A. To estimate the fetal weight
B. To locate a pocket of fluid
C. To determine multiparity
D. To prescreen for fetal anomalies - ansB. To locate a pocket of fluid

An ultrasound is done to locate a pocket of amniotic fluid and the placenta prior to an amniocentesis. This decreases the risk of injury to the fetus.

A nurse is caring for a client who is at 38 weeks of gestation. Which of the following actions should the nurse take prior to applying an external transducer for fetal monitoring?

A. Determine progression of dilatation and effacement.
B. Perform Leopold maneuvers.
C. Complete a sterile speculum exam.
D. Prepare a Nitrazine paper test. - ansB. Perform Leopold maneuvers.

The nurse should perform Leopold maneuvers to assess the position of the fetus to best determine the optimal placement for the external fetal monitoring transducer.

A nurse is caring for a client who is experiencing preeclampsia and has a new prescription for IV magnesium sulfate. Which of the following medications should the nurse anticipate administering if the client develops magnesium toxicity?

A. Calcium gluconate
B. Hydralazine
C. Medroxyprogesterone acetate
D. Methylergonovine - ansA. Calcium gluconate

The nurse should anticipate administering calcium gluconate if the client develops magnesium toxicity. Calcium gluconate is the antidote.

A nurse is caring for a client who is pregnant in an antepartum clinic.

Which of the following findings should the nurse report to the provider?
Select the 3 findings that should be reported.

Vital Signs
0900:
Temperature 36.6° C (97.9° F), Heart rate 88/min, Respiratory rate 18/min, Blood pressure 130/70 mm Hg, Oxygen saturation 97% on room air
1000:
Heart rate 76/min, Respiratory rate 20/min, Blood pressure 138/68 mm Hg, Oxygen saturation 98% on room air

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Medical History
0900:
Gravida 3, - ansA. Uterine contractions
The client is experiencing regular uterine contractions and cervical change, which are indicators of preterm labor; therefore, the nurse should notify the provider about this finding.

C. Gestational age
The client is at 32 weeks of gestation and is experiencing regular uterine contractions and cervical dilation, which indicates that the client is in preterm labor; therefore, the nurse should notify the provider about this finding.

D. Vaginal examination
The client's cervix is dilated to 2 cm and is 50% effaced, which indicate the client is in preterm labor; therefore, the nurse should notify the provider about this finding.

A nurse is caring for a client who is pregnant.

Which of the following actions are the nurse's priorities?
Select the 4 actions that the nurse should take immediately.

Medical History
Gravida 1 Para 0
41 weeks of gestation
Induction of labor due to postdates

Nurses' Notes
1400:
Client received epidural anesthesia for reports of a pain level of 7 on a scale of 0 to 10 from uterine contractions.
Contractions occurring every 4 to 5 min, lasting 60 seconds, palpate moderate.
FHR: Baseline 135/m - ansB. Administer a bolus of IV fluids.
A priority intervention that the nurse should perform when using the urgent vs. nonurgent approach to client care is to address the client's hypotension and fetal bradycardia and minimal variability. The nurse should plan to administer a bolus of IV fluids to increase the client's blood volume and improve uterine and intervillous space blood flow.

D. Reposition the client to their side.
A priority intervention that the nurse should perform when using the urgent vs. nonurgent approach to client care is to address the fetal bradycardia and minimal variability caused by decreased uteroplacental perfusion. The nurse should plan to turn

C. Apply oxygen to the client at 2 L/min via nasal cannula.
D. Place the client in the lithotomy position and apply fundal pressur - ansA. Insert two gloved fingers into the vagina and apply upward pressure to the presenting part.

The nurse should quickly apply gloves and insert two fingers into the vagina toward the cervix, exerting upward pressure onto the presenting part to relieve umbilical cord compression and increase oxygenation to the fetus.

A nurse is preparing to administer magnesium sulfate 2 g/hr IV to a client who is in preterm labor. Available is 20 g magnesium sulfate in 500 mL of dextrose 5% in water (D5W). The nurse should set the IV infusion pump to administer how many mL/hr? (Round the answer to the nearest whole number. Use a leading zero if it applies. Do not use a trailing zero.) - ans50 mL/hr

2 g/hr x 500 mL = 1,000 mL/g/hr
1,000 mL/g/hr / 20g = 50 mL/hr

A nurse is preparing to collect a blood specimen from a newborn via a heel stick. Which of the following techniques should the nurse use to help minimize the pain of the procedure for the newborn?

A. Apply a cool pack for 10 min to the heel prior to the puncture.
B. Request a prescription for IM analgesic.
C. Use a manual lancet blade to pierce the skin.
D. Place the newborn skin to skin on the mother's chest. - ansD. Place the newborn skin to skin on the mother's chest.

Placing the newborn skin to skin on the mother's chest is an effective technique to significantly decrease the newborn's pain level and anxiety. The nurse should implement this technique before, during, and after the procedure.

A nurse is providing discharge teaching to a client who had a cesarean birth 3 days ago. Which of the following instructions should the nurse include?

A. "You can resume sexual activity in 1 week."
B. "You won't need to do Kegel exercises since you had a cesarean."
C. "You can still become pregnant if you are breastfeeding."
D. "You are safe to start adding sit-ups to your exercise routine in 2 weeks." - ansC. "You can still become pregnant if you are breastfeeding."

The nurse should instruct the client that breastfeeding does not prevent ovulation. Therefore, the client can become pregnant. The nurse should discuss contraception that is safe to use while breastfeeding.

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A nurse is teaching a newly licensed nurse about collecting a specimen for the universal newborn screening. Which of the following statements should the nurse include in the teaching?

A. "Obtain an informed consent prior to obtaining the specimen."
B. "Collect at least 1 milliliter of urine for the test."
C. "Ensure that the newborn has been receiving feedings for 24 hours prior to obtaining the specimen."
D. "Premature newborns may have false negative tests due to immature development of liver - ansC. "Ensure that the newborn has been receiving feedings for 24 hours prior to obtaining the specimen."

The nurse should ensure that the newborn has been receiving regular feedings for at least 24 hr prior to testing.

A nurse is transporting a newborn back to the parent's room following a procedure. Which of the following actions should the nurse take?

A. Verify that the parent's identification band matches the newborn's identification band.
B. Scan the newborn's identification band to verify their identity.
C. Check the newborn's security tag number to ensure it matches the newborn's medical record.
D. Match the newborn's date and time of birth to the information in the parent's medical record. - ansA. Verify that the parent's identification band matches the newborn's identification band.

The nurse should verify the newborn's identity every time the newborn is returned to the parents. The nurse should match the information on the parent's identification band to the information on the newborn's identification band.

The nurse is reviewing laboratory results in the adolescent's medical record.

The nurse is planning care for the adolescent. Which of the following prescriptions should the nurse expect the provider to prescribe?
Drag words from the choices below to fill in each blank in the following sentence.

History and Physical
Adolescent is sexually active with two current partners.
IUD in place
Reports not using condoms during sexual activity.
History of type 1 diabetes mellitus

Nurses' Notes
1300: Adm - ansC. Ceftriaxone & E. Doxycycline

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Ceftriaxone is an anti-infective used to treat a variety of infections, including gonorrheal infection. Ceftriaxone is administered as a one-time IM injection for the treatment of gonorrhea. The adolescent is exhibiting manifestations of a gonorrheal infection. Therefore, the nurse should anticipate a provider's prescription for ceftriaxone. Doxycycline is an anti-infective used to treat a variety of infections. Doxycycline and ceftriaxone are anti-infectives used in the treatment of mild to moderate PID. The adolescent is exhibiting manifestations of a gonorrheal infection and PID. Therefore, the nurse should anticipate a provider's prescription for doxycycline.

The nurse is reviewing laboratory results in the adolescent's medical record.

The nurse is reviewing the adolescent's medical record. Which of the following conditions is the client most likely developing?
Complete the following sentence by using the list of options.

History and Physical
Adolescent is sexually active with two current partners.
IUD in place
Reports not using condoms during sexual activity.
History of type 1 diabetes mellitus

Nurses' Notes
1300: Admitted adolescent reporting" - ansThe adolescent is most likely developing
A. Pelvic inflammatory disease
Pelvic inflammatory disease (PID) is an infection that involves the pelvic reproductive organs. There are several causative agents that lead to infection, including Neisseria gonorrhoeae and C. trachomatis. PID occurs as a result from untreated infections ascending from the vagina.. Manifestations include fever, increased C-reactive protein, nausea, and vomiting; therefore, the nurse should suspect the adolescent is developing PID

As evidenced by
C. C-reactive protein
The adolescent's C-reactive protein is elevated, which is a manifestation of PID.A charge nurse on a labor and delivery unit is teaching a newly licensed nurse how to perform Leopoid maneuvers. Which of the following images indicates the first step of Leopoid maneuvers? - ANSPicture of nurse palpating top of belly; where bottom is

A nurse administers betamethasone to a client who is at 33 weeks gestation to stimulate fetal lung maturity. Which planning care for the newborn, which of the following conditions should the nurse identify as an adverse effect of this medication?
Hyperthermia
Decreased blood glucose

B. Murmur at the left sternal border
An audible murmur heard at the left sternal border is an expected manifestation in newborns.

C. Substernal chest retractions while sleeping
Substernal chest retractions can indicate respiratory distress syndrome in the newborn. This manifestation requires further assessment and intervention by the nurse.

D. Positive Babinski reflex
A positive Babinski reflex is an expected manifestation in newborns. This reflex is elicited when a newborn's sole is stroked with a finger upward along the lateral aspect of the sole and then across the ball of the foot and, in response, the toes hyperextend, and the large toe dorsiflexes.

A nurse is assessing a newborn who is 16 hr old. Which of the following findings should the nurse report to the provider? - ANSSubsternal Retractions

A nurse is assessing a newborn who was born at 26 weeks of gestation using the New Ballard Score. Which of the following findings should the nurse expect? - ANSMinimal arm recoil

A nurse is assessing a newborn who was born at 39 wks gestation. What finding should the nurse expect?
a. symmetric rib cage
b. lanugo abundant on the back
c. dry, wrinkled skin
d. vernix over the entire body - ANSa. symmetric rib cage

A newborn who is born at 39 weeks of gestation is full-term and should have normal, smooth skin with good turgor and the presence of subcutaneous fat pockets. A postmature newborn, greater than 42 weeks of gestation, will have dry, cracked skin with a wrinkled appearance.

A nurse is assessing a newborn who was delivered vaginally and experienced a tight nuchal cord. Which of the following findings should the nurse expect? - ANSPetechiae over the head

A nurse is assessing fetal heart tones for a client who is pregnant. The nurse has determined the fetal position as left occipital anterior. To which of the following areas of the client's abdomen should the nurse apply the ultrasound transducer to assess the point of maximum intensity of the fetal heart? - ANSA. Left upper quadrant
B. Right upper quadrant
C. Left lower quadrant
D. Right lower quadrant

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Answer: Left lower quadrant

A. Left upper quadrant
The fetal heart tones of a fetus in the left sacrum anterior position are best heard in the left upper quadrant.

B. Right upper quadrant
The fetal heart tones of a fetus in the right sacrum anterior position are best heard in the right upper quadrant.

C. Left lower quadrant
The fetal heart tones of a fetus in the left occipital anterior position are best heard in the left lower quadrant.

D. Right lower quadrant
The fetal heart tones of a fetus in the right occipital anterior position are best heard in the right lower quadrant.

A nurse is assessing four newborns. Which of the following findings should the nurse report to the provider? - ANSA newborn who is 18 h old and has an axillary temperature of 99.9° F

A nurse is assessing the newborn of a client who took selective serotonin reuptake inhibitor (SSRI) during pregnancy. Which of the following manifestations should the nurse identify as an indication of withdrawal from an SSRI? - ANSA. Large for gestational age
B. Hyperglycemia
C. Bradypnea
D. Vomiting

Answer: Vomiting

A. Large for gestational age
Low birth weight is an expected manifestation of fetal exposure to SSRIs.

B. Hyperglycemia
Hypoglycemia is an expected manifestation of fetal exposure to SSRIs.

C. Bradypnea
Tachypnea is an expected manifestation of fetal exposure to SSRIs.

D. Vomiting
Expected manifestations associated with fetal exposure to SSRIs include irritability, agitation, tremors, diarrhea, and vomiting. These manifestations typically last 2 days.

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An amnioinfusion of normal saline or lactated Ringer's is instilled into the amniotic cavity through a transcervical catheter introduced into the uterus to supplement the amount of amniotic fluid. The instillation reduces the severity of variable decelerations caused by cord compression for clients who are in labor. This is not a diagnostic test used for clients who have a positive contraction stress test.

C. Biophysical profile (BPP)
The nurse should prepare the client for a BPP to further assess fetal well-being. A positive contraction stress test indicates there is potential uteroplacental insufficiency. A BPP uses a real time ultrasound to visualize physical and physiological characteristics of the fetus and observe for fetal biophysical responses to stimuli.

D. Chorionic villus sampling (CVS)
CVS is the assessment of a portion of the developing placenta, which is aspirated through a thin sterile catheter inserted through the abdominal wall or intravaginally through the cervix under ultrasound guidance. This procedure is done during the first trimester. This is not a diagnostic test used for clients who have a positive contraction stress test.

A nurse is caring for a client who is experiencing preeclampsia and has a new prescription for IV magnesium sulfate. Which of the following medications should the nurse anticipate administering if the client develops magnesium toxicity? - ANSCalcium Gluconate

A nurse is caring for a client who is experiencing preterm labor at 29 weeks of gestation and has a prescription for betamethasone. Which of the following statements should the nurse make about the indication for medication administration? - ANSA. "This medication will stop your labor."
B. "This medication stimulates fetal lung maturity."
C. "This medication will decrease your risk for uterine infections."
D. "This medication will increase your baby's weight."

Answer: "This medication stimulates fetal lung maturity."

A. "This medication will stop your labor."
Betamethasone is not a tocolytic and does not stop labor.

B. "This medication stimulates fetal lung maturity."
The nurse should inform the client that betamethasone is a glucocorticoid that enhances fetal lung maturity by promoting the release of enzymes that release lung surfactant.

C. "This medication will decrease your risk for uterine infections."
Betamethasone is not given to decrease the client's risk for uterine infections.

D. "This medication will increase your baby's weight."

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Answer: Apply sacral counterpressure.

A. Apply sacral counterpressure.
The nurse should apply sacral counterpressure to assist in relieving back labor pain related to fetal posterior position.

B. Perform transcutaneous electrical nerve stimulation (TENS).
The nurse should perform TENS during the first stage of labor.

C. Initiate slow-paced breathing.
The nurse should transition a client to pattern-paced breathing during this stage of labor.

D. Assist with biofeedback.
The nurse should teach the client about biofeedback during the prenatal period for it to be effective during labor.

A nurse is caring for a client who is in labor. A vaginal examination reveals the following information: 2cm, 50%, +1, right occiput anterior. Based on this information, which of the following position should the nurse document in the medical record?
Transverse
Breech
Vertex
Mentum - ANSVertex

ROA describes the relationship of the presenting part of the fetus to the client's pelvis. In this case, the occipital bone is the presenting part and is located anteriorly in the client's right side. Based on the presentation of the fetus, the position is vertex.

A nurse is caring for a client who is in labor. The client questions the application of an internal fetal scalp monitor. Which of the following responses should the nurse make?
"Don't worry. Your baby is fine."
"You will need to ask your provider."
"Your provider feels it would be best."
"We need to observe your baby more closely." - ANSWe need to observe your baby more closely

The client has asked an information-seeking question. This therapeutic response provides information to the client in an honest, nonthreatening manner. The use of an internal fetal scalp monitor, or an internal spiral electrode, provides a more accurate assessment of fetal well-being during labor.

A nurse is caring for a client who is in the latent phase of labor and is experiencing low back pain. What action should the nurse take?
a. position the client supine with legs elevated

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Newborns who are premature have abundant lanugo, fine hair, especially over their back. A full-term newborn typically has minimal lanugo present only on the shoulders, pinnas, and forehead.

A nurse is caring for a newborn who is premature in the neonatal ICU. what action should the nurse take to promote development?
a. discourage the use of pacifiers
b. position the naked newborn on the parents bare chest
c. provide frequent periods of visual and auditory stimulation
d. rapidly advance oral feedings - ANSb. position the naked newborn on the parents bare chest

A nurse is caring for a newborn who is undergoing phototherapy to treat hyperbilirubinemia. Which of the following actions should the nurse take? - ANSA. Cover the newborn's eyes while under the phototherapy light.
B. Keep the newborn in a shirt while under the phototherapy light.
C. Apply a light moisturizing lotion to the newborn's skin.
D. Turn and reposition the newborn every 4 hr while undergoing phototherapy.

Answer: Cover the newborn's eyes while under the phototherapy light.

A. Cover the newborn's eyes while under the phototherapy light.
Applying an opaque eye mask prevents damage to the newborn's retinas and corneas from the phototherapy light.

B. Keep the newborn in a shirt while under the phototherapy light.
It is acceptable for the nurse to keep a diaper or other covering over the newborn's genitals and buttocks, but the nurse should remove all other clothing and blankets to expose as much body surface area as possible to the phototherapy light.

C. Apply a light moisturizing lotion to the newborn's skin.
The nurse should not apply any cream or moisture to the newborn's skin because it can absorb heat and cause burns.

D. Turn and reposition the newborn every 4 hr while undergoing phototherapy.
The nurse should turn and reposition the newborn every 2 to 3 hr to allow for maximum exposure of body surfaces to the phototherapy light.

A nurse is caring for a newborn who was born to a client who has a narcotic use disorder. Which of the following nursing actions should the nurse identify as a contraindication for the care of the newborn?
Promoting maternal-newborn bonding
Tight swaddling of the newborn
Small frequent feedings
Frequent stimulation - ANSFrequent stimulation

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This newborn needs a quiet, calm environment with minimal stimulation to promote rest and reduce stress. A stimulating environment can trigger irritability and hyperactive behaviors.

A nurse is caring for a newborn who was transferred to the nursery 30 min after birth because of mild respiratory distress. Which of the following actions should the nurse take first? - ANSA. Confirm the newborn's Apgar score.
B. Verify the newborn's identification.
C. Administer vitamin K to the newborn.
D. Determine obstetrical risk factors.

Answer: Verify the newborn's identification.

A. Confirm the newborn's Apgar score.
The Apgar score is a physiological assessment that occurs 1 min following birth and again at 5 min. The nurse should confirm the score when the newborn arrives in the nursery. However, there is another action the nurse should take first.

B. Verify the newborn's identification.
When using the safety/risk reduction approach to client care, the first action the nurse should take is to verify the newborn's identity upon arrival to the nursery.

C. Administer vitamin K to the newborn.
The nurse should administer Vitamin K to the newborn soon after birth to increase clotting factors and prevent bleeding. However, the injection can be delayed until after initial bonding time and the first breastfeeding if necessary. Therefore, there is another action the nurse should take first.

D. Determine obstetrical risk factors.
The nurse should identify obstetrical risk factors to determine if interventions are required for the newborn. However, there is another action the nurse should take first.

A nurse is caring for a newborn who weighs 4lb. How many kg does the newborn weigh? - ANS1.8

A nurse is caring for a newborn whose mother received magnesium sulfate to treat preterm labor. Which of the following clinical manifestations in the newborn indicates toxicity due to the magnesium sulfate therapy?
Respiratory depression
Hypothermia
Hypoglycemia
Jaundice - ANSRespiratory depression

Increased maternal temperature is incorrect.
The use of oxytocin will have no effect on maternal temperature.

A nurse is preparing to collect a blood specimen from a newborn via a heel stick. Which of the following techniques should the nurse use to help minimize the pain of the procedure for the newborn - ANSPlace the newborn skin to skin on the mothers chest

A nurse is preparing to perform Leopold maneuvers for a client. Identify the sequence the nurse should follow. (Move the steps into the box on the right, placing them in order of performance. Use all the steps.) - ANSThe first step the nurse should take when performing Leopold maneuvers is to palpate the client's fundus to identify the fetal part.

Second, the nurse should determine the location of the fetal back.

Third, the nurse should palpate for the fetal part presenting at the inlet.

Finally, the nurse should palpate the cephalic prominence to identify the attitude of the head.

A nurse is providing dietary teaching to a client who has hyperemesis gravidarum. Which of the following statements by the client indicated an understanding of the teaching? - ANSA. "I will eat foods that taste good instead of balancing my meals."
B. "I will avoid having a snack before I go to bed each night."
C. "I will have a cup of hot tea with each meal."
D. "I will eliminate products that contain dairy from my diet."

Answer: "I will eat foods that taste good instead of balancing my meals."

A. "I will eat foods that taste good instead of balancing my meals."
Clients who have hyperemesis gravidarum should eat foods they like in order to avoid nausea, rather than trying to consume a well-balanced diet.

B. "I will avoid having a snack before I go to bed each night."
Clients who have hyperemesis gravidarum should avoid going to bed with an empty stomach. The nurse should instruct the client to eat a healthy snack before going to bed.

C. "I will have a cup of hot tea with each meal."
Clients who have hyperemesis gravidarum should alternate liquids and solids every 2 to 3 hr to avoid an empty stomach and over filling at each meal.

D. "I will eliminate products that contain dairy from my diet."
Clients who have hyperemesis gravidarum do not need to eliminate dairy products from their diet. The client should be encouraged to consume dairy products, because they are less likely to cause nausea than other foods.

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The client should keep the diaphragm in place for at least 6 hr after intercourse to provide protection against pregnancy.

C. "You should use an oil-based product as a lubricant when inserting the diaphragm."
The client should avoid using oil-based products because they can weaken the rubber in the diaphragm.

D. "You should insert the diaphragm when your bladder is full."
The client should have an empty bladder prior to inserting the diaphragm.

A nurse is providing teaching about nonpharmological pain management to a client who is breastfeeding and has engorgement. The nurse should recommend the application of which of the following items? - ANSCold cabbage leaves

A nurse is providing teaching for a client who has a new prescription for combined oral contraceptives. Which of the following findings should the nurse include as an adverse effect of this medication? - ANSDepression

A nurse is providing teaching for a client who have birth 2 hr ago about the facility policy for newborn safety. Which of the following client statements indicates an understanding of the teaching? - ANSthe person who comes to take my baby's pictures will be wearing a photo identification badge

A nurse is providing teaching to a client about the physiological changes that occur during pregnancy. The client is at 10 weeks of gestation and has a BMI within the expected reference range. Which of the following client statements indicates an understanding of the teaching? - ANS"I will likely need to use alternative positions for sexual intercourse".

A nurse is providing teaching to a client who is at 8 wks gestation about manifestations to report to the provider during pregnancy. What info should the nurse include in the teaching?
a. nausea upon awakening
b. blurred or double vision
c. increase in white vaginal discharge
d. leg cramps when sleeping - ANSb. blurred or double vision

A nurse is providing teaching to a client who is at 40 weeks of gestation and has a new prescription for misoprostol. Which of the following instructions should the nurse include in the teaching? - ANS"I can administer oxytocin 4 hours after the insertion of the medication"

A nurse is providing teaching to a client who is planning to breastfeed her newborn. What statement by the client indicates an understanding of the teaching?
a. I must drink milk every day in order to assure good quality breast milk

D. "If this concerns you, perhaps you should reconsider and use another form of contraception."

Answer: "This procedure should have no effect on your sexual performance or adequacy."

A. ??????
The nurse is dismissing the client's question, providing no information to help the client make an informed decision.

B. "This procedure should have no effect on your sexual performance or adequacy."
The nurse is giving the client the information she is seeking. Sexual function depends on various hormonal and psychological factors. Therefore, tubal occlusion should have no physiological effect on sexual function.

C. "You'll be fine. I can't imagine you and your partner will have any problems with sexual function."
The nurse is giving the client unwarranted reassurance without addressing the information the client is seeking.

D. "If this concerns you, perhaps you should reconsider and use another form of contraception."
The nurse is giving the client unwarranted advice which might imply that there is a reason to be concerned about the effect of the procedure on sexual function.

A nurse is speaking with an expectant father who says that he feels resentful of the added attention others are giving to his wife since the pregnancy was announced several weeks ago. Which of the following responses should the nurse make?
"Has your wife sensed your anger toward her and the baby?"
"These feelings are common to expectant fathers in early pregnancy."
"I'm sure that it's really hard to accept this when it's your baby, too."
"It would be wise for you to speak to a therapist about these feelings." - ANSThese feelings are common to expectant fathers in early pregnancy

A nurse is teaching a client about a nonstress test. Which of the following statements by the client indicates an understanding of the teaching?
"I know not to eat anything after midnight."
"I will have medication given to me to cause contractions."
"I should press the button on the handheld marker when my baby moves."
"I will have to stimulate my breast to cause contractions." - ANSI should press the button on the handheld marker when my baby moves

The purpose of the test is to assess fetal well-being. The client should press the button on the handheld marker when she feels fetal movement.

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fourth degree laceration - ANSskin and muscles of perineum and anal sphincter and anterior rectal wall

fourth stage of labor - ANSstabilization of vital signs first four hours postpartum

GBS can be tested when? - ANS35-37 weeks gestation

high risk of _____ with external cephalic version - ANScord prolapse

how long should the newborn nurse? - ANS15-20 min

if a BPP comes back as a 6 - ANSit should be retested

Indomethacin - ANSNSAID that suppresses preterm labor and uterine contractions

labor occurs ___ hours after ROM - ANS24 hours

latent phase of labor - ANS0-3 cm, mild to moderate contractions q5-30 min lasting 30-40 seconds

low birth weight - ANSless than 2500g

marked variability - ANSmore than 25 contractions per min

meds given for postpartum hemorrhage - ANSoxytocin, methergen, cytotec, hembate

milia - ANSraised white spots (normal)

minimal variability - ANSless than 5 contractions per min

moderate variability - ANS6-25 contractions per min, normal

mongolian spots - ANSpurple spots of pigmentation

MSAFP can be done when - ANS16-18 weeks gestation

MSAFP screening is done at - ANS15-22 weeks gestation

nevus flamues (port wine stains) - ANScapillary angioma purple or red on newborns face that does not go away

newborns should have how many wet diapers per day? - ANS6-8 wet diapers and 3-4 stools per day