ATI EXIT EXAM CORRECT AND VERIFIED STUDY GUIDE

Rationale: The pregnant woman needs a well-balanced diet high in iron and protein and adequate in calories for weight gain. Iron supplements that are taken during pregnancy tend to cause constipation. Constipation causes the client to strain during defecation, inadvertently performing the Valsalva maneuver, which causes blood to rush to the heart and overload the cardiac system. The pregnant woman, then, should increase her intake of fluids and fiber. An unlimited intake of sodium (pretzels, cheese, nachos) could cause overload of the circulating blood volume and contribute to the cardiac condition.

A nurse is reviewing the records of the clients admitted to the maternity unit during the past 24 hours. Which of the following clients does the nurse recognize as being at risk for the development of disseminated intravascular coagulation (DIC)? **Select all that apply.**

M. ☑ A client with septicemia Correct

N. ☑ A client with mild preeclampsia Incorrect

O. ☑ A client with diabetes mellitus who delivered a 10-lb baby Incorrect

P. ☑ A client who had a cesarean section because of abruptio placentae Correct

Q. ☐ A client who delivered 12 hours ago and has lost 475 mL of blood

Rationale: DIC is a pathologic form of clotting that is diffuse and consumes large amounts of clotting factors, including platelets, fibrinogen, prothrombin, and factors V and VII. In the obstetric population, DIC occurs as a result of abruptio placentae, amniotic fluid embolism, dead fetus syndrome (in which the fetus has died but is retained in utero for at least 6 weeks), severe preeclampsia, septicemia, cardiopulmonary arrest, or hemorrhage. A loss of 475 mL is not considered hemorrhage .A mild case of preeclampsia is not a risk factor for DIC. It is not unusual for a client with diabetes mellitus to deliver a large baby, and this condition is unrelated to DIC.

A delivery room nurse is preparing a client for a cesarean delivery. The client is placed on the delivery room table, and the nurse positions the client:

R. ○ Prone

S. ○ In a semi-Fowler position

T. ○ In the Trendelenburg position

U. ◉ Supine with a wedge under the right hip Correct

Rationale: The pregnant client is positioned so that the uterus is displaced laterally to prevent compression of the inferior vena cava, which causes decreased placental perfusion. This is accomplished by placing a wedge under the hip. Positioning for abdominal surgery necessitates a supine position. The Trendelenburg position places pressure from the pregnant uterus on the diaphragm and lungs, decreasing respiratory capacity and oxygenation. A semi-Fowler or prone position is not practical for this type of abdominal surgery.

A nurse is preparing to perform the Leopold maneuvers on a pregnant client. The nurse should first:

V. ○ Locate the fetal heart tone

W. Position the woman supine

X. Ask the client to empty her bladder Correct

Y. Count the fetal heart rate for 1 minute

Rationale: In preparation for the Leopold maneuvers, the nurse first asks the woman to empty her bladder, which will contribute to the woman's comfort during the examination. Next the nurse positions the client supine with a wedge placed under the hip to displace the uterus. Often the Leopold maneuvers are performed to aid the examiner in locating the fetal heart tones. Counting the fetal heart rate is not associated with Leopold maneuvers.

A nurse is assessing the lochia of a client who delivered a viable newborn 1 hour ago. Which type of lochia would the nurse expect to note at this time?

Z. Lochia alba

AA. Lochial clots Incorrect

AB. Lochia serosa

AC. Dark-red lochia rubra Correct

Rationale: When the perineum is assessed, the lochia is checked for amount, color, and the presence of clots. The color of the lochia during the fourth stage of labor (1 to 4 hours after birth) is dark red (rubra). This is an expected occurrence until the third day after delivery. Then, from days 4 through 10, the discharge is brownish pink (serosa). Alba is a white discharge that occurs on days 11 to 14.

A nurse provides instructions to a breastfeeding mother who is experiencing breast engorgement about measures for treating the problem. The nurse tells the mother to:

AD. Take a cool shower just before breastfeeding

AE. Avoid breastfeeding during the night time hours to ensure adequate rest

AF. Gently massage the breasts during breastfeeding to help empty the breasts Correct

AG. Apply heat packs to the breasts for 15 to 20 minutes between feedings to reduce swelling

Rationale: Gently massaging the breasts during breast feeding will help empty the breasts. The mother should not avoid breastfeeding during the night; instead, she should breastfeed every 2 hours or pump the breasts. The nurse instructs the woman to apply ice packs, not heat packs, to the breasts between feedings to reduce swelling. It may be helpful for the mother to stand in a warm shower just before feeding to foster relaxation and letdown.

When, during the normal postpartum course, would the nurse expect to note the fundal assessment shown in the figure?

CR. Pulls on the umbilical cord as the mother bears down

CS. Applies strong traction on the cord when signs of separation occur

CT. Instructs the mother to push when signs of separation have occurred **Correct**

Rationale: To assist in the delivery of the placenta, the woman is instructed to push when signs of separation have occurred. If possible, the placenta should be expelled by means of maternal effort during a uterine contraction. Alternate compression and elevation of the fundus plus minimal controlled traction on the umbilical cord may be used to facilitate delivery of the placenta and amniotic membranes.

A multigravida woman with a history of multiple cesarean births is admitted to the maternity unit in labor. The client is experiencing excessively strong contractions, and the nurse monitors the client closely for uterine rupture. Which assessment findings are indicative of complete uterine rupture? **Select all that apply.**

CU. Fetal bradycardia **Correct**

CV. Maternal tachypnea **Correct**

CW. Excessive vaginal bleeding

CX. Increased uterine contractions

CY. Maternal complaint of sudden sharp abdominal pain **Correct**

Rationale: In a complete uterine rupture, the woman may complain of sudden sharp, shooting abdominal pain and may state that she felt like "something gave way." If she is in labor, her contractions will cease and the pain is relieved. In a complete uterine rupture, bleeding will be concealed, and therefore the client will exhibit signs of hypovolemic shock resulting from hemorrhage (hypotension, tachypnea, pallor, and cool, clammy skin). The fetus is the most common indicator of uterine rupture. Such changes in the fetal heart rate as late or variable decelerations, a decrease in baseline variability, or an increase or decrease in rate are commonly exhibited during a rupture. If the placenta separates, the fetal heart rate will be absent and fetal parts may be palpated through the abdomen.

A client is admitted to the hospital for an emergency cesarean delivery. Contractions are occurring every 15 minutes, the client has a temperature of 100° F, and the client reports that she last ate 2 hours ago. The client also states that "everything happened so fast" and that she has had no preparation for the cesarean delivery. Which of the following actions should the nurse take first?

CZ. Continuing to time the contractions

DA. Beginning teaching about the cesarean delivery

DB. Reporting the time of last food intake to the physician **Correct**

DC. Giving acetaminophen (Tylenol) to lower the client's temperature

Rationale: Supportive interventions are instituted immediately to maintain cardiac and respiratory function, and oxygen is a necessary supportive therapy. The woman is intubated, and positive end expiratory pressure (PEEP) may be prescribed. The family should be notified; however, the nurse would first administer the oxygen, then prepare for intubation. A cardiac monitor may be needed, but this is not the initial action.

After a vaginal delivery, a woman suddenly begins to complain of severe pelvic pain and extreme fullness in the vagina, and the nurse suspects uterine inversion. The nurse immediately prepares to:

FI. Insert a Foley catheter

FJ. Perform fundal massage

FK. Administer oxytocin (Pitocin)

FL. Assist in repositioning the uterus through the vagina into a normal position **Correct**

Rationale: Uterine inversion occurs when the uterus turns completely or partially inside out, usually during the third stage of labor. The physician tries to replace the uterus, by way of the vagina, in a normal position. If this is not possible, laparotomy with replacement is performed. A hysterectomy may be required. Two intravenous lines are established to allow rapid fluid and blood replacement. A tocolytic medication or general anesthesia usually is needed to relax the uterus enough to replace it. To help ensure that the inverted fundus is not trapped in the cervix, oxytocin is not given until the uterus has been repositioned. Fundal massage should be avoided if possible, but, if it is prescribed, it should be conducted very carefully. A Foley catheter may be inserted to keep the bladder empty so that the uterus can contract well, but this is not the immediate action.

A nurse is performing an assessment of a pregnant woman to determine whether labor has begun. For which sign of true labor does the nurse assess the client?

FM. A lack of cervical changes

FN. A soft uterus with indentable contractions

FO. Contractions that are irregular in rhythm and duration

FP. Contractions that begin in the lower abdomen and back and radiate over the entire abdomen **Correct**

Rationale: Discomfort and pain associated with true labor contractions typically begin in the lower abdomen and back, then radiate over the entire abdomen. Mild, irregular contractions and a lack of changes in the cervix are findings associated with false labor. A firm uterus is present when contractions occur.

A nurse is preparing to assess the fetal heartbeat in a pregnant woman who is at gestational week 12. Which piece of equipment does the nurse use to assess the fetal heartbeat?

FQ. Fetoscope

FR. Adult stethoscope

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HZ. Liver function tests will be prescribed

IA. A repeat hepatitis screen will be performed during the pregnancy

IB. The infant should receive both the vaccine and hepatitis immune globulin soon after birth **Correct**

Rationale: A hepatitis B screen is performed to detect the presence of antigens in maternal blood. If antigens are present, the infant should receive hepatitis immune globulin and a vaccine soon after birth. Repeating the screen and prescribing liver function tests are incorrect measures and are unnecessary.

A client in the first trimester of pregnancy arrives at the clinic and reports that she has been experiencing vaginal bleeding. Threatened abortion is suspected, and the nurse provides instructions to the client regarding care. Which statement by the client indicates the need for further instruction?

IC. "I need to stay in bed for the rest of my pregnancy." **Correct**

ID. "I need to avoid having sex until the bleeding has stopped."

IE. "I need to watch for stuff that looks like tissue coming from my vagina."

IF. "I need to count the number of perineal pads that I use each day and make a note of the amount and color of blood on each pad."

Rationale: Strict bed rest throughout the remainder of the pregnancy is not required. The woman is advised to avoid sexual activities until bleeding has ceased and for 2 weeks after the last evidence of bleeding, as recommended by the physician or nurse-midwife. The woman is instructed to count the perineal pads she uses each day and to note the quantity and color of blood on each pad. The woman should also watch for the evidence of the passage of tissue.

A licensed practical nurse (LPN) is changing the diaper of a 1-day-old full-term female newborn. The nurse notes that the labia are edematous and darker than the surrounding skin and that a white mucous vaginal discharge is present. On the basis of these findings, the nurse determines that the appropriate action is:

IG. Contacting the registered nurse

IH. Documenting the findings **Correct**

II. Obtaining a specimen of the discharge for culture

IJ. Reviewing the mother's record to determine whether she has a history of gonorrhea

Rationale: The labia of a newborn female may be darker in color than the surrounding skin; this is a normal finding, a result of exposure to the mother's hormones before birth. Edema of the labia and a white mucous vaginal discharge are also normal. Therefore the nurse would document the findings. The other options are unnecessary.

Integrated Process: Nursing Process/Implementation

Content Area: Newborn

References: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). *Maternal-child nursing* (3rd ed., p. 1473). St. Louis: Elsevier.
Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). *Maternal-child nursing care* (4th ed., p. 769). St. Louis: Elsevier.

Awarded 0.0 points out of 1.0 possible points.

C. 83. ID: 327528075

A nurse is performing an assessment of a female client with suspected mittelschmerz. Which question does the nurse ask the client to elicit data specific to this disorder?

A. "Do you have continuous heavy vaginal bleeding?"

B. "Do you have pain at the beginning of your period?"

C. "Do you have pain every time you have intercourse?"

D. "Do you have sharp pain on the right or left side of your pelvis?" **Correct**

Rationale: Mittelschmerz ("middle pain") refers to pelvic pain that occurs midway between menstrual periods or at the time of ovulation. The pain is due to growth of the dominant follicle within the ovary or to rupture of a follicle and subsequent spillage of follicular fluid and blood into the peritoneal space. The pain, which is fairly sharp, is felt on the right or left side of the pelvis. It generally lasts a few hours to 2 days, and slight (not profuse) vaginal bleeding may accompany the discomfort. The pain is not associated with intercourse.

Test-Taking Strategy: Use the process of elimination. Recalling that mittelschmerz is "middle pain," that this condition occurs as a result of growth or rupture of the follicle, and that it generally lasts a few hours to 2 days will assist you in answering correctly. If you are unfamiliar with this condition, review this content.

Level of Cognitive Ability: Analyzing

Client Needs: Physiological Integrity

Integrated Process: Nursing Process/Assessment

Content Area: Reproductive

Reference: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). *Maternal-child nursing* (3rd ed., p. 775). St. Louis: Elsevier.

Awarded 0.0 points out of 1.0 possible points.

Integrated Process: Nursing Process/Analysis

Content Area: Maternity/Antepartum

Reference: Perry, S. E., Hockenberry, M. J., Lowdermilk, D. L., & Wilson, D. (2010). *Maternal-child nursing care* (4th ed., pp. 328, 329). St Louis: Mosby.

Awarded 0.0 points out of 1.0 possible points.

H. 88. ID: 327529200

A woman with severe preeclampsia delivers a healthy newborn infant and continues to receive magnesium sulfate therapy in the postpartum period. Twenty-four hours after delivery, the client begins passing more than 100 mL of urine every hour. The nurse recognizes this volume of urine output as an indication of:

A. Imminent seizures

B. Hyperkalemia

C. High-output renal failure

D. Diminished edema and vasoconstriction in the brain and kidneys **Correct**

Rationale: In this client, diuresis is a positive sign, indicating that edema and vasoconstriction in the brain and kidneys have decreased. Diuresis also reflects increased tissue perfusion in the kidneys. Clients with severe preeclampsia are not considered out of danger until birth and diuresis have taken place. Diuresis is not an indication of impending seizures. Although renal failure is a complication of severe preeclampsia, it is not the high-output type of failure. Potassium is lost through the urine; therefore hyperkalemia is not associated with diuresis.

Test-Taking Strategy: Use the process of elimination. Recalling that oliguria is associated with severe preeclampsia will help you determine that diuresis in this scenario is associated with an improvement in preeclampsia. This will direct you to the correct option. If you had difficulty with this question, review the expected responses to treatment of severe preeclampsia.

Level of Cognitive Ability: Analyzing

Client's Needs: Physiological Integrity

Integrated Process: Nursing Process/Analysis

Content Area: Maternity/Postpartum

References: McKinney, E., James, S., Murray, S., & Ashwill, J. (2009). *Maternal-child nursing* (3rd ed., p. 627). St. Louis: Elsevier.
Perry, S., Hockenberry, M., Lowdermilk, D., & Wilson, D. (2010). *Maternal-child nursing care* (4th ed., pp. 345, 346). St. Louis: Elsevier.