

1. The delivery nurse is reporting to the postpartum nurse about the client who just delivered her first baby, a term newborn. Which number should the delivery nurse report for the client's parity?

_____ Parity (Record your answer as a whole number.)

ANSWER: 1

The client has given birth to her first child; her parity is 1.

2. Immediately after delivery of the client's placenta, the nurse palpates the client's uterine fundus. The fundus is firm and located halfway between the umbilicus and symphysis pubis. Which action should the nurse take based on the assessment findings?

- A. Immediately begin to massage the uterus
- B. Document the findings of the fundus
- C. Assess the client for bladder distention
- D. Monitor for increased vaginal bleeding

ANSWER: B

- A. Uterine massage is indicated only if the uterus does not feel firm and contracted.
- B. Immediately after birth, the uterus should contract, and the fundus should be located one-half to two-thirds of the way between the symphysis pubis and umbilicus. Thus the only action required is to document the assessment finding.
- C. There is no indication that the bladder is full. A full bladder will cause uterine displacement to either side of the abdomen.
- D. The uterus is firm; there is no reason to infer that increased vaginal bleeding would occur.

3. The client, who delivered a 4200-g baby 4 hours ago, continues to have bright red, heavy vaginal bleeding. The nurse assesses the client's fundus and finds it to be firm and midway between the symphysis pubis and umbilicus. What should the nurse do next?

- A. Continue to monitor the client's bleeding and weigh the peripads.
- B. Call the client's HCP and request an additional visual examination.

- C. Prepare to give oxytocin to stimulate uterine muscle contraction.
- D. Document the findings as normal with no interventions needed at that time.

ANSWER: B

- A. Although the nurse would definitely need to continue to monitor the amount and quality of bleeding, additional intervention is also needed.
- B. The nurse should consider the possibility of a vaginal wall or cervical laceration, which could produce heavy, bright red bleeding. The HCP should be notified and asked to perform a visual exam of the vagina to assess for possible lacerations in need of repair.
- C. Preparing to administer oxytocin (Pitocin) would be appropriate if the source of bleeding was suspected to be uterine atony, but the uterus is firm and in the expected location.
- D. Documenting the findings without further intervention would lead to a failure to identify the source of increased bleeding resulting in possible client injury. Further assessments and interventions are needed.

4. When looking in the mirror at her abdomen, the postpartum client says to the nurse, “My stomach still looks like I’m pregnant!” The nurse explains that the abdominal muscles, which separate during pregnancy, will undergo which change?

- A. Regain tone Within the first week after birth
- B. Regain prepregnancy tone with exercise
- C. Remain separated, giving the abdomen a slight bulge
- D. Regain tone as the weight gained during pregnancy is lost

ANSWER: B

- A. For most women, it takes about 6 weeks (not one week) to regain abdominal wall muscle tone to the prepregnancy state, and usually only with exercise.
- B. The “still-pregnant” appearance is caused by relaxation of the abdominal wall muscles. With exercise, most women can regain prepregnancy abdominal muscle tone within about 6 weeks.
- C. If the client delivers a very large infant, the abdominal muscles may separate, but the separation will become less apparent over time.
- D. Weight loss alone will not strengthen the abdominal muscles.

5. The clinic nurse reviews the laboratory results illustrated from the postpartum client who is 3 days postdelivery. What should the nurse do in response to these results?

Laboratory Value	Result
Hct	35%
Hgb	11 g/dL
WBCs	20,000/mm ³

- A. Document the laboratory report findings
- B. Assess the client for increased lochia
- C. Assess the client's temperature orally
- D. Notify the health care provider immediately

ANSWER: A

- A. The only action required is to document the findings; all values are within expected parameters. Nonpathological leukocytosis often occurs during labor and in the immediate postpartum period because labor produces a mild pro-inflammatory state. WBCs should return to normal by the end of the first postpartum week. Hct and Hgb will begin to decrease on postpartum day 3 or 4 from hemodilution.
- B. Assessing the client's lochia is unnecessary with these results.
- C. Assessing the client's temperature is unnecessary with these results.
- D. Notifying the HCP is unnecessary with these results.

6 . The Caucasian postpartum client asks the nurse if the stretch marks (striae gravidarum) on her abdomen will ever go away. Which response by the nurse is most accurate?

- A. "Your stretch marks should totally disappear over the next month."
- B. "Your stretch marks will always appear raised and reddened."
- C. "Your stretch marks will lighten in color with good skin hydration."
- D. "Your stretch marks will fade to pale white over the next 3 to 6 months."

ANSWER: D

- A. Stretch marks will fade but will not totally disappear.
- B. Stretch marks will fade and will not always appear reddened.
- C. There is no evidence that keeping the skin hydrated will lighten the appearance of the stretch marks.
- D. In Caucasian women, stretch marks will fade to a pale white over 3 to 6 months.

7. Twenty-four hours post—vaginal delivery, the postpartum client tells the nurse that she is concerned because she has not had a bowel movement (BM) since before delivery. Which action should be taken by the nurse?

- A. Document the data in the client's health care records
- B. Notify the health care provider immediately
- C. Administer a laxative that has been prescribed pm
- D. Assess the client's abdomen and bowel sounds

ANSWER: A

- A. A spontaneous BM may not occur for 2 to 3 days after childbirth due to decreased muscle tone in the intestines during labor and the immediate postpartum period, possible prelabor diarrhea, and decreased food intake and dehydration during labor. Thus, documentation of the lack of a BM is the only action required.
- B. There is no need to notify the HCP for a normal finding.
- C. A laxative is unnecessary since a BM is not expected for 2 to 3 days postdelivery.
- D. Bowel sounds are not altered by a vaginal delivery, even though the passage of stool through the intestines is slowed.

8. The RN and the student nurse are caring for the postpartum client who is 16 hours postdelivery. The RN evaluates that the student needs more education about uterine assessment when the student is observed doing which activity?

- A. Elevating the client's head 30 degrees before doing the assessment
- B. Supporting the lower uterine segment during the assessment
- C. Gently palpating the. uterine fundus for firmness and location
- D. Observing the abdomen before beginning palpation

ANSWER: A

- A. For uterine assessment, the client should be positioned in a supine position so the height of the uterus is not influenced by an elevated position.
- B. When beginning the assessment, one hand should be placed at the base of the uterus just above the symphysis pubis to support the lower uterine segment. This prevents the inadvertent inversion of the uterus during palpation.
- C. Once the lower hand is in place, the fundus of the uterus can be gently palpated.
- D. The abdomen should be observed prior to palpation for contour to detect distention and for the appearance of striae or a diastasis.

9. The nurse is assessing the postpartum client, who is 5 hours postdelivery. Initially, the nurse is unable to palpate the client's uterine fundus. Prioritize the nurse's actions to locate the client's fundus by placing each step in the correct sequence.

- A. Place the side of one hand just above the client's symphysis pubis.
- B. Press deeply into the abdomen.
- C. Place the other hand at the level of the umbilicus.
- D. Massage the abdomen in a circular motion.
- E. Position the client in the supine position.
- F. If the fundus is not felt, move the upper hand lower on the abdomen and repeat the massage.

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

E. Position the client in supine so the height of the uterus is not influenced by an elevated position.

A. Place the side of one hand just above the client's symphysis pubis. This supports the lower uterine segment and prevents the inadvertent inversion of the uterus during palpation.

C. Place the other hand at the level of the umbilicus. This is the expected location of the uterine fundus on the day of delivery.

B. Press deeply into the abdomen to allow the massage to reach the fundus.

D. Massage the abdomen in a circular motion. This massage should stimulate the uterus to contract and allow location of the fundus to be determined.

F. If the fundus is not felt, move the upper hand lower on the abdomen and repeat the massage. Involution could potentially be occurring more rapidly than expected if the client is breastfeeding and/or had an uncomplicated labor and birth.

10. The client delivered a healthy newborn 4 hours ago after being induced with oxytocin. While being assisted to the bathroom to void for the first time after delivery, the client tells the nurse that she doesn't feel a need to urinate. Which explanation should the nurse provide when the client expresses surprise after voiding 900 mL of urine?

- A. "A decreased sensation of bladder filling is normal after childbirth."
- B. "The oxytocin you received in labor makes it difficult to feel voiding."
- C. "You probably didn't empty completely. I will need to scan your bladder."
- D. "Your bladder capacity is large; you likely won't void again for 6—8 hours."

ANSWER: A

- A. The nurse should explain about the decreased sensation of bladder filling after childbirth. It is not uncommon for the postpartum client to have increased bladder capacity, decreased sensitivity to fluid pressure, and a decreased sensation of bladder filling.
- B. Oxytocin (Pitocin) is not expected to cause a change in bladder sensation, but it does have an antidiuretic effect.
- C. There is no indication that the client didn't completely empty; a volume of 900 mL is a large amount.
- D. The postpartum client is at risk for bladder overdistention and should be encouraged to void every 2 to 4 hours.

11. When up to the bathroom for the first time after a vaginal delivery, the client states, "A friend told me that I'm going to have trouble with urinary incontinence now that I have had a baby." Which is the best response by the nurse?

- A. "That's not true. You won't need to worry about this until menopause."
- B. "I will teach you how to do Kegel exercises to strengthen your muscles."
- C. "Wearing a pad similar to a sanitary pad will help contain the incontinence."
- D. "If this occurs, notify your HCP to have surgery to correct urinary incontinence."

ANSWER: B

- A. Women of any life stage can experience urinary incontinence.
- B. Kegel exercises strengthen muscles surrounding the vagina and urinary meatus, preventing urinary incontinence for many women. To perform Kegel exercise, contract the muscles around the vagina and hold for 10 seconds, then rest for 10 seconds. This should be repeated 30 or more times each day.
- C. The nurse should educate the client about ways in which to prevent urinary incontinence, not just offer information about how to manage the condition if it should occur.
- D. Surgical repair only occurs in the most extreme circumstances, after less invasive interventions have been unsuccessful.

12. The client, who had preeclampsia and delivered vaginally 4 hours ago, is still receiving magnesium sulfate IV. When assessing the client's deep tendon reflexes (DTRs), the nurse finds that they are both weak, at 1+, whereas previously they were 2+ and 3+. Which actions should the nurse plan? Select all that apply.

- A. Notify the client's HCP about the reduced DTRs.

- B. Prepare to increase the magnesium sulfate dose.
- C. Prepare to administer calcium gluconate IV-
- D. Assess the level of consciousness and vital signs.
- E. Ask the HCP about drawing a serum calcium level.

ANSWER: A, C, D

- A. The HCP should be notified about the decreased DTRs because weakening of these may indicate magnesium sulfate toxicity.
- B. Increasing the magnesium sulfate dose would worsen the situation and could lead to a depressed respiratory rate.
- C. Any time the client is receiving a magnesium sulfate infusion, the nurse should be prepared for the possibility of needing the antidote, calcium gluconate.
- D. The nurse should assess the client's vital signs and level of consciousness, as decreased level of consciousness and respiratory effort are serious side effects of magnesium sulfate.
- E. The nurse should ask the HCP about drawing a serum magnesium level (not a serum calcium level) to determine whether the client is experiencing magnesium toxicity.

13. The postpartum client delivered a full-term infant 2 days previously. The client states to the nurse, "My breasts seem to be growing, and my bra no longer fits." Which statement should be the basis for the nurse's response to the client's concern?

- A. Rapid enlargement of breasts usually is a symptom of infection-
- B. Increasing breast tissue may be a sign of postpartum fluid retention.
- C. Thrombi may form in veins of the breast and cause increased breast size-
- D. Breast tissue increases in the early postpartum period as milk forms.

ANSWER: D

- A. Infection in the breast tissue results in flulike symptoms and redness and tenderness of the breast. It is usually unilateral and does not cause bilateral breast enlargement.
- B. Fluid is not retained during the postpartum period; rather, clients experience diuresis of the excess fluid volume accumulated during pregnancy.
- C. Fullness in both breasts would not be the result of thrombi formation. Symptoms of thrombi include redness, pain, and increased skin temperature over the thrombi.
- D. Breast tissue increases as breast milk forms, so a bra that was adequate during pregnancy may no longer be adequate by the second or third postpartum day.

14. While assessing the postpartum client who is 10 hours post—vaginal delivery, the nurse notes a perineal pad that is totally saturated. To determine the significance of this finding, which question should the nurse ask the client first?

- A. “How often are you experiencing uterine cramping?”
- B. “When was the last time you changed your peri-pad?”
- C. “Are you having any bladder urgency or frequency?”
- D. “Did you pass clots that required changing your peri-pad?”

ANSWER: B

- A. Once the nurse has determined the length of time the pad has been in place, the nurse could decide if asking about uterine cramping is appropriate.
- B. The amount of lochia on a perineal pad is influenced by the individual client’s pad changing practices. Thus, the nurse should ask about the length of time the current pad has been in place before making a judgment about whether the amount is concerning.
- C. Although bladder incontinence could cause pad saturation, it is more important to ask about the length of time the pad has been in place. Based on the client’s answer, the nurse could decide if asking about bladder urgency or frequency needs further assessment.
- D. Passing clots may require more frequent pad change, but first the nurse should determine if the reason for the saturated pad is the length of time it has been in place.

15. Two hours after the client’s vaginal delivery, she reports feeling “several large, warm gushes of fluid” from her vagina. The nurse assesses the client’s perineum and finds a large pool of blood on the client’s bed. Which nursing action is priority?

- A. Encourage the client to ambulate to the bathroom in order to empty her bladder.
- B. Place two hands on the uterine fundus and prepare to vigorously massage the uterus.
- C. Reassure the client that heavy bleeding is expected in the first few hours postpartum.
- D. Support the lower uterine segment with one hand and assess the fundus with the other.

ANSWER: D

- A. A full bladder may displace the uterus, causing increased bleeding. However, a more complete assessment must be performed prior to getting the client out of bed to prevent increased bleeding and syncope.
- B. Vigorously massaging the uterus may result in inversion of the uterus.

- C. The client should not simply be reassured that heavy bleeding is expected because further assessment is necessary before concluding that the client's blood loss is WNL.
- D. The nurse's first action should be to support the lower uterine segment and to assess the fundus. Increased bleeding will occur if soft or "boggy." Failing to support the lower uterine segment may result in inversion of the uterus.

16. The oncoming shift nurse assesses the fundus of the postpartum client 6 hours after a vaginal birth and finds that it is firm. When the nurse then assists the client out of bed for the first time, blood begins to run down the client's leg. Which action by the nurse in response to the client's bleeding is correct?

- A. Explain that extra bleeding can occur with initial standing
- B. Immediately assist the client back into bed
- C. Push the emergency call light in the room
- D. Call the HCP to report this increased bleeding

ANSWER: A

- A. Lochia normally pools in the vagina when the postpartum client remains in a recumbent position for any length of time. When the client then stands, gravity causes the blood to flow out. As long as the nurse knows the fundus is firm and not bleeding, a simple explanation to the client is all that is required.
- B. There is no reason to return the client to bed; the fundus is firm.
- C. There is no reason to push the emergency call light. Increased bleeding is an expected response when standing for the first time.
- D. There is no reason to call the HCP.

17. An LPN asks an RN to assist in locating the fundus of the client who is 8 hours post—vaginal delivery. Place an X at the location on the client's abdomen where the RN should direct the LPN to begin to palpate the fundus.



MoC ANSWER:



Six to 12 hours after birth, the fundus of the uterus rises to the level of the umbilicus due to blood and clots that remain within the uterus and changes in ligament support. Thus, the RN should direct the LPN to locate the client's fundus at the level of the umbilicus.

18. The nurse is caring for the client who just gave birth. Which observation of the client should lead the nurse to be concerned about the client's attachment to her male infant?

- A. Asking the caregiver about how to change his diaper
- B. Comparing her newborn's nose to her brother's nose
- C. Calling the baby "Kelly," which was the name selected
- D. Repeatedly telling her husband that she wanted a girl

ANSWER: D

- A. Seeking information about infant care is a sign that the mother is developing attachment to her infant.
- B. Pointing out family traits or characteristics seen in the newborn is a sign that the mother is developing attachment.
- C. Calling the infant by name is a sign that the mother is developing attachment to her infant.
- D. Attachment is demonstrated by expressing satisfaction with a baby's appearance and sex. Frequent expressions of dissatisfaction with the sex of the infant should be concerning and followed up.

19. The nurse is caring for the postpartum family. The nurse determines that paternal engrossment is occurring when which observation is made of the newborn's father?

- A. Talks to his newborn from across the room
- B. Shows similarities between his and the baby's ears
- C. Expresses feeling frustrated when the infant cries
- D. Seems to be hesitant to touch his newborn

ANSWER: B

- A. Not making face-to-face contact with the infant during communication demonstrates a lack of engrossment.
- B. In North American culture, engrossment is demonstrated by the father touching the infant, making eye contact with the infant, and verbalizing awareness of features in the newborn that are similar to his and that validate his claim to that newborn.
- C. Feelings of frustration are not uncommon to fathers and are characteristic of the second stage, or reality stage, of the transition to fatherhood but are not a sign of engrossment.
- D. A hesitation to touch the infant demonstrates a lack of engrossment.

20. The nurse is caring for the postpartum primiparous client who is 13 hours post—vaginal delivery. The nurse observes that the client is passive and hesitant about making decisions about her own and her newborn's care. In response to this observation, which interventions should be implemented by the nurse? Select all that apply.

- A. Question her closely about the presence of pain.
- B. Ask if she would like to talk about her birth experience.
- C. Encourage her to nap when her infant is napping.
- D. Encourage attendance in teaching sessions about infant care.
- E. Suggest that she begin to write her birth announcements.

ANSWER: A, B, C

- A. Many women hesitate to ask for medication, as they believe their pain is expected. Thus, the nurse should ask the client about pain and assure her that there are methods to decrease her pain.
- B. During the initial postpartum "taking-in" phase, the client may have a great need to talk about her birthing experience and to ask questions for clarification as necessary. By encouraging this verbalization, the nurse helps the client to accept the experience and enables her to move to the next maternal phase.
- C. Physical discomfort can be intense initially postpartum and can interfere with rest. Sleep is a major need and should be encouraged.
- D. Anxiety and preoccupation with her new role often narrow the client's perceptions, and information is not as easily assimilated at this time. Therefore, attending education sessions should be delayed if possible until the mother has completed this "taking in" phase.
- E. The client needs to suspend her involvement in everyday responsibilities during the "taking—in" phase, so writing birth announcements should be delayed until the mother has completed this phase.

21. The client has a vaginal delivery of a full-term newborn. Immediately after delivery, the nurse assesses that the client's perineum and labia are edematous, but she does not have an episiotomy or a perineal laceration. Which intervention should the nurse implement?

- A. Give her an ice pack to apply to the perineum.
- B. Teach her to relax her buttocks before sitting.
- C. Apply warm packs to the affected areas.
- D. Provide a plastic donut cushion for sitting.

ANSWER: A

- A. If perineal edema is present, ice packs should be applied for the first 24 hours. Ice reduces edema and vulvar irritation.
- B. The client should be taught to tighten, not relax, her buttocks when sitting. This compresses the buttocks and reduces pressure on the perineum.
- C. After 24 hours, heat is recommended to increase circulation to the area.
- D. Donut cushions should be avoided because they promote separation of the buttocks and decrease venous blood flow to the area, thus increasing pain.

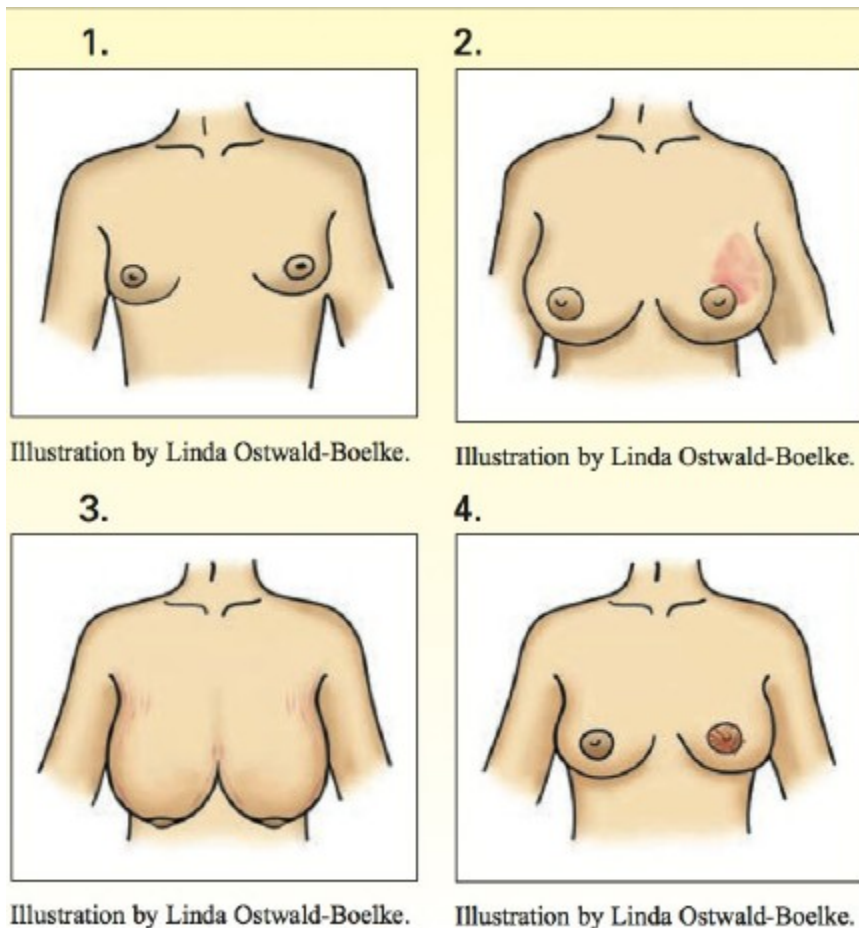
22. The nurse observes the postpartum multiparous client rubbing her abdomen. When asked if she is having pain, the client says, "It feels like menstrual cramps." Which intervention should the nurse implement?

- A. Offer a warm blanket for her to place on her abdomen.
- B. Encourage her to lie on her stomach until the cramps stop.
- C. Instruct the client to avoid ambulation while having pain.
- D. Check her lochia flow; pain sometimes precedes hemorrhage.

ANSWER: B

- A. Heat application to the abdomen should be avoided; it may cause uterine muscle relaxation.
- B. Multiparous women frequently experience intermittent uterine contractions called afterpains. Lying in a prone position applies pressure to the uterus, stimulating continuous uterine contraction. When the uterus maintains a state of contraction, the afterpains will cease.
- C. Ambulation has been shown to decrease muscle pain and should not be avoided.
- D. Afterpains are not a symptom of potential postpartum hemorrhage.

23. The postpartum client tells the nurse that she has pain when she breastfeeds. The nurse identifies that the infant has poor latch during breastfeeding. Which breast appearance shows that the client is experiencing symptoms associated with poor latch?



ANSWER: D

- A. This graphic shows normal breasts.
- B. This graphic shows the left breast with mastitis. Mastitis frequently presents as redness, warmth, and tenderness of the breast tissue, rather than the nipple.
- C. This graphic shows engorged breasts.
- D. This graphic shows breasts that have reddened nipples, one of which is cracked. If proper latch is not obtained during breastfeeding, the new- born's sucking may cause nipple cracking, blistering, and bleeding.

24. TWO hours after delivery, the mother tells the nurse that she will be bottle feeding. She asks what she can do to prevent the terrible pain experienced when her milk came in with her last baby. Which response by the nurse is most appropriate?

- A. "Once you have recovered from the birth, I will help you bind your breasts."
- B. "Engorgement is familial. If you had it with your last baby, it is inevitable."
- C. "I can help you put on a supportive bra; wear one constantly for 1 to 2 weeks."
- D. "Engorgement occurs right after birth; if you don't have it yet, it won't occur."

ANSWER: C

- A. In comparison studies between breast binders and bras, mothers using binders experienced more engorgement and discomfort.
- B. Engorgement is not familial and not inevitable in bottle-feeding mothers.
- C. Wearing a supportive, well-fitting bra within 6 hours after birth can suppress lactation. The bra should be worn continuously, except for showering, until lactation is suppressed (usually 7 to 14 days).
- D. Signs of engorgement usually occur on the third to fifth postpartum day (not right after birth), and engorgement will spontaneously resolve by the tenth day postpartum.

25. The client, who had a vaginal delivery 18 hours ago, asks the nurse how she should take care of her perineal laceration. Which statements by the nurse are appropriate? Select all that apply.

- A. "You should change your peripad at least twice each day."
- B. "Once home, use a warm sitz bath to soothe your perineum."
- C. "Keep your perineum warm and dry until stitches are removed."
- D. "Use your peri-bottle to apply water to the perineum after each void."
- E. "Wash your perineum with mild soap at least once each 24 hours,"
- F. "Check your perineum for foul odor or increased redness, heat, or pain."

ANSWER: B, D, E, F

- A. The peripad should be changed more frequently to reduce the risk of infection. Lochia amount should never exceed a moderate amount (less than a 6-inch stain on a perineal pad).
- B. A warm sitz bath is used after the first 24 hours to provide comfort, increase circulation to the area, and reduce the incidence of infection.
- C. Perineal lacerations are repaired with sutures that dissolve. Clients do not need to have perineal sutures removed.

- D. Cleansing the perineum after each void with the pert-bottle of water provides comfort and helps reduce the chance of infection.
- E. Washing with mild soap and rinsing with water each 24 hours reduces the risk of infection.
- F. Teaching the client to watch for signs and symptoms of infection is important and allows the client to be an active participant in her care.

26 . The nurse is preparing to administer 2 mg hydromorphone hydrochloride to the client who is 28 hours. post—cesarean section. The medication available is in a concentration of 4 mg/mL. How many milliliters should the nurse administer?

_____ mL (Record your answer in tenths.)

ANSWER: 0.5 MG

(2 mg / 4 mg) x 1 mL = 0.5 mL The nurse should administer 0.5 mL hydromorphone hydrochloride (Dilaudid).

27. The postpartum client, who is 24 hours post—cesarean section, tells the nurse that she has much less lochial discharge after this birth than with her vaginal birth 2 years ago. The client asks if this is normal after a cesarean birth. Which statement should be the basis for the nurse's response?

- A. A decrease in her lochia is not expected; further assessment is needed.
- B. Women usually have increased lochial discharge after cesarean births.
- C. Women normally have less lochial discharge after a cesarean birth.
- D. The lochia amount depends on whether surgery was emergent or planned.

ANSWER: C

- A. A decrease in lochia is expected after a cesarean birth; no further assessment is needed regarding the lochial amount unless it is totally absent.
- B. A decrease in lochia is expected after a cesarean birth, not an increase.
- C. The client's lochial discharge is usually decreased after cesarean birth because the uterus is cleaned during surgery.
- D. The amount of lochia is not dependent on whether the surgery was emergent or planned because the uterus is cleaned during surgery in both situations.

28. In the process of preparing the client for discharge after cesarean section, the nurse addresses all of the following areas during discharge education. Which should be the priority advice for the client?

- A. How to manage her incision
- B. Flaming for assistance at home
- C. Infant care procedures
- D. Increased need for rest

ANSWER: B

- A. Although the client needs information about incision care, the priority need is for assistance at home so that she can get the rest needed for multiple demands.
- B. Because the client has had a surgical procedure, the priority consideration is for the mother to plan for additional assistance at home. Without this assistance, it is difficult for the mother to get the rest she needs for healing, pain control, and appropriate infant care.
- C. Infant care is important, but having assistance at home after a surgical procedure is more important.
- D. The need for increased rest is important, but she would not be able to obtain adequate rest without assistance at home.

29. The client, who is 12 days postpartum, telephones the clinic and tells the nurse that she is concerned that she may have an infection because her vaginal discharge has been creamy white for two days now. Which response by the nurse is correct?

- A. "You need to come to the clinic as soon as possible."
- B. "You'll need an antibiotic; which pharmacy do you use?"
- C. "Take your temperature and let me know if it is elevated."
- D. "A creamy white discharge 10 days postpartum is normal."

ANSWER: D

- A. There is no need to be seen in the clinic; vaginal discharge that turns creamy white 10 days postpartum is normal.
- B. The client does not have an infection, and no antibiotic is necessary.
- C. There is no reason to take her temperature when the discharge is normal.
- D. Creamy white discharge 10 to 21 days postpartum is normal. Her lochia changed color on her 10th postpartum day.

30. The postpartum client, who is 24 hours post—vaginal birth and breastfeeding, asks the nurse when she can begin exercising to regain her prepregnancy body shape. Which response by the nurse is correct?

- A. "Simple abdominal and pelvic exercises can begin right now."
- B. "You will need to wait until after your 6-week postpartum checkup."
- C. "Once your lochia has stopped, you can begin exercising."
- D. "You should not exercise while you are breastfeeding."

ANSWER: A

- A. On the first postpartum day, the client should be taught to start abdominal breathing and pelvic rocking. Kegel exercises, which should have been taught during pregnancy, should be continued. Simple exercises should be added daily until, by 2 to 3 weeks postpartum, the mother should be able to do sit-ups and leg raises.
- B. Abdominal and pelvic exercises can begin right away and not wait for the 6-week postpartum checkup.
- C. There is no reason for the client to wait until the lochia has stopped before beginning exercises.
- D. There is no reason that a breastfeeding mother should not begin abdominal and pelvic exercises now.

31. The nurse is teaching the Muslim client how to correctly latch her baby to her breast for breastfeeding. Two student nurses are observing the instruction. Later, the client requests that the nurse not be allowed to provide her postpartum care. What most likely caused the client to be uncomfortable with the nurse?

- A. Muslim women do not want to breastfeed while in the hospital.
- B. Muslim women wait for their milk to come in before they breastfeed.
- C. Muslim women are uncomfortable breastfeeding in public situations.
- D. Muslim women only breastfeed after the infant is given boiled water.

ANSWER: C

- A. Korean mothers resist breastfeeding in the hospital.
- B. Some Asian women believe colostrum is "bad," and therefore they do not feed until actual breast milk is present.
- C. Most Muslim women breastfeed because the Koran encourages it; however, they are uncomfortable about breastfeeding in public situations and prefer privacy. Having two students observing the feeding process most likely would make the client uncomfortable, as she would desire more privacy.

- D. Some Asian cultures believe the newborn must be given boiled water until the milk is actually present.

32. The nurse asks the 12-hour postpartum client, who is breastfeeding her baby now, why she has not yet received a dinner tray. The client states that her mother is bringing curry and that she won't be eating the hospital food tonight. Which response by the nurse is best?

- A. "Please let me know if you change your mind. I can order food for you later."
- B. "Since you are breastfeeding, you should avoid eating highly spiced food."
- C. "I will ask the dietitian to meet with you so you can discuss your nutritional needs."
- D. "You should not be eating highly spiced food 12 hours after delivery."

ANSWER: A

- A. Offering to order food later if the client changes her mind is the best response. Many clients have culturally based beliefs about food and beverages that should be consumed in the postpartum period. Unless contraindicated, nurses should support and encourage women to incorporate food preferences with cultural significance into their postpartum diet.
- B. Some breastfeeding infants are sensitive to certain flavors, seasonings, or foods, but, there is no evidence to support maternal food restrictions unless the infant shows a sensitivity. If there is a strong family history of a food allergy that causes anaphylaxis, such as a peanut allergy, these foods may be avoided.
- C. Many women would benefit from speaking to a dietitian, but this client is not at any increased risk that would make a dietary consultation necessary.
- D. There are no food restrictions 12 hours after delivery unless there have been complications.

33. The nurse is evaluating a breastfeeding session. The nurse determines that the infant has appropriately latched on to the mother's breast when which observations are made? Select all that apply.

- A. The mother reports a firm tugging feeling on her nipple.
- B. A smacking sound is heard each time the baby sucks.
- C. The infant's mouth covers only the mother's nipple.
- D. The baby's nose, mouth, and chin are touching the breast.
- E. The infant's cheeks are rounded when sucking.
- F. The infant's swallowing can be heard after sucking.

ANSWER: A, D, E, F

- A. If the latch is correct, the mother should feel only a firm tugging and not pain or pinching when the infant sucks.
- B. A smacking or clicking noise heard when the infant sucks is an indication that the latch is incorrect and that the infant's tongue may be inappropriately placed.
- C. Sucking only on the mother's nipple will cause sore nipples, and milk will not be ejected from the milk ducts.
- D. When an infant is correctly latched to the breast, 2 to 3 centimeters (1/3 to 3/4 inch) of areola should be covered by the infant's mouth. If this occurs, it will result in the infant's nose, mouth, and chin touching the breast.
- E. When the infant is latched correctly, the cheeks will be rounded rather than dimpled.
- F. When the infant is latched correctly, the swallowing will be audible.

34. The primiparous client, who is bottle feeding her infant, asks the nurse when she can expect to start having her menstrual cycle again. Which response by the nurse is most accurate?

- A. "Most women who bottle feed can expect their period within 6 to 10 weeks after birth."
- B. "Your period should return a few days after your lochial discharge stops."
- C. "Your lochia will change from pink to white; when white, your period should return."
- D. "Bottle feeding delays the return of a normal menstrual cycle until 6 months postbirth."

ANSWER: A

- A. In nonlactating women, the average time to first ovulation is 45 days, and the return of menstruation usually happens within 6 to 10 weeks postbirth.
- B. Most women can expect to have lochial discharge for up to 24 days. However, the cessation of discharge is not related to the return of menstruation.
- C. The change in lochial color is not related to the return of menstruation.
- D. The return of ovulation and menstruation is associated with a rise in serum progesterone levels. Bottle feeding does not affect when this change occurs in the client's body.

35. Twenty-four hours after the birth of her first child, the 25-year-old single client tells the nurse that she has several different male sex partners and asks the nurse to recommend an appropriate birth control method for her. Considering her lifestyle, which method of birth control should the nurse suggest?

- A. An intrauterine device (IUD)
- B. Depot-medroxyprogesterone acetate injections
- C. A female condom with nonoxynol-9
- D. A diaphragm

ANSWER: C

- A. IUDs offer no protection against STIs. They are recommended for women who are in a stable, mutually monogamous relationship.
- B. Depot-medroxyprogesterone acetate (Depo- Provera) is a long-acting progestin that is highly effective for birth control. A single injection will provide contraception for 3 months but does not offer protection against STIs.
- C. A female condom does provide protection against some of the pathogens that cause STIs, and it would be readily available over the counter.
- D. A diaphragm offers no protection against STIs.

36 . After delivering the full-term infant, the breastfeeding mother asks the nurse if there is any contraceptive method that she should avoid while she is breastfeeding. Which contraceptive should the nurse advise the client to avoid?

- A. A diaphragm
- B. An intrauterine device (IUD)
- C. The combined oral contraceptive (COC) pill
- D. The progesterone-only mini pill

ANSWER: C

- A. Because a diaphragm must be fitted to the individual female cervix, the diaphragm must be rechecked for correct size after each childbirth; however, use of the diaphragm will not affect breast milk production.
- B. An IUD will not affect breast milk production unless the IUD is inserted within the first 48 hours postpartum; insertion should be delayed until 4 weeks postpartum.
- C. Birth control pills containing progesterone and estrogen (COC) can cause a decrease in milk volume and may affect the quality of the breast milk.
- D. The progesterone—only mini pill may be used by breastfeeding clients because it does not interfere with breast milk production. However, it is

recommended that the mother wait 6 to 8 weeks before starting this method of contraception.

37. While assessing the breastfeeding mother 24 hours postdelivery, the nurse notes that the client's breasts are hard and painful. Which interventions should be implemented by the nurse? Select all that apply.

- A. Tell her to feed a small amount from both breasts at each feeding.
- B. Apply ice packs to the breasts at intervals between feedings.
- C. Give supplemental formula at least once in a 24-hour period.
- D. Administer an anti-inflammatory medication pre-scribed pm.
- E. Apply warm, moist packs to the breasts between feedings.
- F. Pump the breasts as needed to ensure complete emptying.

ANSWER: B, D, F

- A. Moving the baby from the initial breast to the second breast during the feeding, before the initial breast is completely emptied, may result in neither breast being totally emptied and thus promote continued engorgement.
- B. Because engorgement is caused, in part, by swelling of the breast tissue surrounding the milk gland ducts, applying ice at intervals between feedings will help to decrease this swelling.
- C. Giving supplemental formula, thus limiting the time the baby nurses at the breast, prevents total emptying of the breast and promotes increased engorgement.
- D. Administering anti-inflammatory medication will decrease breast pain and inflammation.
- E. Because heat application increases blood flow, moist heat packs would exacerbate the engorgement.
- F. Pumping the breasts may be necessary if the infant is unable to completely empty both breasts at each feeding. Pumping at this time will not cause a problematic increase in breast milk production.

38. The nurse is teaching the postpartum client, who is breastfeeding, about returning to sexual activity after vaginal delivery. Which statement should the nurse include?

- A. "Orgasm may decrease the amount of breast milk you produce."
- B. "You may need to use lubrication when resuming sexual intercourse."
- C. "You should not have sexual intercourse until two months postpartum."
- D. "Your IICP will let you know when you can resume sexual activity."

ANSWER: B

- A. Oxytocin is released when the client has an orgasm and may cause breast milk to leak or squirt from the breasts. The production of breast milk may increase, not decrease.
- B. The nurse should inform the client that she may need lubrication with sexual intercourse because the low estrogen levels in the early postpartum period causes vaginal dryness.
- C. Women should refrain from sexual intercourse until lochia has ceased, which usually takes about 3 weeks. There is no need to wait two months if the lochia has ceased.
- D. The client's HCP does not need to give approval to return to sexual activity.

39. During the first postpartum checkup, the nurse is assessing whether the client's chloasma has diminished. At which anatomical location is the nurse performing the assessment?

- A. Perineum
- B. Abdomen
- C. Breasts
- D. Face

ANSWER: D

- A. Chloasma does not appear on the perineum.
- B. Chloasma does not appear on the abdomen.
- C. Chloasma does not appear on the breasts.
- D. The nurse should be assessing the skin over the cheeks, nose, and forehead for chloasma.

40. The postpartum client's blood type is A negative, and her newborn infant's blood type is AB negative. The client received RhoGAM in her second trimester and another dose in her third trimester, after a minor car accident. The client is preparing for discharge and asks the nurse when she will receive her RhoGAM injection. The nurse correctly responds with which statement?

- A. "You already received two doses of RhoGAM and do not need an additional dose."
- B. "I will give your last dose of RhoGAM today, before you are discharged to home."
- C. "You and your baby have negative blood types; a dose of RhoGAM is not needed."
- D. "RhoGAM would have been already given while you were in the delivery room."

ANSWER: C

- A. The number of RhoGAM doses given in pregnancy does not affect whether or not the client receives a dose postpartum.
- B. Both the client and newborn are Rh negative; no dose is required.
- C. Rh immune globulin (RhoGAM) is administered to women with Rh negative blood types at approximately 28 weeks of gestation and again after any trauma, such as a car accident or fall. After delivery, RhoGAM is only indicated if the newborn has a positive blood type; both the client and newborn are Rh negative.
- D. For postpartum clients who require RhoGAM, the dose is given within 72 hours of delivery. However, no dose is necessary because the client and newborn are both Rh negative.

41. The client with mastitis asks the nurse if she should stop breastfeeding because she has developed a breast infection. Which response by the nurse is best?

- A. "Continuing to breastfeed will decrease the duration of your symptoms."
- B. "Breastfeeding should only be continued if your symptoms decrease."
- C. "Stop feeding for 24 hours until antibiotic therapy begins to take effect."
- D. "It is best to stop breastfeeding because the infant may become infected."

ANSWER: A

- A. Continuing to breastfeed is recommended when the client has mastitis. If the breasts continue to be emptied by either breastfeeding or pumping, the duration of symptoms and the incidence of a breast abscess are decreased.
- B. Continuing to breastfeed will decrease the symptoms of mastitis; there is no need to wait for symptoms to decrease.
- C. Usually an oral penicillinase-resistant penicillin or cephalosporin that is safe for the infant while breast-feeding is given to treat mastitis. There is no need for the client to stop breastfeeding for 24 hours.
- D. The infant's nose and throat are the most common sources of the organism that causes mastitis. Infants of women with mastitis generally remain well; thus, concern that the mother will infect the infant if she continues breastfeeding is unwarranted.

42. The postpartum client is being admitted for mastitis. The nurse should prepare the client for which interventions? Select all that apply.

- A. Walking at least four times in 24 hours
- B. Receiving a prescribed oral antibiotic
- C. Applying warm packs to the breasts
- D. Getting a prescribed anti-inflammatory drug

- E. Limiting oral fluid intake to 1000 mL per day
- F. Emptying the milk from her breasts frequently

ANSWER: B, C, D, F

- A. Rest is important to promote healing. Bed rest may be initially prescribed for 24 hours.
- B. Treatment for mastitis includes administration of antibiotics to treat the infection.
- C. Application of warm packs decreases pain and promotes milk flow and breast emptying.
- D. Treatment for mastitis includes anti-inflammatory medications to treat fever and decrease breast inflammation.
- E. Increasing fluid intake to at least 2 to 3 liters is recommended, not limiting intake.
- F. If the breasts continue to be emptied by either breastfeeding or pumping, the duration of symptoms and the incidence of a breast abscess are decreased.

43. The nurse educates the breastfeeding client diagnosed with mastitis. The nurse evaluates that the client has an adequate understanding of how to prevent mastitis in the future when the client makes which statements? Select all that apply.

- A. "Incorrect latch of my baby can lead to mastitis."
- B. "I should perform hand hygiene before I breastfeed."
- C. "I should rinse my baby's mouth before I let her latch."
- D. "A tight underwire bra has support that prevents mastitis."
- E. "I should allow my nipples to air-dry after breastfeeding."

ANSWER: A, B, E

- A. Incorrect latch can cause nipple tissue to blister, crack, and bleed. These breaks in the tissue may serve as an entry point for pathogens.
- B. Hand hygiene prior to breastfeeding reduces the number of pathogens available for invasion.
- C. While the infant's nose and throat are sources of pathogenic organisms that might cause mastitis, washing the infant's mouth would be difficult and would not provide adequate protection for the mother.
- D. Wearing a tight bra, especially with an underwire, may restrict milk ducts, providing milk stasis and a medium for pathogenic growth.
- E. Allowing breasts to air—dry helps to reduce skin breakdown that might be caused by a moist, wet environment.

44. The client, who is 20 days postpartum, telephones the perinatal clinic to tell the nurse that she is having heavy, bright red bleeding since hospital discharge 18 days ago. Which instruction to the client is correct?

- A. "You need to come to the clinic immediately."
- B. "Decrease physical activity until the bleeding stops."
- C. "There is no need for concern; this is expected after birth."
- D. "Call next week if the bleeding has not stopped by then."

ANSWER: A

- A. Lochia rubra that persists for longer than 2 weeks is suggestive of subinvolution of the uterus, which is the most common cause of delayed postpartum hemorrhage. The client should be seen in the clinic immediately to determine what is causing her abnormal lochial discharge.
- B. Increased physical activity can lead to increased lochial discharge, but the client is reporting continuous lochia rubra, which is abnormal.
- C. Lochia rubra is expected to last for up to 3 days after birth, not 20 days.
- D. Waiting until next week to be seen only delays determining the cause for her abnormal bleeding and increases the risk of the client for other complications.

45. The postpartum client suffered a fourth-degree perineal laceration during her vaginal birth. Which interventions should the nurse add to the client's plan of care? Select all that apply.

- A. Limit ambulation to bathroom privileges only.
- B. Decrease fluid intake to 1000 mL every 24 hours.
- C. Instruct the client on a high-fiber diet.
- D. Monitor the uterus for firmness every 2 hours.
- E. Give pm prescribed stool softeners in the am. and at h.s.

ANSWER: C, E

- A. Activity should be increased, not decreased, to reduce the potential for constipation.
- B. Fluids should be increased, not decreased, to reduce the potential for dehydration and constipation.
- C. The client with a fourth-degree perineal laceration should be instructed to increase dietary fiber to help maintain bowel continence and decrease perineal trauma from constipation.
- D. A perineal laceration will not affect the condition of the uterus; there is no need to increase uterine monitoring.

- E. The client with a fourth-degree perineal laceration should be given a stool softener bid to help maintain bowel continence and decrease perineal trauma from constipation.

46 . The postpartum client, who had a forceps-assisted vaginal birth 4 hours ago, tells the nurse that she is having continuing perineal pain rated at 7 out of 10 and rectal pressure. An oral analgesic was given and ice applied to the perineum earlier.

What should the nurse do now?

- A. Call the HCP to report the pain
- B. Closely reinspect the perineum
- C. Help her out of bed to ambulate
- D. Administer a stool softener

ANSWER: B

- A. Reexamination of the perineum should be completed before calling the HCP to report the pain level.
- B. A forceps-assisted delivery can increase the risk of hematoma development. Rectal pressure and perineal pain can indicate a hematoma in the posterior vaginal wall. The nurse should closely examine the perineum and the vaginal introitus for ecchymosis and a bulging mass.
- C. Ambulation would not help the perineal pain.
- D. A stool softener would be appropriate to avoid constipation but would not help the immediate problem.

47. The nurse is caring for the client who is 28 hours postpartum. Which assessment findings should prompt the nurse to notify the HCP of possible puerperal infection? Select all that apply.

- A. Oral temperature of 102.2°F (39°C)
- B. Telangiectasis on the neck and chest
- C. Mild abdominal tenderness with palpation
- D. Lochial discharge that is foul smelling
- E. White blood cell count of 16,500 cells/mm³

ANSWER: A, D

- A. A temperature of 100.4°F (38°C) or higher after 24 hours postpartum is associated with a puerperal infection.
- B. Telangiectasis is red, slightly raised vascular “spiders” that may appear during pregnancy over the neck, thorax, face, or arms and remain or fade during the postpartum period. It is not indicative of an infection.
- C. Slight abdominal tenderness with palpation is a normal postpartum finding.

- D. Malodorous lochia is a common sign of a puerperal infection.
- E. A WBC count of 16,500 is normal for the postpartum client; labor produces a mild pro- inflammatory state.

48. The nurse is caring for four postpartum clients. Which client should be the nurse's priority for monitoring for uterine atony?

- A. Client who is 2 hours post-cesarean birth for a breech baby
- B. Client who delivered a macrosomic baby after a 12-hour labor
- C. Client who has a firm fundus after a vaginal delivery 4 hours ago
- D. Client receiving oxytocin intravenously for past 2 hours

ANSWER: B

- A. Although the client post—cesarean birth for a breech baby may be at risk for uterine atony and should be monitored, the client who delivered a macrosomic baby is more at risk.
- B. This client is the nurse's priority for monitoring for uterine atony. A macrosomic baby stretches the client's uterus, and thus the muscle fibers of the myometrium, beyond the usual pregnancy size. After delivery the muscles are unable to contract effectively.
- C. A firm fundus indicates that the client's uterine muscles are contracting.
- D. Oxytocin (Pitocin) is being administered to increase uterine contractions. Although prolonged use of oxytocin can result in uterine exhaustion, two hours of use is not prolonged.

49. The postpartum client is being discharged to home with a streptococcal puerperal infection. The client is taking antibiotics but asks the nurse what precautions she should take at home to prevent spreading the infection to her husband, newborn, and toddler. Which is the best response by the nurse?

- A. "No precautions are necessary since you are taking antibiotics."
- B. "You should always wear a mask when caring for your newborn and toddler."
- C. "Wash your hands before caring for your children and after toileting and perineal care."
- D. "Your husband should provide all cares for both children until your infection is gone."

ANSWER: C

- A. The course of an endometrial infection is approximately 7 to 10 days, and thus standard precautions should be in place for that period of time even if the client has started antibiotics.

- B. Puerperal infections are not spread by droplets, and thus a mask is not necessary.
- C. Other than hand hygiene, no additional precautions need to be taken by the client in her home.
- D. The client is able to provide cares for her children, but hand washing is required before cares.

50. The student nurse reports to an experienced nurse finding a warm, red, tender area on the left calf of the client who is 48 hours post—vaginal delivery. The nurse assesses the client and explains to the student that postpartum clients are at increased risk for thrombophlebitis due to which factors? Select all that apply.

- A. The fibrinogen levels in the blood of postpartum clients are elevated.
- B. Fluids normally shift from the interstitial to the intravascular space.
- C. Postpartum hormonal shifts irritate vascular basement membranes.
- D. Pressure is placed on the legs when elevated in stirrups during delivery.
- E. Dilation of veins in the lower extremities occurs during pregnancy.
- F. Compression of the common iliac vein occurs during pregnancy.

ANSWER: A, D, E, F

- A. During pregnancy, fibrinogen levels increase, and this increase continues to be present in the postpartum period. The increased levels can contribute to clot formation.
- B. There is not a shift of fluid from the interstitial to the vascular spaces in the postpartum period. Actual blood volume increases during pregnancy and is further increased immediately after delivery. This fluid volume is eventually lost through diuresis during the first postpartum week.
- C. Postpartum hormonal changes do occur, but they do not affect the vascular basement membranes.
- D. Elevation of the legs in stirrups during delivery leads to pooling of blood and vascular stasis.
- E. Dilation of the veins in the lower extremities occurs during pregnancy and increases the risk of venous stasis.
- F. Compression of the common iliac vein occurs during pregnancy due to an enlarging fetus and increases the risk of venous stasis.

51. The postpartum client delivered a healthy newborn 36 hours previously. The nurse finds the client crying and asks what is wrong. The client replies, “Nothing, really. I’m not in pain or anything, but I just seem to cry a lot for no reason.” What should be the nurse’s first intervention?

- A. Call the client’s support person to come and sit with her.
- B. Remind her that she has a healthy baby and that she shouldn’t be crying.
- C. Contact the HCP to have the counselor come see the client.
- D. Ask the client to discuss her birth experience.

ANSWER: D

- A. The client’s support person should be given information about postpartum blues before the client is discharged from the hospital. However, contacting that individual should not be the first intervention.
- B. Reminding the client that she has a healthy baby is a nontherapeutic communication technique that implies disapproval of the client’s actions.
- C. There is no need to notify the HCP, as postpartum blues is a common self-limiting postpartum occurrence.
- D. A key feature of postpartum blues is episodic tearfulness without an identifiable reason. Interventions for postpartum blues include allowing the client to relive her birth experience.

52. The nurse is educating the postpartum client. Which prevention strategies for postpartum depression should the nurse include? Select all that apply.

- A. Attend a support group that has other postpartum women.
- B. Use the baby’s nap time to complete household chores.
- C. Keep a journal of feelings during the postpartum period.
- D. Call the HCP if feelings of sadness do not subside quickly.
- E. Develop a daily schedule of activities, and follow the plan.

ANSWER: A, C, D, E

- A. A postpartum support group can be a place where realistic information about postpartum depression can be discussed and symptoms recognized.
- B. Fatigue is a major concern for all postpartum women. Clients should be encouraged to nap when their infant is napping rather than using that time for other activities.
- C. Keeping a journal can be emotionally cathartic and can help prevent postpartum depression.

- D. Postpartum mothers should be encouraged to call their HCPs if symptoms of postpartum depression, such as feelings of sadness, do not subside quickly or if the symptoms become severe.
- E. Structuring activity with a schedule helps counteract inertia that comes with feeling sad or unsettled.

53. The husband of the postpartum client diagnosed with moderate postpartum depression (PPD) asks the nurse about the treatments his wife will require. The nurse's response should be based on knowing that which treatments are included in the initial collaborative plan of care? Select all that apply.

- A. Antidepressant medication
- B. Individual or group psychotherapy
- C. Removal of the infant from the home
- D. Sedative-hypnotic agents
- E. Electroconvulsive therapy (ECT)

ANSWER: A, B

- A. SSRIs are first—line agents for treating moderate PPD.
- B. Individual or group psychotherapy is a treatment for moderate PPD.
- C. If the client is displaying rejection of or aggression toward the infant, she should not be left alone with the infant, but the infant does not need to be removed from the home.
- D. Hypnotic agents are medications that promote sleep, but they are not to be used during the post- partum period. If sleep deprivation is occurring, a TCA may be prescribed.
- E. ECT would not be used in the initial treatment of moderate PPD. If puerperal psychosis develops, ECT is a treatment option.

54. The client is diagnosed with moderate postpartum depression (PPD) after vaginal delivery of a 10 lb baby. One week following the delivery, the nurse is completing a home visit. Which finding should be the nurse's priority?

- A. Lochia has a foul-smelling odor.
- B. Small but tender hemorrhoids.
- C. Yells at her baby to stop crying.
- D. Client cries throughout the visit.

ANSWER: C

- A. Lochia that is foul smelling could indicate that the client has a postpartum infection. The client needs to be seen by an HCP, but the safety of the infant is priority.
- B. The presence of tender hemorrhoids may be uncomfortable and should be addressed, but this is not priority.
- C. It is inappropriate for the client to yell at her baby to stop crying. Verbal abuse can escalate to physical abuse. The safety of the infant should be the nurse's priority.
- D. Persistent crying is a sign of PPD and would be expected. However, persistent crying should be further explored because treatment may be ineffective.

55. The client, whose parity is 1, had a vaginal delivery 6 days ago and arrived home yesterday after treatment for endometritis. The home health nurse visits the client and plans teaching after seeing which most concerning item in the client's bathroom?

- A. A box of tampons on the floor outside of the shower stall.
- B. Loofa bath sponge sitting on the seat of the shower stall.
- C. Damp towel bunched on the towel bar and near the floor.
- D. Can of bathroom cleaner on the floor of the shower stall.

ANSWER: A

- A. The nurse should plan teaching about the use of tampons during postpartum. The tampon may irritate or dry the vagina, holds lochia in the body, and increases the risk of infection. The client should be instructed to wear a peripad.
- B. Loofas or bath sponges for bathing the body postpartum are not contraindicated.
- C. While it is a good idea to hang towels neatly so that they dry more rapidly and reduce mold growth, this is not a priority for teaching.
- D. The bathroom cleaner would be dangerous to an older child who is more mobile, but the client's parity is 1. The client would be wise to start considering safety issues by placing this out of reach, but this is not the priority teaching item.

56 . The home care nurse is visiting the mother and her 6—day—old son. The nurse observes that the infant is sleeping in a crib on his back and has a blanket draped over his body. The mother had been sleeping in a nearby room. Which statements are appropriate for the nurse to make in response to this situation? Select all that apply.

- A. "I'm glad to see that you are sleeping while your baby sleeps."

- B. "Having your baby sleep on his back reduces the risk of SIDS."
- C. "It is best for you to sleep in the same room as your newborn."
- D. "Position your baby on his tummy and side when he is awake."
- E. "When using a blanket, always tuck its sides under the mattress."

ANSWER: A, B, D

- A. This is an appropriate statement. Sleeping while the infant sleeps will help the mother get the rest she needs.
- B. This is an appropriate statement. The American Academy of Pediatrics recommends the supine position for infant sleeping to decrease the risk of SIDS.
- C. The mother should be in close proximity and ready to respond when the infant wakes and/or cries, but she does not need to sleep in the same room as the infant.
- D. This is an appropriate statement. While awake the infant should be positioned prone and side-lying to help build neck muscles and decrease the chance of deformation plagiocephaly. Deformation plagiocephaly is a malformation of the skull caused by consistently lying on the back.
- E. A blanket, if used, should swaddle the infant rather than being draped over the infant. Swaddling helps prevent suffocation. Tucking the blanket sides under the mattress does not prevent suffocation.

57. Two days after hospital discharge, the nurse is assessing the mother and her newborn twins in their home. Which statement or question made by the nurse best demonstrates empathy?

- A. "You may be feeling overwhelmed. This is normal."
- B. "I can't imagine how tired you must be with twins."
- C. "How are you feeling about being the mother of twins?"
- D. "I saw that laundry is piling up. Do you want a home aide?"

ANSWER: C

- A. Projecting feelings onto the client does not demonstrate empathy.
- B. This statement imposes a personal assumption and does not demonstrate empathy.
- C. This question demonstrates empathy. The nurse is asking a question to allow the client to explain her situation and feelings while the nurse listens. The nurse is attempting to understand the experience as lived by the client.
- D. Acknowledging that laundry is piling up and offering home aide services do not demonstrate empathy. Commenting on the laundry on the first visit may suggest to the client that she lacks support, and she may be defensive or hurt by the acknowledgement.

58. The nurse caring for the postpartum client who is 15 years old is concerned about this client's ability to parth a newborn. Which behavior is characteristic of the developmental level of the 15 -year-old that justifies the nurse's concern?

- A. Developing autonomy
- B. Follows rules established by others
- C. Career oriented
- D. Egocentric

ANSWER: D

- A. The development of autonomy is a developmental task of toddlerhood.
- B. School-age children are motivated to follow rules established by others.
- C. Adult women are concerned about the effect of childbearing on careers.
- D. Although it is biologically possible for the adolescent female to become a parent, her egocentricity and concrete thinking interfere with her ability to parent effectively. Because of this normal development, the adolescent may inadvertently neglect her child.

59. Before 1105pitalization, an adolescent client had decided to give up her newborn for adoption. The client had an uncomplicated vaginal delivery and is still committed to her decision. Which intervention should the nurse exclude?

- A. Offer to the client a transfer to a different unit within the hospital.
- B. Talk to the client about having possible feelings of ambivalence.
- C. Initiate a case management or social work consult for the client.
- D. Notify her family to ensure that support is avail- able upon her discharge.

ANSWER: D

- A. Offering to transfer the client is appropriate and would not be excluded. The postpartum unit may be filled with sounds and sights that may distress the client.
- B. It would be appropriate for the nurse to discuss possible ambivalence with the client, as she may have increased feelings of attachment, love, and grief after delivery. Having those feelings does not necessarily mean that the client has made the wrong decision.
- C. Initiating a case management or social work consult is appropriate and would not be excluded. The client may not have support systems available because she may not have disclosed her pregnancy to others.
- D. The adolescent may not have disclosed the pregnancy to family. Although it would be appropri- ate for the nurse to explore the client's support system with the client, the nurse should not contact the client's family.

60. The nurse receives report for four postpartum clients. In which order should the nurse assess the clients? Prioritize the clients in order from first to last.

- A. The client who had a normal, spontaneous vaginal delivery 30 minutes ago.
- B. The client who had a cesarean section 48 hours ago and is bottle feeding her newborn infant.
- C. The client who had a vaginal delivery 32 hours ago and is having difficulty breastfeeding.
- D. The client who delivered her newborn via scheduled C—section 8 hours ago and has a PCA pump with morphine for pain control.

ANSWER: A, D, C, B

A. The client who had a normal, spontaneous vaginal delivery 30 minutes ago is priority. The first 2 hours after delivery is a time of transition, characterized by rapid changes in hemodynamic and physiological state for both the client and her newborn.

D. The client who delivered her newborn via scheduled C-section 8 hours ago and has a PCA pump with morphine for pain control should be assessed next. Although she is 8 hours post-partum and probably stable, she is receiving morphine, and her respiratory status should be monitored regularly.

C. The client who had a vaginal delivery 32 hours ago and is having difficulty breastfeeding should be assessed next. Newborn infants should successfully breastfeed every 2—3 hours. Failing to breastfeed with adequate amount and frequency may lead to newborn complications such as excessive weight loss and jaundice.

B. The client who had a cesarean section 48 hours ago and is bottle feeding her newborn infant should be seen last; there is nothing indicating urgency.