Maternity Clinical | | Final Written Exam

1) A postpartum nurse is preparing to care for a woman who has just delivered a healthy newborn infant. In the immediate postpartum period the nurse plans to take the woman's vital signs:
1. Every 30 minutes during the first hour and then every hour for the next two hours.
2. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.
3. Every hour for the first 2 hours and then every 4 hours
4. Every 5 minutes for the first 30 minutes and then every hour for the next 4 hours.

2) A postpartum nurse is taking the vital signs of a woman who delivered a healthy newborn infant 4 hours ago. The nurse notes that the mother's temperature is 100.2*F. Which of the following actions would be most appropriate?
1. Retake the temperature in 15 minutes
2. Notify the physician
3. Document the findings
4. Increase hydration by encouraging oral fluids

3) The nurse is assessing a client who is 6 hours PP after delivering a full-term healthy infant. The client complains to the nurse of feelings of faintness and dizziness. Which of the following nursing actions would be most appropriate?
1. Obtain hemoglobin and hematocrit levels
2. Instruct the mother to request help when getting out of bed
3. Elevate the mother's legs
4. Inform the nursery room nurse to avoid bringing the newborn infant to the mother until the feelings of light-headedness and dizziness have subsided.

4) A nurse is preparing to perform a fundal assessment on a postpartum client. The initial nursing action in performing this assessment is which of the following?
1. Ask the client to turn on her side
2. Ask the client to lie flat on her back with the knees and legs flat and straight.
3. Ask the mother to urinate and empty her bladder
4. Massage the fundus gently before determining the level of the fundus.

5) The nurse is assessing the lochia on a 1 day PP patient. The nurse notes that the lochia is red and has a foul-smelling odor. The nurse determines that this assessment finding is:
1. Normal
2. Indicates the presence of infection
3. Indicates the need for increasing oral fluids
4. Indicates the need for increasing ambulation

6) When performing a PP assessment on a client, the nurse notes the presence of clots in the lochia. The nurse examines the clots and notes that they are larger than 1 cm. Which of the following nursing actions is most appropriate?
1. Document the findings
2. Notify the physician
3. Reassess the client in 2 hours
4. Encourage increased intake of fluids.

7) A nurse in a PP unit is instructing a mother regarding lochia and the amount of expected lochia drainage. The nurse instructs the mother that the normal amount of lochia may vary but should never exceed the need for:
1. One peripad per day
2. Two peripads per day
3. Three peripads per day
4. Eight peripads per day (Note: The normal amount of lochia may vary with the individual but should never exceed 4 to 8 peripads per day. The average number of peripads is 6 per day).

8) A PP nurse is providing instructions to a woman after delivery of a healthy newborn infant. The nurse instructs the mother that she should expect normal bowel elimination to return:
1. One the day of the delivery
2. 3 days PP
3. 7 days PP
4. within 2 weeks PP

9) A nurse is caring for a PP woman who has received epidural anesthesia and is monitoring the woman for the presence of a vulva hematoma. Which of the following assessment findings would best indicate the presence of a hematoma?
1. Complaints of a tearing sensation
2. Complaints of intense pain
3. Changes in vital signs
4. Signs of heavy bruising

10) A nurse is developing a plan of care for a PP woman with a small vulvar hematoma. The nurse includes which specific intervention in the plan during the first 12 hours following the delivery of this client?
1. Assess vital signs every 4 hours
2. Inform health care provider of assessment findings
3. Measure fundal height every 4 hours
4. Prepare an ice pack for application to the area.

12) A new mother received epidural anesthesia during labor and had a forceps delivery after pushing 2 hours. At 6 hours PP, her systolic blood pressure has dropped 20 points, her diastolic BP has dropped 10 points, and her pulse is 120 beats per minute. The client is anxious and restless. On further assessment, a vulvar hematoma is verified. After notifying the health care provider, the nurse immediately plans to:
1. Monitor fundal height
2. Apply perineal pressure
3. Prepare the client for surgery
4. Reassure the client

13) A nurse is monitoring a new mother in the PP period for signs of hemorrhage. Which of the following signs, if noted in the mother, would be an early sign of excessive blood loss?
1. A temperature of 100.4*F
2. An increase in the pulse from 88 to 102 BPM
3. An increase in the respiratory rate from 18 to 22 breaths per minute
4. A blood pressure change from 130/88 to 124/80 mm Hg

14) A nurse is preparing to assess the uterine fundus of a client in the immediate postpartum period. When the nurse locates the fundus, she notes that the uterus feels soft and boggy. Which of the following nursing interventions would be most appropriate initially?
1. Massage the fundus until it is firm
2. Elevate the mothers legs
3. Push on the uterus to assist in expressing clots
4. Encourage the mother to void

15) A PP nurse is assessing a mother who delivered a healthy newborn infant by C-section. The nurse is assessing for signs and symptoms of superficial venous thrombosis. Which of the following signs or symptoms would the nurse note if superficial venous thrombosis were present?
1. Paleness of the calf area
2. Enlarged, hardened veins
3. Coolness of the calf area
4. Palpable dorsalis pedis pulses

16) A nurse is providing instructions to a mother who has been diagnosed with mastitis. Which of the following statements if made by the mother indicates a need for further teaching?
1. "I need to take antibiotics, and I should begin to feel better in 24-48 hours."
2. "I can use analgesics to assist in alleviating some of the discomfort."
3. "I need to wear a supportive bra to relieve the discomfort."
4. "I need to stop breastfeeding until this condition resolves."

17) A nurse is assessing a client in the 4th stage if labor and notes that the fundus is firm but that bleeding is excessive. The initial nursing action would be which of the following?
1. Massage the fundus
2. Place the mother in the Trendelenburg's position
3. Notify the physician
4. Record the findings

18) A nurse is caring for a PP client with a diagnosis of DVT who is receiving a continuous intravenous infusion of heparin sodium. Which of the following laboratory results will the nurse specifically review to determine if an effective and appropriate dose of the heparin is being delivered?
1. Prothrombin time
2. Internationalized normalized ratio
3. Activated partial thromboplastin time
4. Platelet count

19) Methergine or pitocin is prescribed for a woman to treat PP hemorrhage. Before administration of these medications, the priority nursing assessment is to check the:
1. Amount of lochia
2. Blood pressure
3. Deep tendon reflexes
4. Uterine tone

20) Methergine or pitocin are prescribed for a client with PP hemorrhage. Before administering the medication(s), the nurse contacts the health provider who prescribed the medication(s) in which of the following conditions is documented in the client's medical history?
1. Peripheral vascular disease
2. Hypothyroidism
3. Hypotension
4. Type 1 diabetes

21) Which of the following factors might result in a decreased supply of breast milk in a PP mother?
1. Supplemental feedings with formula
2. Maternal diet high in vitamin C
3. An alcoholic drink
4. Frequent feedings

22) Which of the following interventions would be helpful to a breastfeeding mother who is experiencing engorged breasts?
1. Applying ice
2. Applying a breast binder
3. Teaching how to express her breasts in a warm shower
4. Administering bromocriptine (Parlodel)

23) On completing a fundal assessment, the nurse notes the fundus is situated on the client's left abdomen. Which of the following actions is appropriate?
1. Ask the client to empty her bladder
2. Straight catheterize the client immediately
3. Call the client's health provider for direction
4. Straight catheterize the client for half of her uterine volume

24) Which of the following findings would be expected when assessing the postpartum client?
1. Fundus 1 cm above the umbilicus 1 hour postpartum
2. Fundus 1 cm above the umbilicus on postpartum day 3
3. Fundus palpable in the abdomen at 2 weeks postpartum
4. Fundus slightly to the right; 2 cm above umbilicus on postpartum day 2

25) A client is complaining of painful contractions, or afterpains, on postpartum day 2. Which of the following conditions could increase the severity of afterpains?
1. Bottle-feeding
2. Diabetes
3. Multiple gestation
4. Primiparity

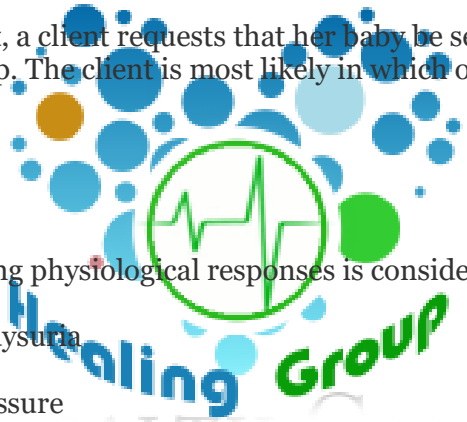
26) On which of the postpartum days can the client expect lochia serosa?
1. Days 3 and 4 PP
2. Days 3 to 10 PP
3. Days 10-14 PP
4. Days 14 to 42 PP

27) Which of the following behaviors characterizes the PP mother in the *taking in* phase?
1. Passive and dependant
2. Striving for independence and autonomy
3. Curious and interested in care of the baby
4. Exhibiting maximum readiness for new learning

28) What type of milk is present in the breasts 7 to 10 days PP?
1. Colostrum
2. Hind milk
3. Mature milk
4. Transitional milk

29) Which of the following complications is most likely responsible for a delayed postpartum hemorrhage?
1. Cervical laceration
2. Clotting deficiency
3. Perineal laceration
4. Uterine subinvolution

30) On the first PP night, a client requests that her baby be sent back to the nursery so she can get some sleep. The client is most likely in which of the following phases?
1. Depression phase
2. Letting-go phase
3. Taking-hold phase
4. Taking-in phase



31) Which of the following physiological responses is considered normal in the early postpartum period?
1. Urinary urgency and dysuria
2. Rapid diuresis
3. Decrease in blood pressure
4. Increase motility of the GI system

32) During the 3rd PP day, which of the following observations about the client would the nurse be most likely to make?
1. The client appears interested in learning about neonatal care
2. The client talks a lot about her birth experience
3. The client sleeps whenever the neonate isn't present
4. The client requests help in choosing a name for the neonate.

33) Which of the following circumstances is most likely to cause uterine atony and lead to PP hemorrhage?
1. Hypertension
2. Cervical and vaginal tears
3. Urine retention
4. Endometritis

34) The nurse examines a woman one hour after birth. The woman's fundus is boggy, midline, and 1 cm below the umbilicus. Her lochial flow is profuse, with two plum-sized clots. The nurse's initial action would be to:
1. Place her on a bedpan to empty her bladder
2. Massage her fundus
3. Call the physician
4. Administer Methergine 0.2 mg IM which has been ordered prn

35) A primiparous woman is in the taking-in stage of psychosocial recovery and adjustment following birth. The nurse, recognizing the needs of women during this stage, should:
1. Foster an active role in the baby's care
2. Provide time for the mother to reflect on the events of and her behavior during childbirth
3. Recognize the woman's limited attention span by giving her written materials to read when she gets home rather than doing a teaching session now
4. Promote maternal independence by encouraging her to meet her own hygiene and comfort needs

36) Parents can facilitate the adjustment of their other children to a new baby by:
1. Having the children choose or make a gift to give to the new baby upon its arrival home
2. Emphasizing activities that keep the new baby and other children together
3. Having the mother carry the new baby into the home so she can show the other children the new baby
4. Reducing stress on other children by limiting their involvement in the care of the new baby

38) A nurse in the labor room is caring for a client in the active phases of labor. The nurse is assessing the fetal patterns and notes a late deceleration on the monitor strip. The most appropriate nursing action is to:
1.Place the mother in the supine position
2.Document the findings and continue to monitor the fetal patterns
3.Administer oxygen via face mask
4.Increase the rate of pitocin IV infusion

39) A nurse is performing an assessment of a client who is scheduled for a cesarean delivery. Which assessment finding would indicate a need to contact the physician?
1.Fetal heart rate of 180 beats per minute
2.White blood cell count of 12,000
3.Maternal pulse rate of 85 beats per minute
4.Hemoglobin of 11.0 g/dL

40) A client in labor is transported to the delivery room and is prepared for a cesarean delivery. The client is transferred to the delivery room table, and the nurse places the client in the:
1.Trendelenburg's position with the legs in stirrups
2.Semi-Fowler position with a pillow under the knees
3.Prone position with the legs separated and elevated
4.Supine position with a wedge under the right hip

41) A nurse is caring for a client in labor who is receiving Pitocin by IV infusion to stimulate uterine contractions. Which assessment finding would indicate to the nurse that the infusion needs to be discontinued?
1.Three contractions occurring within a 10-minute period
2.A fetal heart rate of 90 beats per minute
3.Adequate resting tone of the uterus palpated between contractions
4.Increased urinary output

42) A nurse is beginning to care for a client in labor. The physician has prescribed an IV infusion of Pitocin. The nurse ensures that which of the following is implemented before initiating the infusion?
1.Placing the client on complete bed rest
2.Continuous electronic fetal monitoring
3.An IV infusion of antibiotics
4.Placing a code cart at the client's bedside

43)A nurse is admitting a pregnant client to the labor room and attaches an external electronic fetal monitor to the client's abdomen. After attachment of the monitor, the initial nursing assessment is which of the following?
1.Identifying the types of accelerations
2.Assessing the baseline fetal heart rate
3.Determining the frequency of the contractions
4.Determining the intensity of the contractions

44) During the period of induction of labor, a client should be observed carefully for signs of:
1.Severe pain
2.Uterine tetany
3.Hypoglycemia
4.Umbilical cord prolapse

45) The breathing technique that the mother should be instructed to use as the fetus' head is crowning is:
1.Blowing
2.Slow chest
3.Shallow
4.Accelerated-decelerated

46) When monitoring the fetal heart rate of a client in labor, the nurse identifies an elevation of 15 beats above the baseline rate of 135 beats per minute lasting for 15 seconds. This should be documented as:
1.An acceleration
2.An early elevation
3.A sonographic motion
4.A tachycardic heart rate

47) When examining the fetal monitor strip after rupture of the membranes in a laboring client, the nurse notes variable decelerations in the fetal heart rate. The nurse should:
1.Stop the oxytocin infusion
2.Change the client's position
3.Prepare for immediate delivery
4.Take the client's blood pressure

48) The nurse observes the client's amniotic fluid and decides that it appears normal, because it is:
1.Clear and dark amber in color
2.Milky, greenish yellow, containing shreds of mucus
3.Clear, almost colorless, and containing little white specks
4.Cloudy, greenish-yellow, and containing little white specks

49) The physician asks the nurse the frequency of a laboring client's contractions. The nurse assesses the client's contractions by timing from the beginning of one contraction:
1.Until the time it is completely over
2.To the end of a second contraction
3.To the beginning of the next contraction
4.Until the time that the uterus becomes very firm

50) After doing Leopold's maneuvers, the nurse determines that the fetus is in the ROP position. To best auscultate the fetal heart tones, the Doppler is placed:
1.Above the umbilicus at the midline
2.Above the umbilicus on the left side
3.Below the umbilicus on the right side
4.Below the umbilicus near the left groin

51) A client who is gravida 1, para 0 is admitted in labor. Her cervix is 100% effaced, and she is dilated to 3 cm. Her fetus is at +1 station. The nurse is aware that the fetus' head is:
1.Not yet engaged
2.Entering the pelvic inlet
3.Below the ischial spines
4.Visible at the vaginal opening

52) An ultrasound is performed on a client at term gestation that is experiencing moderate vaginal bleeding. The results of the ultrasound indicate that an abruptio placenta is present. Based on these findings, the nurse would prepare the client for:
1.Complete bed rest for the remainder of the pregnancy
2.Delivery of the fetus
3.Strict monitoring of intake and output
4.The need for weekly monitoring of coagulation studies until the time of delivery

53) A nurse is assessing a pregnant client in the 2nd trimester of pregnancy who was admitted to the maternity unit with a suspected diagnosis of abruptio placentae. Which of the following assessment findings would the nurse expect to note if this condition is present?
1.Absence of abdominal pain
2.A soft abdomen
3.Uterine tenderness/pain
4.Painless, bright red vaginal bleeding

54) A maternity nurse is caring for a client with abruptio placenta and is monitoring the client for disseminated intravascular coagulopathy. Which assessment finding is least likely to be associated with disseminated intravascular coagulation?
1.Swelling of the calf in one leg
2.Prolonged clotting times
3.Decreased platelet count
4.Petechiae, oozing from injection sites, and hematuria

55) A nurse in the labor room is performing a vaginal assessment on a pregnant client in labor. The nurse notes the presence of the umbilical cord protruding from the vagina. Which of the following would be the initial nursing action?
1.Place the client in Trendelenburg's position
2.Call the delivery room to notify the staff that the client will be transported immediately
3.Gently push the cord into the vagina
4.Find the closest telephone and stat page the physician

56) A nurse in the postpartum unit is caring for a client who has just delivered a newborn infant following a pregnancy with placenta previa. The nurse reviews the plan of care and prepares to monitor the client for which of the following risks associated with placenta previa?
1.Disseminated intravascular coagulation
2.Chronic hypertension
3.Infection
4.Hemorrhage

57) A nurse is developing a plan of care for a client experiencing dystocia and includes several nursing interventions in the plan of care. The nurse prioritizes the plan of care and selects which of the following nursing interventions as the highest priority?
1.Keeping the significant other informed of the progress of the labor
2.Providing comfort measures
3.Monitoring fetal heart rate
4.Changing the client's position frequently

58) A nurse is caring for a client in labor and is monitoring the fetal heart rate patterns. The nurse notes the presence of episodic accelerations on the electronic fetal monitor tracing. Which of the following actions is most appropriate?
1.Document the findings and tell the mother that the monitor indicates fetal well-being
2.Take the mothers vital signs and tell the mother that bed rest is required to conserve oxygen.
3.Notify the physician or nurse mid-wife of the findings.
4.Reposition the mother and check the monitor for changes in the fetal tracing

59) A pregnant client is admitted to the labor room. An assessment is performed, and the nurse notes that the client's hemoglobin and hematocrit levels are low, indicating anemia. The nurse determines that the client is at risk for which of the following?
1.A loud mouth
2.Low self-esteem
3.Hemorrhage
4.Postpartum infections

60) A nurse assists in the vaginal delivery of a newborn infant. After the delivery, the nurse observes the umbilical cord lengthen and a spurt of blood from the vagina. The nurse documents these observations as signs of:
1.Hematoma
2.Placenta previa
3.Uterine atony
4.Placental separation

61)A client arrives at a birthing center in active labor. Her membranes are still intact, and the nurse-midwife prepares to perform an amniotomy. A nurse who is assisting the nurse-midwife explains to the client that after this procedure, she will most likely have:

1.Less pressure on her cervix
2.Increased efficiency of contractions
3.Decreased number of contractions
4.The need for increased maternal blood pressure monitoring

62) A nurse is monitoring a client in labor. The nurse suspects umbilical cord compression if which of the following is noted on the external monitor tracing during a contraction?

1.Early decelerations
2.Variable decelerations
3.Late decelerations
4.Short-term variability

63) A nurse explains the purpose of effleurage to a client in early labor. The nurse tells the client that effleurage is:

1.A form of biofeedback to enhance bearing down efforts during delivery
2.Light stroking of the abdomen to facilitate relaxation during labor and provide tactile stimulation to the fetus
3.The application of pressure to the sacrum to relieve a backache
4.Performed to stimulate uterine activity by contracting a specific muscle group while other parts of the body rest

65) A nurse is assigned to care for a client with hypotonic uterine dysfunction and signs of a slowing labor. The nurse is reviewing the physician's orders and would expect to note which of the following prescribed treatments for this condition?

1.Medication that will provide sedation
2.Increased hydration
3.Oxytocin (Pitocin) infusion
4.Administration of a tocolytic medication

67) When the women is 7 cms. Dilated and the presenting part is +1 station the client tell the nurse" I need to push " , the nurse should:

a. Place the client in a lithotomy position.
b. Increase the rate of intravenous fluid.
c. Instruct the client to take deep breathing and not to push.
d. Tell the client to push and bear down.

68)A client is 22 weeks pregnant with her first baby. Her weight gain is normal, but she complains of constipation, what is the most effective recommendation the nuse can make?

e. Take a milk laxative daily.
f. Increase intake of fluids and high fibers food.
g. Relax when trying to move the bowels.
h. Start a strong exercise program.

69)In case of mother having supine hypotension during pregnancy the best position for this condition is:
i. Supine position.
j. Prone position
k. Left or right side position
l. Shock position

70)Which of the following date need to be collected during pre natal assessment:
m. Maternal age and family history.
n. Maternal medical history.
o. Maternal past obstetric history.
p. Maternal present obstetric history.
q. All the above.

71)The Mechanisms of labor are:
r. External Rotation, Expulsion, engagement and flexion.
s. Engagement, Descent, Flexion, internal rotation, extension, external rotation
t. Engagement descent, flexion, internal rotation, external rotation, extension and expulsion.
u. Engagement, flextion descent, internal rotation extension, external rotation and expulsion.

72)In case of Mgs"magnisum sulfate" toxicity, which of the following antidote its action:
a. Hydrazine.
b. Dopamine.
c. Calcium gluconate.
d. Apresoline.

73)A client is pregnant for the third time she has a 3 years old girl, she also has had a spontaneous abortion at 16 weeks gestation . which of the following is correct method of recroding her obstetric status.
b. gravida 2, para 1.
c. Gravida 2, para 2.
d. Gravida 3, para 1.
e. Gravida 3, para 2.

74)A multigravida in her 34wk of gestation came to the emergency department complain of vaginal bleeding, which is your first action:
f. Start IV fluid.
g. Assess fetal heart rate.
h. Assess v/s of the mother.
i. Prepare for cesarean section.

75)You performed the leopold's maneuver and found the following: breech presentation, fetal back at the right side of the mother. Based on these findings, you can hear the fetal heart beat (PMI) BEST in which location?
j. Left lower quadrant
k. Right lower quadrant
l. Left upper quadrant
m. Right upper quadrant

76)When a pregnant woman experiences leg cramps, the correct nursing intervention to relieve the muscle cramps is:
n. Allow the woman to exercise
o. Let the woman walk for a while
p. Let the woman lie down and dorsiflex the foot towards the knees
q. Ask the woman to raise her legs

77)From the 33rd week of gestation till full term, a healthy mother should have prenatal check up every:
a. week
b. 2 weeks
c. 3 weeks
d. 4 weeks

78)In the Batholonew's rule of 4, when the level of the fundus is midway between the umbilicus and xyphoid process the estimated age of gestation (AOG) is:
e. 5th month
f. 6th month
g. 7th month
h. 8th month

79)The following are ways of determining expected date of delivery (EDD) when the LMP is unknown EXCEPT:
i. Naegele's rule
j. Quickening
k. Mc Donald's rule
l. Batholomew's rule of 4

80)If the LMP is Jan. 30, the expected date of delivery (EDD) is
m. Oct.7
n. Oct. 24
o. Nov.7
p. Nov. 8

81)You want to perform a pelvic examination on of your pregnant clients. You prepare your client for the procedure by:
q. Asking her to void
r. Taking her vital signs and recording the readings
s. Giving the client a perineal care
t. Doing a vaginal prep

82)When preparing the mother who is on her 4th month of pregnancy for abdominal ultrasound, the nurse should instruct her to:
a. Observe NPO from midnight to avoid vomiting
b. Do perineal flushing properly before the procedure
c. Drink at least 2 liters of fluid 2 hours before the procedure and not void until the procedure is done
d. Void immediately before the procedure for better visualization

83)Mrs. Santos is on her 5th pregnancy and has a history of abortion in the 4th pregnancy and the first pregnancy was a twin. She is considered to be
e. G 4 P 3
f. G 5 P 3
g. G 5 P 4
h. G 4 P 4

84)You are performing abdominal exam on a 9th month pregnant woman. While lying supine, she felt breathless, had pallor, tachycardia, and cold clammy skin.
The correct assessment of the woman's condition is that she is
i. Experiencing the beginning of labor
j. Having supine hypotension
k. Having sudden elevation of BP
l. Going into shock

85)A pregnant mother is admitted to the hospital with the chief complaint of profuse vaginal bleeding, AOG 36 wks, not in labor. The nurse must always consider which of the following precautions:
m. The internal exam is done only at the delivery under strict asepsis with a double set-up
n. The preferred manner of delivering the baby is vaginal
o. An emergency delivery set for vaginal delivery must be made ready before examining the patient
p. Internal exam must be done following routine procedure

86)The nursing measure to relieve fetal distress due to maternal supine hypotension is:
a. Place the mother on semi-fowler's position
b. Put the mother on left side lying position
c. Place mother on a knee chest position
d. Any of the above

87)When giving narcotic analgesics to mother in labor, the special consideration to follow is:
e. The progress of labor is well established reaching the transitional stage
f. Uterine contraction is progressing well and delivery of the baby is imminent
g. Cervical dilatation has already reached at least 8 cm. and the station is at least (+)2
h. Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.

88)The cervical dilatation taken at 8:00 A.M. in a G1P0 patient was 6 cm. A repeat I.E. done at 10 A.M. showed that cervical dilation was 7 cm. The correct interpretation of this result is:
i. Labor is progressing as expected
j. The latent phase of Stage 1 is prolonged
k. The active phase of Stage 1 is protracted
l. The duration of labor is normal

89)To monitor the frequency of the uterine contraction during labor, the right technique is to time the contraction
m. From the beginning of one contraction to the end of the same contraction
n. From the beginning of one contraction to the beginning of the next contraction
o. From the end of one contraction to the beginning of the next contraction
p. From the deceleration of one contraction to the acme of the next contraction

90)The peak point of a uterine contraction is called the
a. Acceleration
b. Acme
c. Deceleration
d. Axiom

91)The fetal heart beat should be monitored every 15 minutes during the 2nd stage of labor. The characteristic of a normal fetal heart rate is
e. The heart rate will decelerate during a contraction and then go back to its pre-contraction rate after the contraction
f. The heart rate will accelerate during a contraction and remain slightly above the pre-contraction rate at the end of the contraction
g. The rate should not be affected by the uterine contraction.
h. The heart rate will decelerate at the middle of a contraction and remain so for about a minute after the contraction

92)The normal umbilical cord is composed of:
i. 2 arteries and 1 vein
j. 2 veins and 1 artery
k. 2 arteries and 2 veins
l. none of the above

93)The second stage of labor begins with ___ and ends with __?
m. Begins with full dilatation of cervix and ends with delivery of placenta
n. Begins with true labor pains and ends with delivery of baby
o. Begins with complete dilatation and effacement of cervix and ends with delivery of baby
p. Begins with passage of show and ends with full dilatation and effacement of cervix

94)As soon as the placenta is delivered, the nurse must do which of the following actions?
a. Inspect the placenta for completeness including the membranes
b. Place the placenta in a receptacle for disposal
c. Label the placenta properly
d. Leave the placenta in the kidney basin for the nursing aide to dispose properly

95)In vaginal delivery done in the hospital setting, the doctor routinely orders an oxytocin to be given to the mother parenterally. The oxytocin is usually given after the placenta has been delivered and not before because:
e. Oxytocin will prevent bleeding
f. Oxytocin can make the cervix close and thus trap the placenta inside
g. Oxytocin will facilitate placental delivery
h. Giving oxytocin will ensure complete delivery of the placenta

99)The normal dilatation of the cervix during the first stage of labor in a nullipara is
i. 1.2 cm./hr
j. 1.5 cm./hr.
k. 1.8 cm./hr
l. 2.0 cm./hr

100)The placenta should be delivered normally within ___ minutes after the delivery of the baby.
m. 5 minutes
n. 30 minutes
o. 45 minutes
p. 60 minutes

101)The fundus of the uterus is expected to go down normally postpartally about __ cm per day.
q. 1.0 cm
r. 2.0 cm
s. 2.5 cm
t. 3.0 cm

102)The lochia on the first few days after delivery is characterized as
a. Pinkish with some blood clots
b. Whitish with some mucus
c. Reddish with some mucus
d. Serous with some brown tinged mucus

103)Lochia normally disappears after how many days postpartum?
e. 5 days
f. 7-10 days
g. 18-21 days
h. 28-30 days

104)To enhance milk production, a lactating mother must do the following interventions EXCEPT:
i. Increase fluid intake including milk
j. Eat foods that increases lactation which are called galactagues
k. Exercise adequately like aerobics
l. Have adequate nutrition and rest

105)The nursing intervention to relieve pain in breast engorgement while the mother continues to breastfeed is
m. Apply cold compress on the engorged breast
n. Apply warm compress on the engorged breast
o. Massage the breast
p. Apply analgesic ointment

106)A woman who delivered normally per vagina is expected to void within ___ hours after delivery.
q. 3 hrs
r. 4 hrs.
s. 6-8 hrs
t. 12-24 hours

107)To ensure adequate lactation the nurse should teach the mother to:
a. Breast feed the baby on self-demand day and night
b. Feed primarily during the day and allow the baby to sleep through the night
c. Feed the baby every 3-4 hours following a strict schedule
d. Breastfeed when the breast are engorged to ensure adequate supply

108)An appropriate nursing intervention when caring for a postpartum mother with thrombophlebitis is:
e. Encourage the mother to ambulate to relieve the pain in the leg
f. Instruct the mother to apply elastic bondage from the foot going towards the knee to improve venous return flow
g. Apply warm compress on the affected leg to relieve the pain
h. Elevate the affected leg and keep the patient on bedrest

109)The nurse should anticipate that hemorrhage related to uterine atony may occur postpartally if this condition was present during the delivery:
i. Excessive analgesia was given to the mother
j. Placental delivery occurred within thirty minutes after the baby was born
k. An episiotomy had to be done to facilitate delivery of the head
l. The labor and delivery lasted for 12 hours

110)Which of the following is an abnormal vital sign in postpartum?
m. Pulse rate between 50-60/min
n. BP diastolic increase from 80 to 95mm Hg
o. BP systolic between 100-120mm Hg
p. Respiratory rate of 16-20/min

111)The uterine fundus right after delivery of placenta is palpable at
q. Level of Xyphoid process
r. Level of umbilicus
s. Level of symphysis pubis
t. Midway between umbilicus and symphysis pubis

112) After how many weeks after delivery should a woman have her postpartal check-up based on the protocol followed by the DOH?
a. 2 weeks
b. 3 weeks
c. 6 weeks
d. 12 weeks

113)When the uterus is firm and contracted after delivery but there is vaginal bleeding, the nurse should suspect
e. Laceration of soft tissues of the cervix and vagina
f. Uterine atony
g. Uterine inversion
h. Uterine hypercontractility

114)The following are interventions to make the fundus contract postpartally EXCEPT
i. Make the baby suck the breast regularly
j. Apply ice cap on fundus
k. Massage the fundus vigorously for 15 minutes until contracted