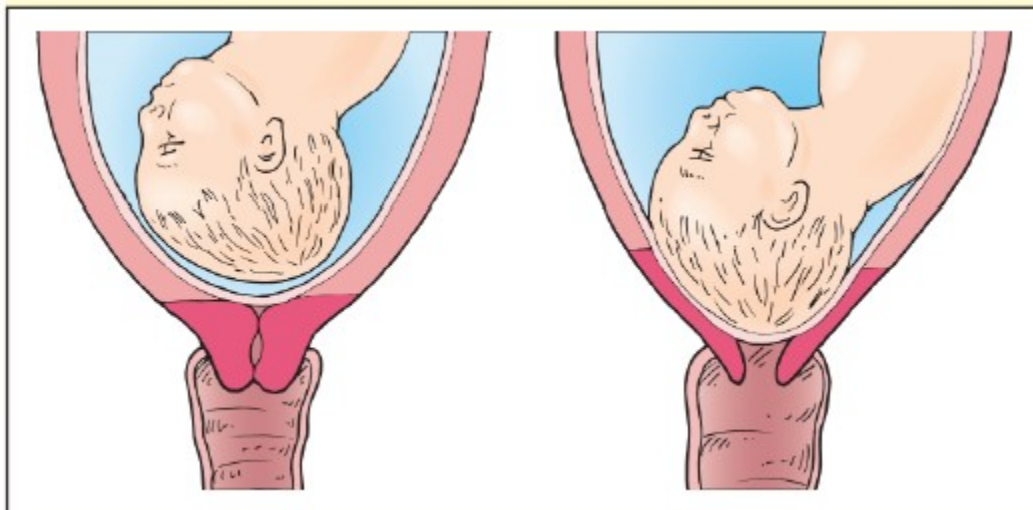
38. The laboring client tells the nurse that she wants to avoid an episiotomy if possible. Which response by the nurse is best?

- A. "Usually making an episiotomy incision is avoided whenever possible."
- B. "Having an episiotomy reduces prolonged pushing and perineal trauma."
- C. "An episiotomy is routine because it can prevent pelvic floor damage."
- D. "Tell me more about your concerns about having an episiotomy."

ANSWER: A

- A. This statement is best. An episiotomy may be used in some circumstances but is usually avoided if possible.
- B. Use of episiotomy increases (not reduces) perineal trauma and increases healing time.
- C. Use of episiotomy is not routine, does not decrease pelvic floor damage, and may increase the severity of the trauma.
- D. Having the client tell the nurse more about her concerns regarding episiotomy is unnecessary and avoids responding to the client's comment.

39. The nurse is evaluating the client in triage for possible labor. The client's contractions are every 3 to 4 minutes, 60 to 70 seconds in duration, and moderate by palpation. Her cervical exam in the office was illustration 1. Her current exam is illustration 2. What conclusions should the nurse draw from illustration 2?



- A. The client is not dilated or effaced.
- B. The client is completely dilated but not effaced.
- C. The client has minimally dilated, but completely effaced.
- D. The client is not dilated, but completely effaced.

ANSWER: C

- A. Illustration 1 (not illustration 2) shows that the client is neither effaced nor dilated.
- B. The cervical opening is minimally dilated, not completely dilated, and completely effaced.

- C. In illustration 2, the client is completely effaced and has some dilation.
- D. Illustration 2 shows some dilation.

40. The laboring client is requesting IV pain medication instead of epidural anesthesia. The nurse determines that which factor would most definitely contraindicate the administration of nalbuphine hydrochloride?

- A. Completely dilated and 100 percent effaced
- B. Fetal heart rate (FHR) of 120 beats per minute
- C. Reassuring FHR variability and accelerations
- D. Variable decelerations with reassuring FHR

ANSWER: A

- A. Systemic medications, such as nalbuphine hydrochloride (Nubain), should not be administered when advanced dilation is present (transition stage of labor) because its use can lead to respiratory depression if given too close to the time of delivery.
- B. An FHR of 120 bpm is within normal parameters of 120 to 160 bpm.
- C. Reassuring FHR variability and accelerations are interpreted as adequate placental oxygenation and do not contraindicate administration of nalbuphine hydrochloride.
- D. If mild variable decelerations are present but the FHR pattern remains reassuring, nalbuphine hydrochloride can still be administered.

41 - The client on the labor unit has been experiencing frequent, painful contractions for the last 6 hours. The contractions are of poor quality, and there has been no cervical change. Which interventions should the nurse implement? Select all that apply.

- A. Maintain bed rest
- B. Administer a sedative
- C. Administer an analgesic
- D. Prepare for cesarean delivery
- E. Prepare to start oxytocin

ANSWER: A, B, C, E

- A. This client is experiencing a hypertonic labor pattern in which her contractions are frequent and painful, but no cervical change has occurred. This client should be encouraged to rest often.
- B. A sedative should be given to assist the client to rest.
- C. Because the contractions are painful, an analgesic should be administered to help the client relax and cope more effectively.

- D. A cesarean birth is not a treatment for a hypertonic labor pattern unless a nonreassuring F HR pattern is present.
- E. If the hypertonic labor pattern continues, augmentation should be initiated with either an oxytocin infusion or amniotomy.

42. The nurse reviews information and assesses the laboring client at 42 weeks' gestation before an HCP induces labor. Which findings should be reported to the I-ICP because they are contraindications to labor induction? Select all that apply.

- A. Umbilical cord prolapse
- B. Transverse fetal lie
- C. Cervical dilation not progressing
- D. Premature rupture of membranes
- E. Previous cesarean incision

ANSWER: A, B, E

- A. Inducing labor with an umbilical cord prolapsed can cause fetal trauma and is contraindicated. This should be reported to the HCP.
- B. Inducing labor with a transverse fetal lie can produce trauma to the fetus and mother and is contraindicated. This should be reported to the HCP.
- C. Lack of progressive cervical dilation is an indication for labor induction, not a contraindication.
- D. Premature rupture of the membranes is an indication for labor induction, not a contraindication.
- E. Women with a previous cesarean incision should not be stimulated because it is a contraindication for a vaginal birth and warrants an immediate repeat cesarean birth. This should be reported to the HCP.

43. The client has been in labor for 21 hours. Induction was started 16 hours ago, and she is now dilated 5 cm. She has made little progress, and there has been no fetal descent. The I-ICP identifies cephalopelvic disproportion (CPD). The nurse should prepare the client for which mode of delivery?

- A. Traditional vaginal delivery
- B. Forceps-assisted delivery
- C. Vacuum-assisted delivery
- D. Cesarean section delivery

ANSWER: D

- A. A vaginal delivery is contraindicated once CPD has been identified due to the risk of fetal and maternal trauma.

- B. Forceps delivery is contraindicated once CPD has been identified due to the risk of fetal and maternal trauma.
- C. Vacuum delivery is contraindicated once CPD has been identified due to the risk of fetal and maternal trauma.
- D. A fetus diagnosed with CPD is unable to be delivered vaginally and requires a cesarean section birth.

44. The laboring client just had a convulsion after being given regional anesthesia. Which interventions should the nurse implement? Select all that apply.

- A. Establish an airway.
- B. Position on her right side.
- C. Provide 100% oxygen.
- D. Administer diazepam.
- E. Page the anesthesiologist STAT.

ANSWER: A, C, D, E

- A. The client experiencing a convulsion related to anesthesia should first have an airway established.
- B. The client's head should be turned to the side if vomiting occurs, but the client typically remains in a left lateral tilt position so an airway can be maintained. Positioning on the right side can cause aortocaval compression.
- C. The client experiencing a convulsion related to anesthesia should receive 100% oxygen so that the mother and fetus remain oxygenated.
- D. Small doses of diazepam or thiopental can be administered to stop the convulsions.
- E. The anesthesiologist should be STAT paged to provide assistance; the convulsion was initiated by the regional anesthetic.

45. The pregnant client has been pushing for 2½ hours. After some difficulty, the large fetal head emerges. The HCP attempts to deliver the shoulders without success. Place the nurse's actions in caring for this client in the correct sequence.

- A. Apply suprapubic pressure per direction of the HCP.
- B. Place the client in exaggerated lithotomy position.
- C. Catheterize the client's bladder.
- D. Call for the neonatal resuscitation team to be present.
- E. Prepare for an emergency cesarean birth.

ANSWER: D. B. A. C, E

- D. Call for the neonatal resuscitation team to be present because of fetal distress.

- B. Place the client in exaggerated lithotomy position so the McRoberts' maneuver can be performed (flexing her thighs sharply on her abdomen may widen the pelvic outlet and let the anterior shoulder be delivered).
- A. Apply supra pubic pressure per direction of the HCP. This is completed in an effort to dislodge the shoulder from under the pubic bone.
- C. Catheterize the client's bladder. This will empty the bladder to make more room for the fetal head.
- E. Prepare for an emergency cesarean birth. This will be performed if all efforts for a vaginal birth fail.

46. The full-term pregnant client presents with bright red vaginal bleeding and intense abdominal pain. Her BP is 150/96 mm Hg, and her pulse is 109 bpm. The nurse should immediately implement interventions for which possible complication?

- A. Placenta previa
- B. Placental abruption
- C. Bloody show
- D. Succenturiate placenta

ANSWER: B

- A. Placenta previa is marked by painless vaginal bleeding.
- B. The nurse should immediately implement interventions for placental abruption. This occurs when the placenta separates from the uterine wall before the birth of the fetus. It is commonly associated with preeclampsia.
- 3. Bloody show is a normal physiological sign associated with normal labor progression and is marked by bloody, mucuslike consistency.
- 4. Succenturiate placenta is the presence of one or more accessory lobes that develop on the placenta with vascular connections of fetal origin.

47. The laboring client suddenly experiences a dramatic drop in the FHR from the 150 to the 110. A vaginal exam reveals the presence of the fetal cord protruding through the cervix. What should be the nurse's first intervention?

- A. Put continuous pressure on the presenting part to keep it off the cord
- B. Place the bed in Trendelenburg position
- C. Insert a urinary catheter and instill saline
- D. Continue to monitor the FHR

ANSWER: A

- A. The nurse should first exert continuous pressure on the presenting part to prevent further cord compression. This is continued until birth, which is usually by cesarean section.
- B. The bed should be placed in Trendelenburg position to further prevent pressure on the cord, but only after pressure is placed on the presenting part.
- C. A catheter may be inserted and 500 mL of warmed saline instilled to help float the head and prevent further compression, but only after pressure is placed on the presenting part.
- D. The fetus is continually monitored throughout until birth.

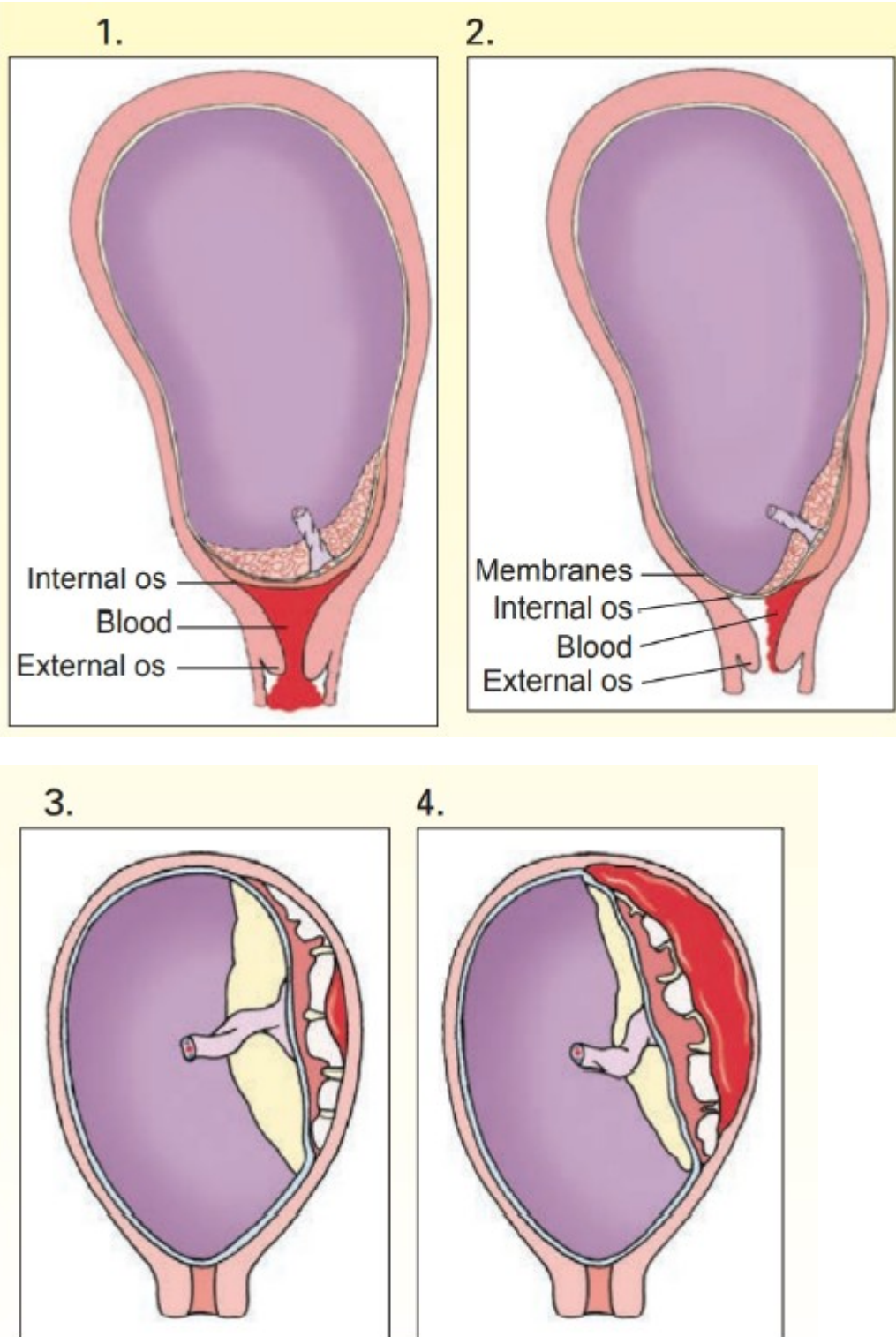
48. The client in active labor has moderate to strong contractions occurring every 2 minutes and lasting 60 to 70 seconds. The client states extreme pain in the small of her back. Her abdomen reveals a small depression under the umbilicus. Which fetal position should the nurse document?

- A. Occiput anterior
- B. Occiput posterior
- C. Left occiput anterior
- D. Right occiput anterior

ANSWER: B

- A. When a fetus presents anterior, it is uncommon for the mother's chief symptom to be back pain, and the uterus should appear smooth.
- B. An occiput posterior position is characterized by intense back pain (back labor). A depression under the umbilicus occurs as a result of the posterior shoulder.
- C. When a fetus presents anterior, it is uncommon for the mother's chief symptom to be back pain, and the uterus should appear smooth.
- D. When a fetus presents anterior, it is uncommon for the mother's chief symptom to be back pain, and the uterus should appear smooth.

49. The experienced nurse instructs the new nurse that a vaginal examination should not be performed on the newly admitted client with possible grade 3 abruptio placentae. Which illustration shows the new nurse's thinking about the uterus of the client with the grade 3 abruptio placentae?

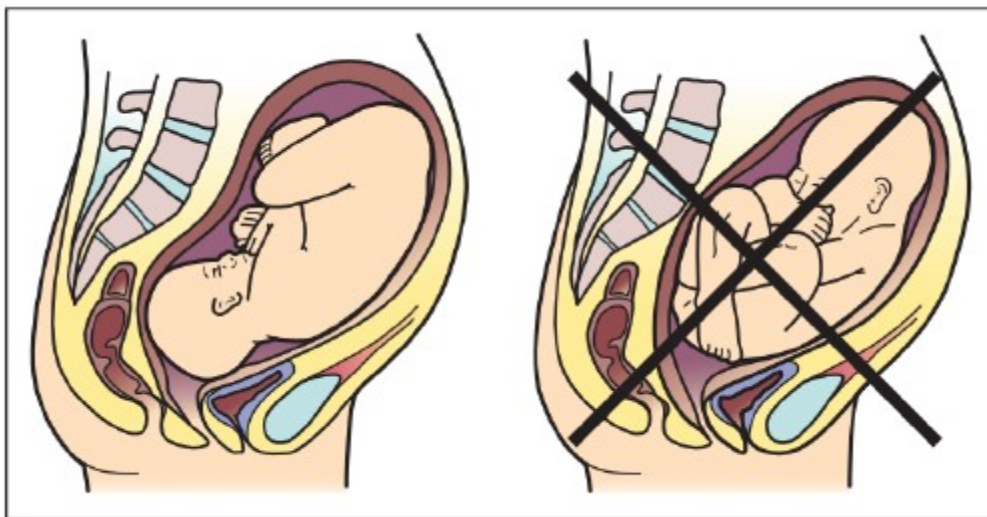
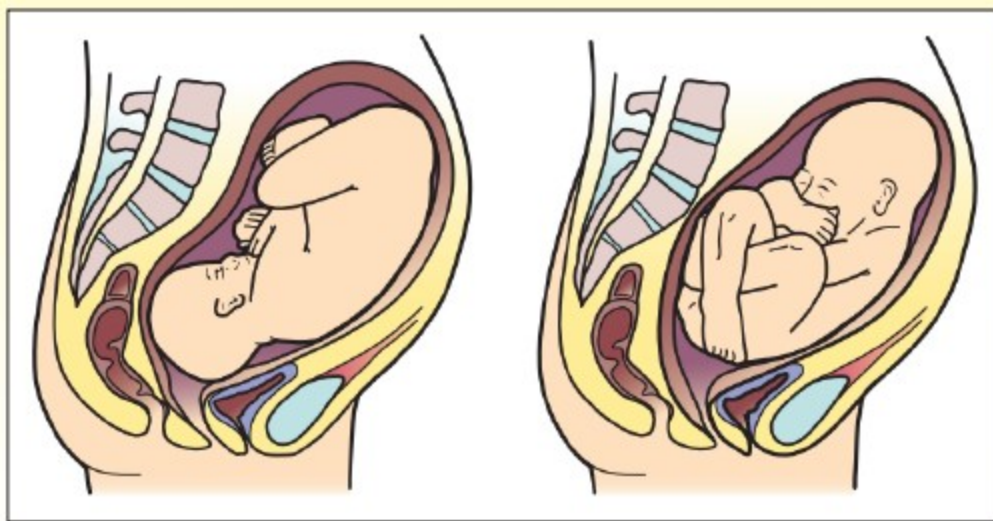


ANSWER: D

- A. Illustration 1 shows complete placenta previa and not abruptio placentae.
- B. Illustration 2 shows partial placenta previa and not abruptio placentae.

- C. Illustration 3 shows mild grade 1 abruptio placentae. Less than 15% of the placenta separates with concealed hemorrhage.
- D. Illustration 4 shows severe grade 3 abruptio placentae. More than 50% of the placenta separates with concealed hemorrhage.

50. The nurse is caring for two maternity clients who are in labor. The nurse determines that head entrapment is most likely to occur with which delivery presentation? Place an X on the correct illustration.



A breech delivery is most likely to be associated with head entrapment because the head is the largest part of the fetal body, and it is delivered last in a breech delivery.

51 . The nurse is caring for the 30-weeks-pregnant client who is having contractions every 1½ to 2 minutes with spontaneous rupture of membranes 2 hours ago. Her cervix is 8 cm dilated and 100% effaced. The nurse determines that delivery is imminent. What intervention is the most important at this time?

- A. Administering a tocolytic agent
- B. Providing teaching information on premature infant care
- C. Notifying neonatology of the impending birth
- D. Preparing for a cesarean section birth

ANSWER: C

- A. Tocolytic agents, such as nifedipine (Procardia), can be used for short-term intervention to slow down contractions and delay birth, but it is too late to administer a tocolytic agent.
- B. Teaching is important but is not appropriate at this time.
- C. The most important intervention is to notify the neonatal team of the delivery because the team members will be needed for respiratory support and possible resuscitation.
- D. A cesarean birth is indicated if there are other obstetrical needs.

52- The nurse is evaluating the 39-weeks-pregnant client who reports greenish, foul-smelling vaginal discharge. Her temperature is 101.6°F (38.7°C), and the FHR is 120 with minimal variability and no accelerations. The client's group beta streptococcus (GBS) culture is positive. Which interventions should the nurse plan to implement? Select all that apply.

- A. Prepare for cesarean birth due to chorioamnionitis
- B. Start oxytocin for labor induction
- C. Start antibiotics as directed for the GBS infection
- D. Prepare the client for epidural anesthesia
- E. Notify the neonatologist of the client's status
- F. Administer a cervical ripening agent

ANSWER: A , C , D, E

- A. Because this client is not in labor and chorioamnionitis is possible, a cesarean birth is indicated.
- B. Starting oxytocin (Pitocin) would prolong the time to delivery.
- C. The client should be given antibiotics as prescribed to treat the infection.

- D. Because epidural anesthesia offers the least risk to the fetus, preparation for epidural anesthesia should begin.
- E. The pediatrician or neonatologist should be notified and available for the impending delivery.
- F. Administering a cervical ripening agent would prolong the time to delivery.

53- At one minute after birth, a neonate is pink, except for blue extremities. The neonate is crying, gagging, and grimacing when the bulb syringe is used and has some flexion of extremities and an HR of 97. Based on the Apgar score, what should the nurse do next?

- A. Notify the health care provider
- B. Recheck the Apgar at 5 minutes after birth
- C. Initiate resuscitation measures immediately
- D. Swaddle and hand to mother for breastfeeding

ANSWER: B

- A. Notifying the HCP is not necessary at this time. The one-minute Apgar score is 6, very close to the 7 to 10 normal limits. This newborn has a good cry, indicating good transition to the extrauterine environment thus far.
- B. Rechecking the Apgar score at 5 minutes after birth will determine if the newborn is continuing to make a good transition to the extrauterine environment.
- C. Initiating resuscitation measures immediately is not necessary. This would be done if the newborn were not crying and demonstrated a blue or pale body.
- D. Swaddling and giving the newborn to the mother for breastfeeding are important but should occur after the 5-minute Apgar, if the score is WNL. Keeping this newborn in the radiant warmer, rather than giving him or her to the mother, will help prevent hypothermia and promote better transition to extrauterine life.

54. A 5-minute-old newborn in a delivery room has a good cry, HR 88, well flexed, good reflex irritability, and blue extremities with a completely pink body. What Apgar score would the nurse document for this newborn?

_____ Apgar score (Record your answer as a whole number.)

ANSWER: 8

The newborn would receive one point because the HR is below 100 bpm, two points for a good cry (respiratory effort), two points for being well flexed (muscle tone),

two points for good reflex irritability (reflex response), and one point for a pink body with blue extremities (color).

55. The nurse is doing a one-minute Apgar score on a newborn and tells the parents that it is 7 points. When the parents ask what this means, how should the nurse best respond?

- A. "This score is good, but the baby needs to have a score of 10 in five minutes."
- B. "The Apgar score can predict intelligence and neurological development."
- C. "Your baby is fine and should have no difficulty adapting outside the womb."
- D. "Your baby has good vital signs and is classified as full-term gestational age."

ANSWER: C

- A. A score of 7 to 10 is considered acceptable for a one-minute Apgar. However, when the scoring is repeated at 5 minutes of age, a score of 7 to 10, not just 10, is within normal range.
- B. The Apgar score is used to systematically assess an infant at one and five minutes after birth to determine if immediate care is necessary. It is not used to predict intelligence or neurological development.
- C. This response is best because a score of 7 to 10 is within a normal range and indicates that the newborn is not demonstrating any signs of distress.
- D. Although the Apgar score does mean that the newborn's VS are WNL, the Apgar score is not designed to classify gestational age.