

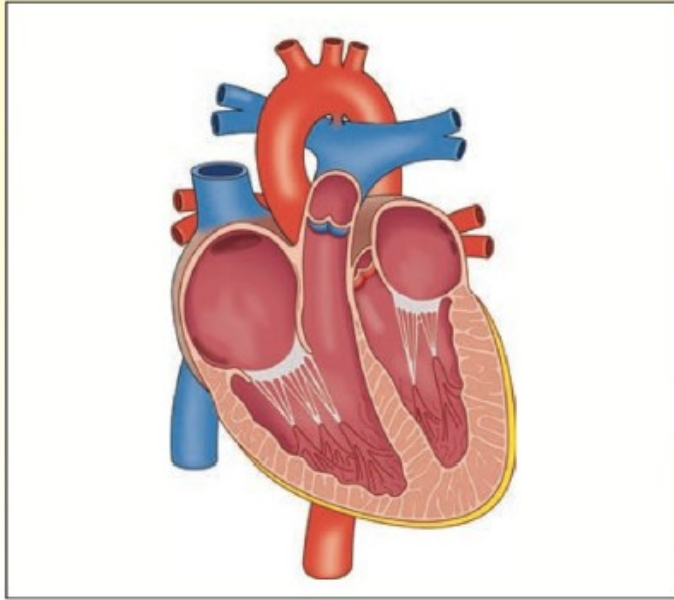
1. The nurse meets the frantic father at an ED door. He says he just delivered his wife's full-term newborn in the car when the temperature outside is only 10°F (−12.2°C). In response to the cold environment, the nurse knows that the infant's body will immediately begin to produce heat by which mechanism?

- A. Shivering
- B. Metabolizing body fat
- C. Dilating surface blood vessels
- D. Decreasing flexion of the extremities

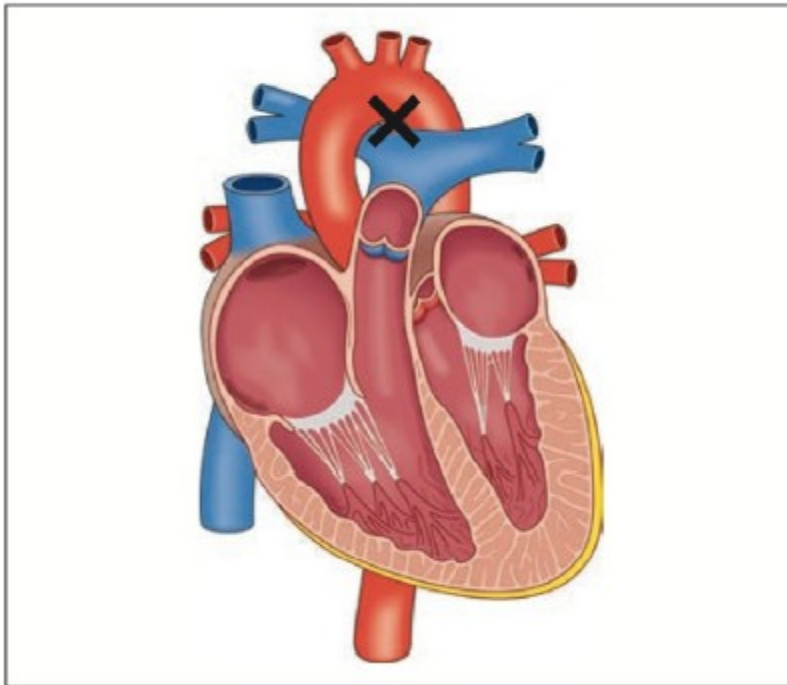
ANSWER: B

- A. Shivering is rarely seen in newborns, and it does little to produce heat.
- B. When skin receptors of full-term newborns perceive a drop in environmental temperature, the sympathetic nervous system is stimulated. This in turn stimulates metabolism of brown fat, thus producing heat that is transferred to the peripheral circulation.
- C. Newborns are able to conserve body heat by constricting, not dilating, blood vessels.
- D. Decreasing flexion promotes heat loss by exposing more skin surface to the environment. Full-term newborns normally maintain a flexed posture.

2. At a prenatal class, the nurse utilizes a picture of the fetal heart to explain that functional closure of the ductus arteriosus occurs within 15 hours after birth. Place an X at the location on the fetal heart illustrated where the nurse should be pointing to identify the ductus arteriosus.



ANSWER:



The ductus arteriosus connects the pulmonary artery to the descending aorta (X) and acts as a shunt to carry blood directly from the right ventricle into the aorta. This should close within 15 hours after birth.

3. The nurse finds documentation in the 4-hour-old newborn's medical record that states, "Clamping of the umbilical cord was delayed until cord pulsations ceased." When assessing and collecting additional information about the newborn, what effect should the nurse find as a result of the delayed cord clamping?

- A. More rapid expulsion of meconium by the newborn
- B. Increased level of newborn alertness after birth
- C. An increase in the newborn's initial temperature
- D. An increase in the newborn's hemoglobin and hematocrit

ANSWER: D

- A. Full-term newborns normally pass meconium naturally within 8 to 24 hours after birth. Delayed clamping of the umbilical cord will not affect this process.
- B. The healthy newborn is born awake and active. This alertness typically lasts for 30 minutes after birth and is known as the first period of reactivity. This will not be affected by delayed cord clamping.
- C. At birth, the newborn's temperature may fall due to evaporative heat loss. Delayed cord clamping will not affect this evaporation process.
- D. Newborn Hgb and Hct values will be higher when placental transfusion, accomplished through delayed cord clamping, occurs at birth. Blood volume increases by up to 50% with delayed cord clamping.

4. The nurse is completing the 1-minute Apgar assessment on the full-term newborn. The newborn's HR is 80 bpm. What should the nurse do next?

- A. Assign a 2 for the Apgar score that pertains to the heart rate.
- B. Suction the excess secretions from the newborn's oral cavity.
- C. Wrap in warm blankets and place on the mother's abdomen.
- D. Begin immediate positive pressure ventilation on the newborn.

ANSWER: D

- A. To score a 2 on the HR criterion of the Apgar scoring, the newborn's HR must be above 100 bpm.
- B. During birth, as soon as the head emerges, the newborn's mouth is suctioned first (because the newborn is an obligate nose breather) and then the nares with a bulb syringe to prevent aspiration of mucus, amniotic fluid, or meconium. Suctioning should be completed during the newborn's care, but there is no indication that this is needed.

- C. The newborn would not be wrapped and placed on the mother's abdomen until the assessment is complete; the HR is only the first parameter to be scored on the Apgar scoring system.
- D. A newborn HR of less than 100 bpm scores as a 1 on the HR criterion and indicates a need to begin positive pressure ventilation by bag mask or Neopuff® ventilation.

5. The client with oligohydramnios and possible intrauterine growth restriction gives birth. The newborn's 1-minute Apgar score was 6, and the 5-minute Apgar score is 7. Which conclusion should the nurse make from this information?

- A. A low Apgar score at 1 minute correlates with infant mortality.
- B. The 5-minute Apgar score of 7 is within normal parameters.
- C. Neurological problems are unlikely with a 5-minute score of 7.
- D. Oligohydramnios would not have affected the Apgar score.

ANSWER: B

- A. Whereas a low 1-minute Apgar score is not associated with infant mortality, a low 5-minute Apgar score is.
- B. A 5-minute Apgar score at or above 7 is considered normal.
- C. The Apgar score at 5 minutes in full-term infants is a poor predictor of neurological outcome.
- D. Oligohydramnios is the presence of too little amniotic fluid. This as well as other variables such as gestational age, resuscitation measures, and medications can all affect the Apgar score.

6 . The nurse is caring for the newborn infant. Which initial measures should the nurse take to maintain the newborn's axillary body temperature between 97.7°F (36.5°C) and 98.9°F (37.2°C)? Select all that apply.

- A. Carefully dry the infant immediately after birth.
- B. Place the infant skin-to-skin with the mother.
- C. Apply leggings to both of the newborn's legs.
- D. Cover the infant's head with a stocking cap.
- E. Place the infant in a bassinette close to the wall.

ANSWER: A, B, D

- A. Drying the newborn immediately after birth prevents heat loss through evaporation.
- B. Skin-to-skin contact between mother and baby at birth assists to maintain newborn body temperature.

- C. if other appropriate warming measures are taken, there is no need to wrap the infant's legs in leggings.
- D. The newborn's head is dried first after birth, and a stocking cap is placed on the head to conserve heat.
- E. Placing the bassinette close to the wall will cause radiation heat loss because the wall is cooler in temperature than the newborn.

7. As the nurse prepares to administer prophylactic eye treatment to prevent gonorrhea] conjunctivitis in the full-term newborn, the newborn's father asks if it is really necessary to put something into his baby's eyes. Which statement should be the basis for the nurse's response?

- A. It is the law in the United States that newborns receive this prophylactic treatment.
- B. This treatment is recommended but may be omitted at the parent's verbal request.
- C. The antibiotic used for the treatment can be given orally at the parent's request.
- D. The eye prophylaxis can be given anytime up until the infant is 1 year old.

ANSWER: A

- A. Currently every US. state requires that newborns receive prophylactic eye treatment against gonorrhea] conjunctivitis.
- B. If a parent objects to the treatment, the parent will be asked to sign formal documentation of informed refusal.
- C. The antibiotic can only be administered topically, not orally.
- D. The eye prophylaxis must be administered Within 1 hour of birth to be effective.

8. The nurse has just assisted with the birth of a full-term infant. The nurse should take which measures immediately to promote parent-infant attachment? Select all that apply.

- A. Have the mother nap before interacting with her newborn.
- B. Dim the lights in the birthing room-
- C. Place the newly delivered infant on the mother's abdomen.
- D. Delay instilling the ophthalmic antibiotic for an hour.
- E. Play loud music to keep the infant stimulated.
- F. Ask the parents to delay phone calls for an hour after birth.

ANSWER: B, C, D, F

- A. If the mother naps immediately after birth, the alert newborn period may be missed.
- B. Dimming the lights in the birthing room encourages the newborn to open his or her eyes. This in turn encourages eye contact between the parent and the newborn.
- C. Skin-to-skin contact between mother and baby at birth improves mother-baby interaction.
- D. Instillation of ophthalmic antibiotic ointment may cause temporary blurred vision in the newborn, thereby decreasing the ability to engage in eye-to-eye contact with the parents. This can be given up to 1 hour after birth.
- E. Avoiding loud noises encourages parent-infant communication.
- F. The newborn is alert for up to 1 hour after birth. Parents should be encouraged to use this time for attachment and to delay phone calls.

9. The agitated father of the 12-hour-old newborn reports to the nurse that his baby's hands and feet are blue. The nurse confirms acrocyanosis and intervenes by taking which action?

- A. Immediately stimulates the infant to cry
- B. Explain that this is normal in a newborn
- C. Assess the newborn's temperature
- D. Assess the newborn's cardiac status

ANSWER: B

- A. It is unnecessary to stimulate the infant to cry because acrocyanosis is normal.
- B. Acrocyanosis, which is blueness of hands and feet, is a normal newborn phenomenon in the first 24 to 48 hours after birth. The nurse should explain this to the father to relieve his anxiety.
- C. It is unnecessary to assess the newborn's temperature because acrocyanosis is normal.
- D. It is unnecessary to assess the newborn's cardiac status because acrocyanosis is normal.

10. The nurse is measuring both the chest and head circumference during the full-term newborn's initial assessment. The newborn's father observes this and asks the nurse why both measurements are necessary. Which explanation is most accurate?

- A. "Comparing the measurements helps determine if there are head or chest size abnormalities."

- B. "Measuring the head circumference provides information about future intellectual ability."
- C. "Measuring the newborn's chest provides needed information when assessing cardiac health."
- D. "Comparing the head and chest measurements helps to determine future adult body size."

ANSWER: A

- A. The circumference of the normal newborn's head is approximately 2 centimeters greater than the circumference of the newborn's chest at birth. Any extreme difference in head size may indicate microcephalus, hydrocephalus, or increased ICP.
- B. Head size is not related to intelligence. Heredity and interpersonal relationships play critical roles in intellectual development of the child.
- C. Chest size does not provide information needed to assess cardiac status.
- D. The relationship of the head and chest does not predict adult body size. Heredity, nutrition, and hormones are the major determinant of physical adult size.

11. The nurse assesses that the 8-hour-old infant's axillary temperature is 97°F (361°C). Which intervention should the nurse implement first?

- A. Document the findings as abnormal.
- B. Place the infant under a radiant warmer.
- C. Feed the infant formula that is warmed.
- D. Call the HCP to report the temperature.

ANSWER: B

- A. Only after an intervention should the nurse document the findings because the temperature is abnormal.
- B. This infant's axillary temperature of 97°F (361°C) is below the normal range of 97.7°F (365°C) to 98.9°F (372°C). The infant should be gradually rewarmed under a temperature-controlled radiant warmer.
- C. Feeding warm formula is unnecessary and may affect the mother's breast milk production if she is breastfeeding.
- D. There is no need to call the HCP unless the nurse is unable to warm the infant using appropriate interventions.

12. The nurse receives a laboratory report result showing that the blood glucose is 48 mg/dL for a full-term newborn. Which action should be taken by the nurse?

- A. Have the mother breastfeed her newborn now.
- B. Immediately feed the infant water with 10% dextrose.
- C. Report the results immediately to the health care provider.
- D. Document the information in the newborn's medical record.

ANSWER: D

- A. Although breast- or formula feeding helps to prevent hypoglycemia in newborns, feeding is not necessary because a blood sugar of 48 mg/dL is within normal parameters.
- B. Oral glucose water can cause a rapid increase in glucose followed by an abrupt decrease and should not be given to treat hypoglycemia.
- C. A blood sugar of 48 mg/dL is within normal parameters; there is no need to notify the HCP.
- D. Normal blood sugar values for a full-term newborn are 45 to 65 mg/dL. Therefore the only action required is to document the findings.

13. During an assessment of the full-term, 1-hour-old newborn, the nurse obtains an apical HR of 120 bpm and auscultates a soft murmur at the left sternal border, third intercostal space. In response to these assessment findings, which action should be taken by the nurse?

- A. Immediately report the findings to the HCP.
- B. Document the heart rate and murmur.
- C. Recheck the murmur in the left side-lying position.
- D. Stimulate crying and then reassess the cardiac status.

ANSWER: B

- A. The assessment reveals normal findings so there is no need to notify the HCP.
- B. Documentation of the findings is all that is required. Both the HR and murmur are expected findings. The apical HR of the term newborn is normally between 100 and 160 bpm. A murmur heard at the sternal border, third intercostals space, is most likely caused by delayed closure of the foramen ovale, which functionally closes within 1 to 2 hours after birth. Permanent closure of the foramen ovale occurs within 6 months to 1 year after birth.
- C. A left side-lying position brings the heart closer to the chest wall to better hear a murmur, but this is not necessary because the presence of a murmur is expected.

- D. There is no need to stimulate crying; crying will make it more difficult to hear heart sounds.

14. The nurse is assessing the full-term Caucasian infant who is 40 hours old. Which technique should the nurse use to evaluate the infant for jaundice?

- A. Remove the infant's diaper and look at the color of the genitalia.
- B. Apply pressure on the forehead for 3 seconds, release, and evaluate the skin color.
- C. Assess the color of the palms and compare that skin color to the color of the soles-
- D. Open the infant's mouth to assess the color of the infant's tongue and palate.

ANSWER: B

- A. Jaundice is generally first noticed in the head and then progresses gradually down the body; thus the change in skin color would not be evident as quickly in the genitalia.
- B. To differentiate cutaneous jaundice from normal skin color, the nurse should apply pressure with a finger over a bony area such as the forehead. If jaundice is present, the blanched area will look yellow before the capillaries refill.
- C. The change in skin color would not be evident as quickly in the extremities as in the head.
- D. Since the tongue and palate are naturally darker in color than the rest of the skin, it is more difficult to determine jaundice by assessing in these areas.

15. Calculating from the date of the mother's last menstrual period, the nurse determines that her newborn's gestational age is 40 weeks. Which normal findings should the nurse expect when assessing this newborn at birth? Select all that apply.

- A. Hypertonic flexion of all extremities.
- B. Sole creases on the anterior two-thirds of the sole.
- C. Well-defined incurving of the entire ear pinna.
- D. Presence of a prominent clitoris.
- E. Infant is able to support the head momentarily when pulled to a sitting position.

ANSWER: A, C, E

- A. As the fetal muscular tone matures, the posture becomes more flexed; thus the full-term newborn exhibits hypertonic flexion of all extremities.
- B. Sole creases over the anterior two-thirds of the sole indicate a gestational age of approximately 37 weeks.
- C. Cartilage gives the ear its shape. At full term, the newborn ear has enough cartilage to produce a well-defined incurving of the entire pinna.
- D. A prominent clitoris is found in a female infant whose gestational age is between 30 and 32 weeks. As the fetus matures, the labia majora become large enough to completely cover the clitoris and labia minora.
- E. The full-term infant has the muscle strength to momentarily support his or her head when pulled to a sitting position.

16 . While supervising the LPN, the RN determines that the LPN needs additional instruction in newborn care. Which action by the LPN prompted the nurse's conclusion?

- A. Assessed the newborn's heart rate apically
- B. Covered the newborn's head with a stocking cap
- C. Checked the newborn's temperature rectally
- D. Positioned the newborn supine while sleeping

ANSWER: C

- A. The newborn's HR should always be assessed apically because radial and temporal pulses are difficult to palpate.
- B. A stocking cap is often utilized to conserve heat in newborns.
- C. The LPN needs additional instruction when observed monitoring the newborn's temperature rectally. Taking the temperature rectally may cause rectal mucosal irritation and increase the chances of rectal perforation.
- D. The American Academy of Pediatrics recommends that healthy full-term infants be placed on their backs to sleep because this has been found to reduce deaths from SIDS.

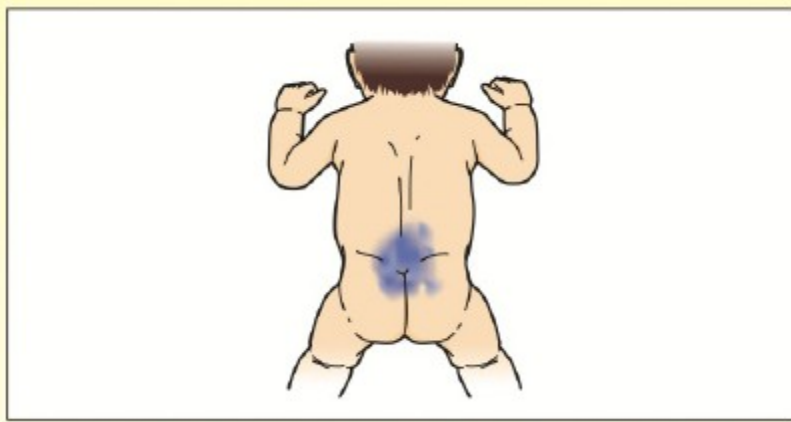
17. The first-time mother of the 2-hour-old full-term newborn worriedly tells the nurse, "Something black is coming out of my baby." After determining that the newborn has passed stool, which statement by the nurse is most appropriate?

- A. "Black stools could be from bleeding. I will notify your provider now."
- B. "Breastfeeding will cause all the baby's stools to be this dark in color."
- C. "Babies normally pass this type of stool initially; it is called meconium."
- D. "I'll check the baby's temperature; this occurs when babies need warming."

ANSWER: C

- A. This stool is normal and does not indicate that a newborn has active GI bleeding.
- B. Stools of breastfed babies are usually pale yellow once the meconium has passed.
- C. The majority of full-term infants will normally pass the first meconium stool within 24 hours after birth. It is formed during fetal life from amniotic fluid and intestinal secretions and cells. It is greenish-black in color and normally contains occult blood.
- D. Being cold does not affect the passage of meconium. Exposure to cold will increase the infant's oxygen requirements, decrease glucose levels and surfactant production, and can eventually result in respiratory compromise.

18. While performing an initial assessment on the full-term infant whose parents are Asian, the nurse notes the skin discoloration illustrated. What should be the nurse's interpretation of this finding?



- A. The infant was bruised during or after the delivery.
- B. This is a normally occurring skin variation in newborns.
- C. Hurriedly placing the infant supine can cause this bruising.
- D. Seepage of blood from the intestine occurred during the birth process.

ANSWER: B

- A. Mongolian spots are not a result of injury during delivery; if it were bruising, bruising would not occur this rapidly.
- B. The image is illustrating Mongolian spots, a normal newborn skin variation.

- C. Mongolian spots are not a result of injury from improper handling of the infant; if it were bruising, bruising would not occur this rapidly.
- D. Mongolian spots are not a result of intestinal bleeding.

19. The nurse assesses that the full-term newborn's head has molding. Considering this finding, which information should the nurse expect to see on the mother's labor and delivery documentation?

- A. Vaginal breech birth
- B. Planned cesarean birth, no labor
- C. Was in labor for 16 hours
- D. Precipitous delivery after a 30-minute labor

ANSWER: C

- A. No molding occurs when the fetus is breech because the buttocks not the head are the presenting part.
- B. With planned cesarean section, the head is not pressed against the cervix because labor does not occur.
- C. A 16-hour labor will cause molding. Molding is a change in the shape of the fetal skull from the force of uterine contractions during labor pressing the vertex of the head against the cervix. The degree of molding varies with the amount and length of pressure exerted on the head. Thus a longer labor will increase molding.
- D. A precipitous delivery following only 30 minutes of labor would mean limited time for the vertex to be pressing against the cervix.

20. The nurse is caring for the newborn infant. The nurse should prepare to assess the newborn's anterior fontanel by which method?

- A. Lay the infant on his or her back.
- B. Stimulate the infant to cry strongly.
- C. Feel near the parietal and occipital bones.
- D. Place the infant in a sitting position.

ANSWER: D

- A. Laying the infant supine may cause bulging of the fontanel; assessing in this position is incorrect.
- B. Crying may cause a temporary bulging of the fontanel and should not be stimulated.
- C. Feeling near the parietal and occipital bones will locate the posterior and not anterior fontanel.

- D. To assess the anterior fontanel, the nurse should place the infant in a sitting position (45° to 90°) so its location, size, and any abnormalities can be identified. If indented-appearing, it could indicate dehydration; if bulging, it could indicate increased ICP.

21. The nurse has provided the mother with information about her newborn's milia. The nurse evaluates that the mother understands information when the mother makes which statement?

- A. "I will put lotion on my infant's nose in the morning and at night."
- B. "I understand these raised white spots will clear up without treatment."
- C. "I realize the baby will need surgery to remove these skin lesions."
- D. "I will apply alcohol twice a day to the lesions until they disappear."

ANSWER: B

- A. Lotion may clog the exposed sebaceous glands.
- B. This statement indicates the mother understands information about milia. No treatment is necessary because it will clear spontaneously within the first month.
- C. Surgery is not necessary; these are not skin lesions but milia, which clear up within the first month.
- D. Alcohol is drying and may aggravate milia.

22. The nurse reviews the labor and delivery record of the 2-hour-old male newborn and sees this notation: "40 weeks' gestation, large for gestational (LGA) age-" In response to this information, it is most important for the nurse to plan to assess the infant carefully for which condition?

- A. Acrocyanosis
- B. Undescended testicles
- C. Intact clavicles
- D. Hypothermia

ANSWER: C

- A. Acrocyanosis is common after birth for full-term newborns due to poor peripheral circulation and is not particular to the infant that is LGA.
- B. By full term, the testicles of the male newborn can be found in the lower scrotum. Undescended testicles are not unique to LGA infants.
- C. A major complication for LGA infants is birth trauma, such as a fractured clavicle, due to cephalopelvic disproportion from macrosomia.

- D. Hypothermia is always a concern with newborns; however, the increased amounts of subcutaneous fat in LGA infants provide added thermal protection.

23. The nurse evaluates that the newborn's Moro reflex is WNL- Which response by the newborn prompted the nurse's conclusion?

- A. Straightens extremities and then flexes them in response to a loud noise
- B. Right-side extremity extension when the head is quickly turned right
- C. Turns the head toward the right side when the right cheek is touched
- D. Attempts to walk when the sole of the foot touches a hard surface

ANSWER: A

- A. An intact Moro reflex is demonstrated when the newborn straightens the extremities and then flexes them in response to a loud noise.
- B. Option 2 describes an intact tonic neck reflex.
- C. Option 3 describes the rooting reflex.
- D. Option 4 describes the stepping reflex.

24. The nurse completed discharge education to the Native American parents of a 48-hour-old, full-term infant. The nurse concludes that the mother needs additional teaching about jaundice when she makes which statement?

- A. "I know keeping my baby warm will help to decrease jaundice."
- B. "I know the jaundice should start to decrease after about 3 days-"
- C. "The bilirubin causing the jaundice is eliminated in my baby's stools."
- D. "Feeding my baby frequently will help to decrease the jaundice."

ANSWER: B

- A. The mother is correct to keep her baby warm, as cold stress can result in acidosis, which will decrease available serum albumin binding sites. This in turn will result in a decrease in unconjugated bilirubin being transported via albumin to the liver.
- B. Peak bilirubin levels are reached at 3 to 5 days of age for Caucasian infants. However, Native American babies have higher bilirubin levels than Caucasian babies, and the jaundice persists for longer periods with no apparent ill effects.
- C. Bilirubin is eliminated in the baby's stools; inadequate stooling may result in reabsorption of bilirubin.
- D. Frequent feeding promotes intestinal elimination and provides protein intake necessary for the formation of hepatic binding proteins.

25. The primiparous client, who delivered a term newborn, is a lesbian, achieved her pregnancy via artificial insemination, and is in a monogamous relationship with a female partner. Which intervention should the nurse add to the newborn's care plan?

- A. Avoid acknowledging the client's lesbian relationship.
- B. Encourage the client's partner to participate in newborn cares.
- C. Ask the partner to leave the room when the newborn is present.
- D. Avoid telling the newborn's caregivers about the client's situation.

ANSWER: B

- A. In order to ensure that the needs and desires of the couple are recognized and met, the nurse will need to acknowledge the lesbian relationship with the client.
- B. The nurse should involve the partner in the newborn's care. This shows the partner the same respect, caring, and attention shown to the partners of heterosexual mothers.
- C. Asking the partner to leave the room is disrespectful and judgmental.
- D. The nurse should ensure that the needs and desires of the couple are recognized and met by care- givers. In order to do so, the nurse needs to provide the information about the lesbian relationship to caregivers.

26 . The nurse is preparing the parents of a full-term, 24-hour—old male newborn for discharge with their infant. Which are the expected discharge criteria that should be met before the infant leaves the hospital? Select all that apply.

- A. Infant vital signs have been normal for the last 12 hours.
- B. The infant has passed at least three meconium stools.
- C. The infant has gained weight at the minimum 100 grams.
- D. The circumcision has had no bleeding for the last 2 hours.
- E. The infant has had six diaper changes in the last 24 hours.
- F. The infant has completed 2 successful consecutive feedings.

ANSWER: A, D, F

- A. The American Academy of Pediatrics has determined that newborn discharge criteria include stable VS for 12 hours.
- B. One meconium stool, not three, is an expected discharge criterion.
- C. There is no weight gain requirement for discharge; newborns are expected to lose weight during the first 3 to 4 days after birth.
- D. No bleeding from a circumcision for 2 hours is an expected discharge criterion.

- E. Discharge criteria include that the infant has urinated regularly. There is no specified number of diaper changes in a 24-hour period and no specified number of wet diapers.
- F. Completing two successful consecutive feedings is included in the discharge criteria. Successful feeding includes verification that the infant is able to coordinate sucking, swallowing, and breathing while feeding.

27. The nurse is caring for the full-term newborn male who is 24 hours old and was circumcised with a Gomco clamp 30 minutes ago. Which interventions should the nurse plan for care of the newborn's circumcision? Select all that apply.

- A. Monitor the newborn's penis hourly for 4 to 6 hours.
- B. Observe for and document the first voiding after circumcision.
- C. Use prepackaged commercial diaper wipes for perineal cleansing.
- D. Apply petroleum ointment around the penis after each diaper change.
- E. Apply tightly a size-smaller diaper to provide hemostasis.

ANSWER: A, B , D

- A.** After circumcision, the newborn's penis should be closely monitored, especially for swelling and bleeding.
- B.** To evaluate for urinary obstruction, the infant should be monitored frequently for the first urination postcircumcision, and this finding should be documented.
- C.** Prepackaged commercial diaper wipes should be avoided because they may contain alcohol, which could be irritating.
- D.** Petroleum and gauze should be applied to the circumcision site with each diaper change to prevent bleeding and to protect healing tissue.
- E.** When diapering the newborn the nurse should ensure that the diaper is not too tight or too small, which may cause pain. If too loose, it can cause rubbing with movement.

28. The nurse admits the term newborn, who is at risk to develop neonatal abstinence syndrome (NAS), to the newborn nursery. The nurse correctly places this infant in which location?

- A. The general nursery with 15 other infants
- B. A small, well-lit nursery with two other newborns
- C. Alone in a small, darkened nursery room
- D. Right next to the charge nurse's desk

ANSWER: C

- A. Placing the newborn with NAS in with 15 other infants will be too stimulating due to increased noise from other infants.
- B. The light of a well—lit nursery will be too stimulating for the newborn with NAS.
- C. The newborn with NAS will exhibit withdrawal behaviors due to exposure to chemical substances in utero. The nurse should place the newborn alone in a small, darkened nursery room to reduce environmental stimuli.
- D. Placing the newborn with NAS near the charge nurse’s desk will be too stimulating due to environmental noise.

29. The nurse discovers that an African couple from Kenya has not named their 48-hour—old, full—term newborn, and the infant and mother are being discharged to home. Which action should the nurse take in response to this information?

- A. Ask the parents to choose a name before discharge.
- B. Encourage other appropriate attachment behaviors.
- C. Document the discharge and that the baby is unnamed.
- D. Delay discharge until parental attachment is addressed.

ANSWER: C

- A. It would be culturally inappropriate to ask the parents to choose a name before discharge.
- B. It is always appropriate for the nurse to observe for and encourage attachment behaviors; however, in this situation, not naming the infant is not a Sign of inappropriate attachment.
- C. In Kenya, the naming of a child is an important event. In some areas, the name is given on the third day after birth and is marked by a celebration. Therefore, the only intervention needed is to document this information.
- D. There is no need to delay discharge; not naming the infant is not a sign of inappropriate attachment.

30. The home-care nurse is educating the parents of a 1-week-old newborn. Which instruction should the nurse include about the care of the newborn’s umbilical cord?

- A. “Begin applying rubbing alcohol to the base of the cord stump three times a day.”
- B. “Attempt to gently dislodge the cord if it has not fallen off in the next week.”
- C. “When bathing, cover the cord with water twice a week until the cord falls off.”

- D. "Continue to place the diaper below the cord when diapering the infant."

ANSWER: D

- A. There is no evidence that applying alcohol to the cord keeps the baby's cord clean and dry.
- B. The cord should never be pulled. The parents should be instructed not to attempt to remove the cord because this could lead to bleeding and infection.
- C. Covering the cord when bathing would moisten the cord and delay separation, and should be avoided.
- D. Folding the diaper below the cord avoids cord contact with urine and stool. A wet, soiled environment slows drying and increases the risk of infection.

31. The postpartum client (G2P2) asks the nurse for suggestions to help facilitate her 3-year-old's attachment and acceptance of their newborn. Which action should the nurse suggest?

- A. Provide a doll for the 3-year-old to care for and nurture.
- B. Avoid bringing the 3-year-old to the "scary" hospital.
- C. Plan that dad cares for the 3-year-old and mom cares for the baby.
- D. Encourage the child to be "grown up" and accept the newborn.

ANSWER: A

- A. Providing care to a doll encourages the 3-year-old to identify with the parents, which helps to decrease anger and regression to get attention.
- B. Bringing the 3-year-old to the hospital and pointing out similarities to the 3-year-old's birth is encouraged and increases the bond between the two children.
- C. The 3-year-old needs individual attention from both parents to decrease jealousy, which may develop if the newborn is seen as taking all of the mother's time.
- D. Regression is a common occurrence even in well-prepared siblings, and parents should be counseled to expect this and not become concerned.

32. The nurse is caring for a 30-year-old, single female who delivered a term newborn. What is the best way for the nurse to assess the impact of the newborn on the client's lifestyle?

- A. Observe how the client interacts with her hospital visitors.

- B. Review the prenatal record for clues about the client's lifestyle.
- C. Ask the client what plans she has made for new-born care at home.
- D. Observe the relationship between the client and her newborn's father.

ANSWER: C

- A. Observing the mother's interaction with visitors and observing who visits will provide information about her social support system.
- B. Reviewing the prenatal record will provide physical health information and information about attendance at prenatal visits. This may provide insight into the mother's commitment to the pregnancy and the newborn, but it will not provide information about the mother's postdelivery plans.
- C. Open-ended questions will encourage sharing of feelings and examination of available lifestyle options. Low income and lack of a reliable backup person are common problems for the single parent.
- D. Single mothers do not always have an involved father; there is no indication that the father is involved.

33. A new mother of a full-term, 7-lb newborn asks the nurse how to ensure that her baby is taking the correct amount of formula at each feeding. The nurse explains that the infant needs approximately 3 ounces of fluid per pound of body weight per day. How many ounces of formula should her infant be eating every 4 hours? _____ ounces (Record your answer to the nearest tenth.)

ANSWER: 3.5

Multiplying 3 oz by 7 (the weight of the baby) = 21 oz needed per day. Dividing 21 oz by 6 (the number of feedings in 24 hours if the baby is fed every 4 hours) = 3.5 oz per feeding.

34. The nurse completes teaching in preparation to discharge a mother and her 48-hour-old, full-term newborn. The nurse determines there is a need for further instruction about infant car safety when the newborn's father is overhead making which statement?

- A. "We need to face the infant car seat toward the back of the car."
- B. "I disarmed one front seat air bag so we can put the car seat in the front seat."

- C. "Let's check the car seat to make sure it will position the baby at a 45-degree angle."
- D. "I know the baby will need to be in the infant car seat until he is over 20 pounds."

ANSWER: B

- A. Children should face the rear of the vehicle in an infant car seat until they are at least 1 year of age.
- B. The parents should be advised not to disarm air bags and that the rear vehicle seat is the safest place for children of any age to ride.
- C. Infants should ride at approximately a 45-degree angle to prevent slumping and airway obstruction.
- D. Children should remain in a car seat until they weigh at least 20 lb to decrease the risk of cervical spine injury in the event of a crash.

35. A healthy postpartum mother who is breastfeeding her term infant tells the nurse that she has noticed that her roommate is feeding iron-enriched formula to her newborn- The mother asks if she should be giving her baby supplemental iron. Which response by the nurse is correct?

- A. "Your breast milk provides all the iron your baby needs."
- B. "You, not your baby, will need an iron supplement daily."
- C. "Your pediatrician will prescribe iron drops for your baby."
- D. "You should feed your baby iron-fortified formula once daily."

ANSWER: A

- A. It is unnecessary to provide iron supplementation to a breastfeeding infant. Although iron content in breast milk is much lower than in iron-fortified formulas, the iron in breast milk is much more completely absorbed.
- B. Taking an iron supplement does not influence the mineral content of breast milk.
- C. It is unnecessary to provide an iron supplement to a breastfeeding infant when breast milk provides sufficient iron.
- D. Supplementing a breastfed baby with formula decreases the amount of time the infant breast- feeds, thus decreasing breast milk supply- Using a bottle nipple for feeding also may cause nipple confusion in the newborn.

36. The nurse and student nurse are caring for the postpartum client who delivered a term newborn 24 hours previously. The nurse recognizes that the student needs more information on newborn nutrition when making which statement?

- A. About half of the baby's calorie needs are met by the fat in breast milk or formula.
- B. Lactose is the primary source of carbohydrates in breast milk and formula.
- C. Calcium supplements are not needed for the new-born regardless of the feeding method.
- D. Supplemental water should be given to all infants daily, regardless of feeding method.

ANSWER: D

- A. Full-term infants do receive about half of their required calories from the fat in breast milk (52%) or formula (49%).
- B. Lactose is the primary carbohydrate in both breast milk and formula, and its slow breakdown and absorption may increase calcium absorption.
- C. Calcium levels are adequate in both types of milk for bone growth and prevention of tetany.
- D. Breast milk and formula contain almost 90% water, which meets the infant's water needs. Feeding supplemental water can cause hyponatremia and may result in seizures if water consumption is excessive.

37. While preparing parents of a 2-day-old, bottle-feeding newborn for discharge, the nurse recognizes the parents' need for additional teaching about formula feeding. Which statement prompted the nurse's conclusion?

- A. "We plan to clean our baby's bottles in the dishwasher."
- B. "Placing the formula in a bowl of warm water will warm it."
- C. "We will put the bottle of unfinished formula in the refrigerator."
- D. "Using our city tap water to mix the powdered formula is safe."

ANSWER: C

- A. Bottles and nipples can be safely washed in the dishwasher with other family dishes.
- B. If the formula has been refrigerated, it can be warmed to room temperature by placing it in a bowl of warm water. It should never be warmed in the microwave.

- C. The formula remaining in the bottle after feeding has mixed with the infant's saliva and should be discarded, not refrigerated; formula is a good medium for bacterial growth.
- D. Water from a municipal water supply is controlled by drinking water regulations and is safe for use with formula.

38. A breastfeeding mother is being discharged with her 2-day-old, full-term newborn. The nurse recognizes that the mother understands how to determine if her newborn is getting enough breast milk when making which statement?

- A. "He should have at least three wet diapers tomorrow."
- B. "He should have one stool per day during the next week."
- C. "At his 1-week checkup, he should weigh an additional 8 ounces."
- D. "He should nurse for 5 minutes on each breast to get enough milk."

ANSWER: A

- A. This statement indicates the mother's understanding. A 3-day-old infant should produce at least three wet diapers. After 5 days of age, the newborn should produce six well-saturated diapers per day.
- B. Infants typically produce at least 3 to 4 stools per day, and it is not uncommon for a breastfed infant to have 10 stools per day for the first month of life.
- C. It is expected that newborns, especially breastfed newborns, will lose from 5% to 10% of their birth weight during the first week after birth; therefore, the mother should not expect an 8-ounce weight gain.
- D. During a normal feeding session, the infant will nurse 10 to 20 minutes on the first breast, with feeding time on the second breast varying.

39. The nurse caring for a 32-weeks' gestation infant is about to perform a heel stick to obtain blood for a prescribed test- Which intervention should the nurse utilize to minimize the amount of pain the neonate will experience?

- A. Apply an ice pack
- B. Apply a heel warmer
- C. Give morphine sulfate
- D. Give sucrose or Sweet-Ease

ANSWER: D

- A. The use of ice in preterm infants is contraindicated, as it may cause damage to their fragile skin and result in hypothermia.

- B. A heel warmer may be used to improve blood flow to the extremity for easier and quicker collection of the specimen, but it does not alleviate pain.
- C. Morphine sulfate is a potent opioid analgesic and is inappropriate for this procedure.
- D. Sucrose activates the endogenous opioid system through taste. It is given 2 minutes prior to a painful procedure and has an analgesic effect lasting about 3—5 minutes.

40. The nurse is assessing the infant who may have FAS. Which findings, if observed, should the nurse associate with FAS? Select all that apply.

- A. Broad nasal bridge and flat midface
- B. Growth deficit in weight and length
- C. Excessive irritability and hypotonia
- D. Poor feeding and persistent vomiting
- E. Large jaw and overdeveloped maxilla

ANSWER: A, B, C, D

- A. Classic dysmorphic facial features such as a broad nasal bridge and flat midface are associated with FAS due to the effects of alcohol on the developing fetus.
- B. Growth deficiency is associated with FAS due to the deprivation of nutrients needed for growth.
- C. Various nervous system abnormalities including irritability and hypotonia are associated with FAS due to the effects of alcohol on the developing fetus.
- D. Poor feeding and persistent vomiting are associated with FAS due to facial abnormalities and problems with digestion.
- E. With FAS, the infant's jaw may be abnormally small and the maxilla hypoplastic (under— and not overdeveloped).

41. The nurse is caring for the client who has just given birth to a baby boy. The mother is O negative. The nurse should assess for ABO incompatibility and hyper - bilirubinemia if the infant's blood type is which type?

- A. O positive
- B. O negative
- C. A negative
- D. Any type

ANSWER: C

- A. If the infant's blood type is O positive, no ABO incompatibility will occur because there is no antigen on the RBCs and the plasma has A and B antibodies.
- B. If the infant's blood type is O negative, no ABO incompatibility will occur because there is no antigen on the RBCs and the plasma has A and B antibodies.
- C. The nurse should assess for ABO incompatibility when the infant's blood type is A negative. The mother's type O blood has no antigens on the RBCs, whereas the infant has A antigens.
- D. ABO incompatibility is limited to mothers with O blood type who have infants with type A or B. The mother's O blood type has no RBC antigens, and the plasma has A and B antibodies. The plasma of the infant with A blood type will have only B antibodies, and the plasma of the infant with B blood type will have only A antibodies.

42. Before beginning a newborn's physical assessment, the nurse reviews the newborn's medical record and sees this notation: "31 weeks' gestation." Considering this information, the nurse determines that a physical assessment of the infant should reveal which finding?

- A. Flexion of all four extremities
- B. The ability to suck
- C. The absence of lanugo
- D. Vernix covering the infant

ANSWER: D

- A. The preterm infant's posture is characterized by very little, if any, flexion of extremities.
- B. The sucking and swallowing reflexes are absent in the infant younger than 33 weeks' gestation.
- C. Lanugo is usually extensive in a 31-week infant, covering the back, forearms, forehead, and sides of the face.
- D. The preterm infant, 24 to 36 weeks' gestation, typically is covered with vernix caseosa—a waxy, white substance secreted by the fetus's sebaceous glands in utero.

43. An infant had four wet diapers during the 8-hour shift. The weight of a dry diaper is 15 g. The four wet diapers weighed 30 g, 24 g, 21 g, and 25 g. What amount in milliliters should the nurse record for the total 8-hour urine?

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

ANSWER: 40

If a dry diaper weighs 15 g, subtract that weight from the weight of each of the infant's diapers:

$$30 - 15 = 15\text{g}, 24 - 15 = 9\text{g},$$

$$21 - 15 = 6\text{g}, 25 - 15 = 10\text{g}.$$

Then add all of the totals: $15 + 9 + 6 + 10 = 40\text{ g}$ of fluid loss, which equals 4.0 mL of urine output.

44. The nurse is caring for a preterm infant who must be fed via bolus gavage feeding. The infant has a 5 French feeding tube already secured in the left naris. The nurse has aspirated the infant's stomach contents, noting color, amount, and consistency, and has reinserted the residual amount because it was less than one-fourth the previous feeding. Prioritize the remaining steps that the nurse should take to complete this feeding.

- A. Separate the barrel of the syringe from the plunger and connect the syringe barrel to the feeding tube.
- B. Remove the syringe and clear the tubing with 2 to 3 inL of air.
- C. Elevate the syringe 6 to 8 inches over the infant's head.
- D. Position the infant on the right side.
- E. Uncrimp the tubing and allow the feeding to flow by gravity at a slow rate.
- F. Crimp the feeding tube and pour the specified amount of formula or breast milk into the barrel.
- G. Cap the lavage feeding tube.

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

D. Position the infant on the right side. This decreases the risk of aspiration should emesis occurs.

A. Separate the barrel of the syringe from the plunger and connect the syringe barrel to the feeding tube. This allows the feeding to flow via gravity.

F. Crimp the feeding tube and pour the specified amount of formula or breast milk into the barrel. This prevents inadvertent flow of the feeding before the total amount is in the syringe barrel.

C. Elevate the syringe 6 to 8 inches over the infant's head. This allows for a slow gravity flow.

E. Uncrimp the tubing and allow the feeding to flow by gravity at a slow rate.

B. Remove the syringe and clear the tubing with 2 to 3 mL of air to make sure all the feeding is in the infant's stomach.

G. Cap the lavage feeding tube. Capping prevents contamination.

45. The nurse evaluates a preterm infant after a gavage feeding. The nurse determines that feeding intolerance has developed when which finding is noted during assessment?

- A. The infant immediately falls asleep after feeding.
- B. The gastric residual is zero prior to the next feeding.
- C. The infant's abdominal girth has increased in size.
- D. The infant is having soft, loose stools.

ANSWER: C

- A. Falling asleep after eating is a sign of feeding satisfaction.
- B. Increasing gastric residual is a sign of feeding intolerance. No residual present prior to feeding indicates that the previous feeding has passed from the stomach into the intestines.
- C. Signs of feeding intolerance in preterm infants include increasing abdominal girth and abdominal distention. Feeding intolerance may indicate paralytic ileus or NEC.
- D. Soft, loose stools are expected in newborns.

46 . The nurse completes teaching a new mother about swaddling her infant. Which illustration shows that the mother understood the teaching?

1.



2.



3.



4.



ANSWER: B

- A. Illustration 1 shows the newborn wearing a long- sleeved undershirt with hand covers. The hand covers help protect newborns' nails from scratching their sensitive skin.
- B. Illustration 2 shows swaddling. Swaddling is wrapping the blanket snugly around the new- born's body. This provides warmth and a sense of security for the newborn, which can have a calming effect.
- C. Illustration 3 shows the newborn being touched. While touching is important for calming and providing comfort, it is not swaddling.
- D. Illustration 4 shows the mother breastfeeding her newborn. Although the newborn is held snugly against the mother's body with the blanket over the newborn's body, it is not swaddling.

47. The nurse is administering surfactant via ET tube to a 48-hour-old preterm infant with respiratory distress syndrome (RDS). The father asks the nurse how this treatment will help his baby. The nurse should explain that the preterm infant is unable to produce adequate amounts of surfactant and that giving it to his baby will have what effect?

- A. Increase Paoz levels in the bloodstream
- B. Prevent collapse of the alveoli
- C. Decrease Paoz levels in the bloodstream
- D. Prevent pleural effusion

ANSWER: B

- A. Giving surfactant will prevent alveolar collapse and allow the exchange of gases and thus will cause a decrease, not an increase, in Paoz.
- B. Surfactant replacement therapy decreases alveolar collapse that occurs with RDS and thus decreases the severity of RDS.
- C. Giving surfactant will prevent alveolar collapse and allow the exchange of gases and thus will cause an increase, not a decrease, in Paoz.
- D. Pleural effusion does not occur in RDS.

48. The nurse is caring for a preterm infant with respiratory distress syndrome (RDS). Which intervention should the nurse implement to maximize the infant's respiratory status?

- A. Check blood glucose levels every 4 hours.
- B. Cool and humidify all inspired gases.
- C. Weigh the infant every other day.
- D. Place the infant in a prone position.

ANSWER: D

- A. While checking blood glucose levels is important, it will not assist in maximizing respiratory status.
- B. All inspired gases should be warmed and humidified, as cold air or oxygen stimulates increased oxygen consumption by increasing the metabolic rate.
- C. Infants should be weighed daily to monitor for fluid imbalances, which may adversely affect respiratory status.
- D. The prone position allows for better oxygenation of collapsed alveoli. Because the prone position is associated with sudden infant death, infants placed in this position should have continuous cardiorespiratory monitoring.

49. The nurse IS reviewing the following labor history of a postpartum mother: “Mother positive for group B streptococcal (GBS) infection at 37 weeks’ gestation- Membranes ruptured at home 14 hours before presentation to the hospital at 40 weeks’ gestation. Precipitous labor, no antibiotic given.” Considering this information, the nurse should observe her 15-hour-old newborn closely for which finding?

- A. Temperature instability
- B. Pink stains in the diaper
- C. Meconium stools
- D. Presence of erythema toxicum

ANSWER: A

- A. The infant can be infected with CBS from the mother and may start to exhibit symptoms within the first 12 to 24 hours after birth. Temperature instability is one of the most common early symptoms.
- B. Pink stains in the diaper are caused by urates in the urine and are innocuous.
- C. Meconium stools are expected within the first 24 hours after birth.
- D. Erythema toxicum is a rash that is common to newborns and will disappear without treatment.

50. Tire nurse is caring for the infant in the neonatal ICU who has an umbilical artery catheter (UAC) in place. To monitor for and prevent complications with this catheter, which actions should be planned by the nurse? Select all that apply.

- A. Check the position marking on the catheter every shift.
- B. Position the tubing close to the infant’s lower limbs.
- C. Check for erythema or discoloration of the abdominal wall.
- D. Palpate for femoral, pedal, and tibial pulses every 2 to 4 hours.
- E. Reposition the catheter tubing every hour.
- F. Monitor blood glucose levels.

ANSWER: A, C, D, F

- A. The nurse should verify that the catheter is secure and still at the prescribed, documented centimeter marking by examining the position of the centimeter marking on the catheter and comparing it to the mark recorded when the catheter was placed.
- B. The catheter should be positioned away from the infant’s extremities to prevent the infant from accidentally dislocating or removing the catheter by toe or finger entrapment.

- C. After placement of a UAC, the nurse should perform abdominal assessments to monitor for intra-abdominal blood loss that may occur if an umbilical vessel becomes perforated.
- D. At least every 2 to 4 hours, the nurse should systematically evaluate perfusion to the distal extremities. This includes examining the legs for color, temperature, and capillary refill, as well as assessing the extremity pulses.
- E. Frequent manipulation of the catheter is a contributing factor in catheter—related bloodstream infection; therefore, manipulation of the catheter should be avoided unless necessary for medical procedures and assessments.
- F. Caregivers should monitor blood glucose levels and compare them to the amount of glucose the infant may be receiving. Abnormal values, especially hypoglycemia, may indicate that the catheter is out of position.

51. While caring for the small-for-gestational-age newborn (SGA), the nurse notes slight tremors of the extremities, a high-pitched cry, and an exaggerated Moro reflex. In response to these assessment findings, what should be the nurse's first action?

- A. Assess the infant's blood sugar level.
- B. Document the findings in the infant's medical record.
- C. Immediately inform the pediatrician of the symptoms.
- D. Assess the infant's axillary temperature.

ANSWER: A

- A. The nurse should first check the infant's blood sugar level. SGA infants are at risk for hypoglycemia because they have poor hepatic glycogen stores and inadequate supplies of enzymes to activate gluconeogenesis.
- B. The nurse should recognize that these symptoms in an SGA infant necessitate action rather than just documentation.
- C. The nurse should check the infant's blood glucose level first and then notify the I-ICP if the level is abnormal.
- D. Assessing the infant's temperature should be completed, as a low temperature could contribute to hypoglycemia; however, this is not the first action.

52. When assessing the infant undergoing phototherapy for hyperbilirubinemia, the nurse notes a maculopapular rash over the infant's buttocks and back. What action should the nurse take next?

- A. Document the results in the newborn's medical record.
- B. Call the HCP immediately to report this finding.
- C. Discontinue the phototherapy immediately-
- D. Assess the infant's axillary temperature.

ANSWER: A

- A. As a side effect of phototherapy, some newborns develop a transient maculopapular rash that does not require treatment. The only action required is to document the findings.
- B. There is no need to call the HCP because the rash does not require treatment.
- C. There is no need to discontinue phototherapy; it is a transient rash.
- D. Newborn temperatures should be monitored per agency standards when the infant is being treated with phototherapy.

53. The full-term newborn is placed under phototherapy lights to treat hyperbilirubinemia. The nurse should assess the newborn for dehydration due to which effect of phototherapy?

- A. Decreases sodium absorption
- B. Increases absorption of bilirubin
- C. Decreases urinary output
- D. Increases insensible water loss

ANSWER: D

- A. Phototherapy has no direct impact on sodium absorption.
- B. Phototherapy is an intervention that breaks bilirubin down to be excreted in the stool.
- C. The nurse should monitor the infant's I&O, but phototherapy by itself has no direct impact on urinary output.
- D. Insensible water losses (IWL) are significantly increased in infants who are treated with phototherapy. Additional water losses may occur with increased stooling associated with either the elimination of bilirubin or a temporary lactose intolerance resulting from exposure to phototherapy.

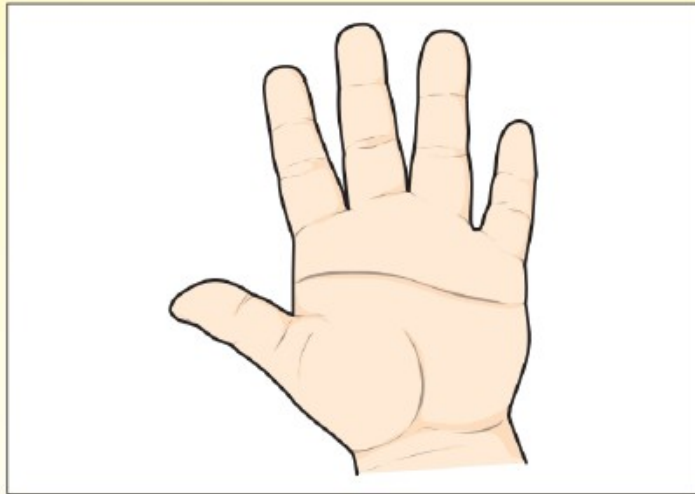
54. The mother of a healthy 15-hour-old term newborn asks the nurse if the PKU blood test could be completed now on her infant because she and her infant are being discharged to home. Which statement should be the basis for the nurse's response?

- A. The PKU test must be completed when the infant is at least 1 month of age.
- B. The parents must sign a consent form if the PKU test is completed before 24 hours of age.
- C. The PKU test is best if completed after the infant is 24 hours old but before 7 days of age.
- D. The PKU test is not needed if the infant is tolerating feedings without diarrhea or vomiting.

ANSWER: C

- A. The PKU test results will not be as accurate if the test is performed at 1 month because it is after the recommended time period.
- B. If parents leave the hospital before their infant is 24 hours old, they are required to obtain the test within the first week after discharge; it cannot be completed now regardless whether the parents sign a consent form.
- C. The PKU test should be performed after 24 hours of life and before the infant is 7 days old. This allows for sufficient intake of protein for accurate results.
- D. The PKU test is needed even if the infant is tolerating feedings; it is part of mandatory newborn screening.

55. While assessing the full-term newborn, the nurse notes the abnormality illustrated in the infant's palm. The nurse should further assess the infant for signs and symptoms of which condition?



- A. Trisomy 13
- B. Turner's syndrome
- C. Trisomy 18
- D. Trisomy 21

ANSWER: D

- A. Trisomy 13, or Patau syndrome, is a chromosomal condition associated with severe intellectual disability and physical abnormalities, but the abnormalities do not include a transverse palmar crease.
- B. Turner syndrome is a chromosomal condition that affects development in females. A common feature is short stature. An infant with Turner's syndrome would not have a transverse palmar crease.
- C. Trisomy 18, or Edwards's syndrome, is a chromosomal condition associated with multiple abnormalities and organ defects. The infant might have clenched fists with overlapping fingers, but the infant would not have a transverse palmar crease.
- D. A transverse palmar crease, also called a simian line, is a sign of trisomy 21 or Down's syndrome. The nurse should further assess for signs of Down's syndrome.

56 . The nurse is concerned that a newborn may have congenital hydrocephalus. Which finding did the nurse likely observe on assessment?

- A. Bulging anterior fontanel
- B. Head and chest circumference equal
- C. A narrowed posterior fontanel

D. Low-set ears

ANSWER: A

- A. A bulging anterior fontanel is an initial sign of congenital hydrocephalus.
- B. The head and chest circumferences of the full-term newborn should be very close to the same size, within 2 to 3 cm.
- C. The posterior fontanel is normally smaller than the anterior fontanel, and molding may make it very narrow.
- D. Low-set ears are a sign of trisomy 21.

57. After assisting in the delivery of a full-term infant with anencephaly, the parents ask the nurse to explain treatments that might be available for their infant. Which statement should be the basis for the nurse's response?

- A. Immediate surgery is necessary to repair the congenital defect.
- B. Anencephaly is incompatible with life; only palliative care should be provided.
- C. A shunting procedure will be necessary initially to relieve intracranial pressure.
- D. Antibiotics are needed initially before any treatment is started.

ANSWER: B

- A. Surgery will not repair anencephaly.
- B. Anencephaly is the absence of both cerebral hemispheres and of the overlying skull. It is a condition that is incompatible with life.
- C. Shunting will not repair anencephaly.
- D. Antibiotics will not repair anencephaly.

58. The nurse is discharging the 3-day-old newborn with a right-sided cephalohematoma. The nurse should instruct the parents to observe their infant closely over the next week for the development of which problem associated with the cephalohematoma?

- A. Jaundice
- B. Difficulty feeding
- C. Pale extremities
- D. Bulging on the right side of the head with crying

ANSWER: A

- A. A cephalohematoma is the collection of blood between a skull bone and its periosteum. As the hematoma resolves, hemolysis of RBCs

occurs, and jaundice may result. A cephalohematoma will resolve without treatment by 3 to 6 weeks.

- B. Difficulty feeding is not associated with a cephalohematoma.
- C. With a cephalohematoma, bleeding stops spontaneously a few days after birth. Usually rebleeding does not recur, and there is no need for the parents to observe for paleness.
- D. The hematoma does not bulge when the infant cries. The bleeding occurs from injury during the birth process, and all bleeding should stop by the second or third day after birth.

59. The nurse is admitting a neonate after delivery who is diagnosed with a myelomeningocele. Which intervention should the nurse implement immediately?

- A. Positions the infant prone and covers the sac with sterile gauze.
- B. Notifies the surgeon on call that the infant is ready for surgery.
- C. Applies a pressure dressing to the sac and starts an intravenous access.
- D. Positions the infant prone, hips slightly flexed, and legs abducted.

ANSWER: D

- A. Applying a dry gauze dressing would cause it to adhere to the sac and increase the risk of rupture of the sac when the gauze is removed. The sac should be covered with a dressing moistened with sterile saline to protect the integrity of the sac and decrease the risk for infection.
- B. Preservation of the integrity of the sac is of primary concern, and surgical intervention will occur when the infant is stabilized and all appropriate measures are complete. Surgery usually occurs within the first few days of life.
- C. A pressure dressing would increase the risk of rupturing the sac.
- D. Positioning the infant prone with hips slightly flexed and legs abducted helps to minimize tension and potential for rupture of the sac.

60. The parents are Visiting their newborn, who is in the neonatal intensive care unit (NTCU) after being diagnosed with a terminal cardiac condition. Which statement best reflects the nurse's judgment about interventions to promote parental attachment?

- A. Interventions should be delayed until it is certain that the newborn will live.
- B. The parents should be encouraged to provide as much care as possible.

- C. The parents should only be encouraged to touch and name their newborn.
- D. The parents should be assured that they did not do anything to cause this condition.

ANSWER: B

- A. Interventions to promote parental attachment should be implemented, even if the newborn is very sick and likely to die.
- B. The parents should be encouraged to provide care for their newborn, even if the newborn is very sick and likely to die. If the infant should die, detachment is easier if attachment has been established because the parents will be comforted by the knowledge that they did all they could for their infant while he or she was alive.
- C. Parents may be hesitant to bond with a sick infant; however, attachment should be encouraged, not limited to touching and naming their baby.
- D. There is not enough information in the question stem to determine the cause of the cardiac condition, but feelings of guilt and failure often plague parents of sick newborns. Rather than assuring the parents that they did nothing wrong, the nurse should allow the parents to express their feelings.