



# MIDWIFERY PAST QUESTIONS AND ANSWERS NMCN

EKWU ONYEKA PETER  
BS.N, RN, RM, RPHN, RHP

# MIDWIFERY PAST QUESTIONS AND ANSWERS NMCN

**ONYEKA PETER**

**RPHN, RHP**

**EKWU**

**BS.N, RN, RM,**

DEDICATION

**This book is dedicated to God and my wonderful midwifery student in Nigeria**

## INTRODUCTION

This is an introduction to a book on midwifery past questions and answers according to the Nursing and Midwifery Council of Nigeria (NMCN). The book is designed to help aspiring and practicing midwives prepare for the NMCN examinations and improve their knowledge and skills in midwifery. The book covers various topics such as anatomy and physiology, obstetrics, gynaecology, neonatology, family planning, ethics and legal issues, and professional development. The book also provides detailed explanations and rationales for each question and answer, as well as references to relevant sources and guidelines. The book is based on the latest NMCN curriculum and standards, and reflects the current trends and best practices in midwifery. The book is intended to be a useful resource for students, tutors, mentors, supervisors, and examiners of midwifery.

### TIPS ON HOW TO USE PAST QUESTIONS.

- 1) **Familiarize yourself with the content of the previous examination or question you are trying to answer. Read the question carefully and understand exactly what it is asking**
- 2) **Review the relevant material or subject area that the question is based on. Refresh your knowledge on the topics and sure you understand the key concepts and principals involved.**
- 3) **Use critical thinking skills. Analyze the question and think through each answer option before selecting the best one. Consider the context of the scenario presented, apply your nursing knowledge and experience, and eliminate any option that are incorrect or unlikely.**
- 4) **Make use of any clue or hints within the question or provided scenario to guide your answer. Look for keywords or phrases that may indicate the correct response.**
- 5) **If you are unsure about a specific question, use the process of elimination. Eliminate any obviously incorrect answer options first, then carefully consider the remaining one to make an educate guess.**
- 6) **Practice answering past nursing questions regularly. This will help you become familiar with the format and types question commonly asked, allowing you to improve your overall test-taking skills.**
  
7. **seek additional resources or support if needed. If you are struggling with a particular subject or topic, don't hesitate to ask for help from instructors, classmates,**

or online resources. This can provide further clarity and understanding, improving your ability to answer past questions in nursing.

#### MIDWIFERY COURSE FOR NMCN PROFESSIONAL EXAMINATION

The midwifery course is designed to prepare candidates for the professional examination conducted by the Nursing and Midwifery Council of Nigeria (NMCN). The course covers the theoretical and practical aspects of midwifery practice, including anatomy and physiology, maternal and child health, obstetrics and gynecology, family planning, ethics and legal issues, communication and counseling skills, research methods and statistics. The course also provides opportunities for clinical placements in various health facilities, where candidates can apply their knowledge and skills under the supervision of qualified midwives. The course duration is 18 months, and the entry requirements are a registered nurse certificate and a current practicing license from the NMCN. The course fee is N200,000, which includes tuition, examination, registration, and certification. Candidates who successfully complete the course and pass the examination will be awarded the certificate of midwifery by the NMCN and will be eligible to practice as midwives in Nigeria.

## MIDWIFERY 1

1. When assessing the adequacy of sperm for conception to occur, which of the following is the most useful criterion?

- A. Sperm count
- B. Sperm motility
- C. Sperm maturity
- D. Semen volume

2. A couple who wants to conceive but has been unsuccessful during the last 2 years has undergone many diagnostic procedures. When discussing the situation with the nurse, one partner states, "We know several friends in our age group and all of them have their own child already, Why can't we have one?". Which of the following would be the most pertinent nursing diagnosis for this couple?

- A. Fear related to the unknown
- B. Pain related to numerous procedures.
- C. Ineffective family coping related to infertility.
- D. Self-esteem disturbance related to infertility.

3. Which of the following urinary symptoms does the pregnant woman most frequently experience during the first trimester?

- A. Dysuria
- B. Frequency
- C. Incontinence
- D. Burning

4. Heartburn and flatulence, common in the second trimester, are most likely the result of which of the following?

- A. Increased plasma HCG levels
- B. Decreased intestinal motility
- C. Decreased gastric acidity

- D. Elevated estrogen levels
5. On which of the following areas would the nurse expect to observe chloasma?
- A. Breast, areola, and nipples
  - B. Chest, neck, arms, and legs
  - C. Abdomen, breast, and thighs
  - D. Cheeks, forehead, and nose
6. A pregnant client states that she “waddles” when she walks. The nurse’s explanation is based on which of the following as the cause?
- A. The large size of the newborn
  - B. Pressure on the pelvic muscles
  - C. Relaxation of the pelvic joints
  - D. Excessive weight gain
7. Which of the following represents the average amount of weight gained during pregnancy?
- A. 12 to 22 lb
  - B. 15 to 25 lb
  - C. 24 to 30 lb
  - D. 25 to 40 lb
8. When talking with a pregnant client who is experiencing aching swollen, leg veins, the nurse would explain that this is most probably the result of which of the following?
- A. Thrombophlebitis
  - B. Pregnancy-induced hypertension
  - C. Pressure on blood vessels from the enlarging uterus
  - D. The force of gravity pulling down on the uterus
9. Cervical softening and uterine souffle are classified as which of the following?
- A. Diagnostic signs
  - B. Presumptive signs
  - C. Probable signs
  - D. Positive signs
10. Which of the following would the nurse identify as a presumptive sign of pregnancy?

- A. Hegar sign
- B. Nausea and vomiting
- C. Skin pigmentation changes
- D. Positive serum pregnancy test

11. Which of the following common emotional reactions to pregnancy would the nurse expect to occur during the first trimester?

- A. Introversion, egocentrism, narcissism
- B. Awkwardness, clumsiness, and unattractiveness
- C. Anxiety, passivity, extroversion
- D. Ambivalence, fear, fantasies

12. During which of the following would the focus of classes be mainly on physiologic changes, fetal development, sexuality, during pregnancy, and nutrition?

- A. Prepregnant period
- B. First trimester
- C. Second trimester
- D. Third trimester

13. Which of the following would be disadvantage of breast feeding?

- A. Involution occurs more rapidly
- B. The incidence of allergies increases due to maternal antibodies
- C. The father may resent the infant's demands on the mother's body
- D. There is a greater chance for error during preparation

14. Which of the following would cause a false-positive result on a pregnancy test?

- A. The test was performed less than 10 days after an abortion
- B. The test was performed too early or too late in the pregnancy
- C. The urine sample was stored too long at room temperature
- D. A spontaneous abortion or a missed abortion is impending

15. FHR can be auscultated with a fetoscope as early as which of the following?

- A. 5 weeks gestation
- B. 10 weeks gestation
- C. 15 weeks gestation

D. 20 weeks gestation

16. A client LMP began July 5. Her EDD should be which of the following?

- A. January 2
- B. March 28
- C. April 12
- D. October 12

17. Which of the following fundal heights indicates less than 12 weeks' gestation when the date of the LMP is unknown?

- A. Uterus in the pelvis
- B. Uterus at the xiphoid
- C. Uterus in the abdomen
- D. Uterus at the umbilicus

18. Which of the following danger signs should be reported promptly during the antepartum period?

- A. Constipation
- B. Breast tenderness
- C. Nasal stuffiness
- D. Leaking amniotic fluid

19. Which of the following prenatal laboratory test values would the nurse consider as significant?

- A. Hematocrit 33.5%
- B. Rubella titer less than 1:8
- C. White blood cells 8,000/mm<sup>3</sup>
- D. One hour glucose challenge test 110 g/dL

20. Which of the following characteristics of contractions would the nurse expect to find in a client experiencing true labor?

- A. Occurring at irregular intervals
- B. Starting mainly in the abdomen
- C. Gradually increasing intervals
- D. Increasing intensity with walking

21. During which of the following stages of labor would the nurse assess "crowning"?

- A. First stage
- B. Second stage
- C. Third stage
- D. Fourth stage

22. Barbiturates are usually not given for pain relief during active labor for which of the following reasons?

- A. The neonatal effects include hypotonia, hypothermia, generalized drowsiness, and reluctance to feed for the first few days.
- B. These drugs readily cross the placental barrier, causing depressive effects in the newborn 2 to 3 hours after intramuscular injection.
- C. They rapidly transfer across the placenta, and lack of an antagonist make them generally inappropriate during labor.
- D. Adverse reactions may include maternal hypotension, allergic or toxic reaction or partial or total respiratory failure

23. Which of the following nursing interventions would the nurse perform during the third stage of labor?

- A. Obtain a urine specimen and other laboratory tests.
- B. Assess uterine contractions every 30 minutes.
- C. Coach for effective client pushing
- D. Promote parent-newborn interaction.

24. Which of the following actions demonstrates the nurse's understanding about the newborn's thermoregulatory ability?

- A. Placing the newborn under a radiant warmer.
- B. Suctioning with a bulb syringe
- C. Obtaining an Apgar score
- D. Inspecting the newborn's umbilical cord

25. Immediately before expulsion, which of the following cardinal movements occur?

- A. Descent
- B. Flexion
- C. Extension
- D. External rotation

26. Before birth, which of the following structures connects the right and left auricles of the heart?

- A. Umbilical vein
- B. Foramen ovale
- C. Ductus arteriosus
- D. Ductus venosus

27. Which of the following when present in the urine may cause a reddish stain on the diaper of a newborn?

- A. Mucus
- B. Uric acid crystals
- C. Bilirubin
- D. Excess iron

28. When assessing the newborn's heart rate, which of the following ranges would be considered normal if the newborn were sleeping?

- A. 80 beats per minute
- B. 100 beats per minute
- C. 120 beats per minute
- D. 140 beats per minute

29. Which of the following is true regarding the fontanel of the newborn?

- A. The anterior is triangular shaped; the posterior is diamond shaped.
- B. The posterior closes at 18 months; the anterior closes at 8 to 12 weeks.
- C. The anterior is large in size when compared to the posterior fontanel.
- D. The anterior is bulging; the posterior appears sunken.

30. Which of the following groups of newborn reflexes below are present at birth and remain unchanged through adulthood?

- A. Blink, cough, rooting, and gag
- B. Blink, cough, sneeze, gag
- C. Rooting, sneeze, swallowing, and cough
- D. Stepping, blink, cough, and sneeze

31. Which of the following describes the Babinski reflex?

- A. The newborn's toes will hyperextend and fan apart from dorsiflexion of the big toe when one side of foot is stroked upward from the ball of the heel and across the ball of the foot.
- B. The newborn abducts and flexes all extremities and may begin to cry when exposed to sudden movement or loud noise.
- C. The newborn turns the head in the direction of stimulus, opens the mouth, and begins to suck when cheek, lip, or corner of mouth is touched.
- D. The newborn will attempt to crawl forward with both arms and legs when he is placed on his abdomen on a flat surface

32. Which of the following statements best describes hyperemesis gravidarum?

- A. Severe anemia leading to electrolyte, metabolic, and nutritional imbalances in the absence of other medical problems.
- B. Severe nausea and vomiting leading to electrolyte, metabolic, and nutritional imbalances in the absence of other medical problems.
- C. Loss of appetite and continuous vomiting that commonly results in dehydration and ultimately decreasing maternal nutrients
- D. Severe nausea and diarrhea that can cause gastrointestinal irritation and possibly internal bleeding

33. Which of the following would the nurse identify as a classic sign of PIH?

- A. Edema of the feet and ankles
- B. Edema of the hands and face
- C. Weight gain of 1 lb/week
- D. Early morning headache

34. In which of the following types of spontaneous abortions would the nurse assess dark brown vaginal discharge and a negative pregnancy tests?

- A. Threatened
- B. Imminent
- C. Missed
- D. Incomplete

35. Which of the following factors would the nurse suspect as predisposing a client to placenta previa?

- A. Multiple gestation
- B. Uterine anomalies
- C. Abdominal trauma

**D. Renal or vascular disease**

**36. Which of the following would the nurse assess in a client experiencing abruptio placenta?**

- A. Bright red, painless vaginal bleeding**
- B. Concealed or external dark red bleeding**
- C. Palpable fetal outline**
- D. Soft and nontender abdomen**

**37. Which of the following is described as premature separation of a normally implanted placenta during the second half of pregnancy, usually with severe hemorrhage?**

- A. Placenta previa**
- B. Ectopic pregnancy**
- C. Incompetent cervix**
- D. Abruptio placentae**

**38. Which of the following may happen if the uterus becomes overstimulated by oxytocin during the induction of labor?**

- A. Weak contraction prolonged to more than 70 seconds**
- B. Tetanic contractions prolonged to more than 90 seconds**
- C. Increased pain with bright red vaginal bleeding**
- D. Increased restlessness and anxiety**

**39. When preparing a client for cesarean delivery, which of the following key concepts should be considered when implementing nursing care?**

- A. Instruct the mother's support person to remain in the family lounge until after the delivery**
- B. Arrange for a staff member of the anesthesia department to explain what to expect postoperatively**
- C. Modify preoperative teaching to meet the needs of either a planned or emergency cesarean birth**
- D. Explain the surgery, expected outcome, and kind of anesthetics**

**40. Which of the following best describes preterm labor?**

- A. Labor that begins after 20 weeks gestation and before 37 weeks gestation**

- B. Labor that begins after 15 weeks gestation and before 37 weeks gestation
  - C. Labor that begins after 24 weeks gestation and before 28 weeks gestation
  - D. Labor that begins after 28 weeks gestation and before 40 weeks gestation
41. When PROM occurs, which of the following provides evidence of the nurse's understanding of the client's immediate needs?
- A. The chorion and amnion rupture 4 hours before the onset of labor.
  - B. PROM removes the fetus most effective defense against infection
  - C. Nursing care is based on fetal viability and gestational age.
  - D. PROM is associated with malpresentation and possibly incompetent cervix
42. Which of the following factors is the underlying cause of dystocia?
- A. Nutritional
  - B. Mechanical
  - C. Environmental
  - D. Medical
43. When uterine rupture occurs, which of the following would be the priority?
- A. Limiting hypovolemic shock
  - B. Obtaining blood specimens
  - C. Instituting complete bed rest
  - D. Inserting a urinary catheter
44. Which of the following is the nurse's initial action when umbilical cord prolapse occurs?
- A. Begin monitoring maternal vital signs and FHR
  - B. Place the client in a knee-chest position in bed
  - C. Notify the physician and prepare the client for delivery
  - D. Apply a sterile warm saline dressing to the exposed cord
45. Which of the following amounts of blood loss following birth marks the criterion for describing postpartum hemorrhage?
- A. More than 200 ml
  - B. More than 300 ml
  - C. More than 400 ml
  - D. More than 500 ml

46. Which of the following is the primary predisposing factor related to mastitis?

- A. Epidemic infection from nosocomial sources localizing in the lactiferous glands and ducts
- B. Endemic infection occurring randomly and localizing in the periglandular connective tissue
- C. Temporary urinary retention due to decreased perception of the urge to void
- D. Breast injury caused by overdistention, stasis, and cracking of the nipples

47. Which of the following best describes thrombophlebitis?

- A. Inflammation and clot formation that result when blood components combine to form an aggregate body
- B. Inflammation and blood clots that eventually become lodged within the pulmonary blood vessels
- C. Inflammation and blood clots that eventually become lodged within the femoral vein
- D. Inflammation of the vascular endothelium with clot formation on the vessel wall

48. Which of the following assessment findings would the nurse expect if the client develops DVT?

- A. Midcalf pain, tenderness and redness along the vein
- B. Chills, fever, malaise, occurring 2 weeks after delivery
- C. Muscle pain the presence of Homans sign, and swelling in the affected limb
- D. Chills, fever, stiffness, and pain occurring 10 to 14 days after delivery

49. Which of the following are the most commonly assessed findings in cystitis?

- A. Frequency, urgency, dehydration, nausea, chills, and flank pain
- B. Nocturia, frequency, urgency dysuria, hematuria, fever and suprapubic pain
- C. Dehydration, hypertension, dysuria, suprapubic pain, chills, and fever
- D. High fever, chills, flank pain nausea, vomiting, dysuria, and frequency

50. Which of the following best reflects the frequency of reported postpartum "blues"?

- A. Between 10% and 40% of all new mothers report some form of postpartum blues

- B. Between 30% and 50% of all new mothers report some form of postpartum blues**
- C. Between 50% and 80% of all new mothers report some form of postpartum blues**
- D. Between 25% and 70% of all new mothers report some form of postpartum blues**

#### Answers and Rationales

- 1) B. Although all of the factors listed are important, sperm motility is the most significant criterion when assessing male infertility. Sperm count, sperm maturity, and semen volume are all significant, but they are not as significant as sperm motility.**
- 2) D. Based on the partner's statement, the couple is verbalizing feelings of inadequacy and negative feelings about themselves and their capabilities. Thus, the nursing diagnosis of self-esteem disturbance is most appropriate. Fear, pain, and ineffective family coping also may be present but as secondary nursing diagnoses.**
- 3) B. Pressure and irritation of the bladder by the growing uterus during the first trimester is responsible for causing urinary frequency. Dysuria, incontinence, and burning are symptoms associated with urinary tract infections.**
- 4) C. During the second trimester, the reduction in gastric acidity in conjunction with pressure from the growing uterus and smooth muscle relaxation, can cause heartburn and flatulence. HCG levels increase in the first, not the second, trimester. Decrease intestinal motility would most likely be the cause of constipation and bloating. Estrogen levels decrease in the second trimester.**
- 5) D. Chloasma, also called the mask of pregnancy, is an irregular hyperpigmented area found on the face. It is not seen on the breasts, areola, nipples, chest, neck, arms, legs, abdomen, or thighs.**
- 6) C. During pregnancy, hormonal changes cause relaxation of the pelvic joints, resulting in the typical "waddling" gait. Changes in posture are related to the growing fetus. Pressure on the surrounding muscles causing discomfort is due to the growing uterus. Weight gain has no effect on gait.**
- 7) C. The average amount of weight gained during pregnancy is 24 to 30 lb. This weight gain consists of the following: fetus – 7.5 lb; placenta and membrane – 1.5 lb; amniotic fluid – 2 lb; uterus – 2.5 lb; breasts – 3 lb; and increased blood volume – 2 to 4 lb; extravascular fluid and fat – 4 to 9 lb. A gain of 12 to 22 lb is insufficient, whereas a weight gain of 15 to 25 lb is marginal. A weight gain of 25 to 40 lb is considered excessive.**
- 8) C. Pressure of the growing uterus on blood vessels results in an increased risk for venous stasis in the lower extremities. Subsequently, edema and varicose vein formation may occur. Thrombophlebitis is an inflammation of the veins due to thrombus formation. Pregnancy-induced hypertension**

is not associated with these symptoms. Gravity plays only a minor role with these symptoms.

- 9) C. Cervical softening (Goodell sign) and uterine soufflé are two probable signs of pregnancy. Probable signs are objective findings that strongly suggest pregnancy. Other probable signs include Hegar sign, which is softening of the lower uterine segment; Piskacek sign, which is enlargement and softening of the uterus; serum laboratory tests; changes in skin pigmentation; and ultrasonic evidence of a gestational sac. Presumptive signs are subjective signs and include amenorrhea; nausea and vomiting; urinary frequency; breast tenderness and changes; excessive fatigue; uterine enlargement; and quickening.
- 10) B. Presumptive signs of pregnancy are subjective signs. Of the signs listed, only nausea and vomiting are presumptive signs. Hegar sign, skin pigmentation changes, and a positive serum pregnancy test are considered probably signs, which are strongly suggestive of pregnancy.
- 11) D. During the first trimester, common emotional reactions include ambivalence, fear, fantasies, or anxiety. The second trimester is a period of well-being accompanied by the increased need to learn about fetal growth and development. Common emotional reactions during this trimester include narcissism, passivity, or introversion. At times the woman may seem egocentric and self-centered. During the third trimester, the woman typically feels awkward, clumsy, and unattractive, often becoming more introverted or reflective of her own childhood.
- 12) B. First-trimester classes commonly focus on such issues as early physiologic changes, fetal development, sexuality during pregnancy, and nutrition. Some early classes may include pregnant couples. Second and third trimester classes may focus on preparation for birth, parenting, and newborn care.
- 13) C. With breast feeding, the father's body is not capable of providing the milk for the newborn, which may interfere with feeding the newborn, providing fewer chances for bonding, or he may be jealous of the infant's demands on his wife's time and body. Breast feeding is advantageous because uterine involution occurs more rapidly, thus minimizing blood loss. The presence of maternal antibodies in breast milk helps decrease the incidence of allergies in the newborn. A greater chance for error is associated with bottle feeding. No preparation is required for breast feeding.
- 14) A false-positive reaction can occur if the pregnancy test is performed less than 10 days after an abortion. Performing the tests too early or too late in the pregnancy, storing the urine sample too long at room temperature, or having a spontaneous or missed abortion impending can all produce false-negative results.
- 15) D. The FHR can be auscultated with a fetoscope at about 20 week's gestation. FHR usually is auscultated at the midline suprapubic region

with Doppler ultrasound transducer at 10 to 12 week's gestation. FHR, cannot be heard any earlier than 10 weeks' gestation.

- 16) C. To determine the EDD when the date of the client's LMP is known use Nagele rule. To the first day of the LMP, add 7 days, subtract 3 months, and add 1 year (if applicable) to arrive at the EDD as follows: 5 + 7 = 12 (July) minus 3 = 4 (April). Therefore, the client's EDD is April 12.
- 17) When the LMP is unknown, the gestational age of the fetus is estimated by uterine size or position (fundal height). The presence of the uterus in the pelvis indicates less than 12 weeks' gestation. At approximately 12 to 14 weeks, the fundus is out of the pelvis above the symphysis pubis. The fundus is at the level of the umbilicus at approximately 20 weeks' gestation and reaches the xiphoid at term or 40 weeks.
- 18) D. Danger signs that require prompt reporting leaking of amniotic fluid, vaginal bleeding, blurred vision, rapid weight gain, and elevated blood pressure. Constipation, breast tenderness, and nasal stuffiness are common discomforts associated with pregnancy.
- 19) B. A rubella titer should be 1:8 or greater. Thus, a finding of a titer less than 1:8 is significant, indicating that the client may not possess immunity to rubella. A hematocrit of 33.5% a white blood cell count of 8,000/mm<sup>3</sup>, and a 1 hour glucose challenge test of 110 g/dl are with normal parameters.
- 20) D. With true labor, contractions increase in intensity with walking. In addition, true labor contractions occur at regular intervals, usually starting in the back and sweeping around to the abdomen. The interval of true labor contractions gradually shortens.
- 21) B. Crowing, which occurs when the newborn's head or presenting part appears at the vaginal opening, occurs during the second stage of labor. During the first stage of labor, cervical dilation and effacement occur. During the third stage of labor, the newborn and placenta are delivered. The fourth stage of labor lasts from 1 to 4 hours after birth, during which time the mother and newborn recover from the physical process of birth and the mother's organs undergo the initial readjustment to the nonpregnant state.
- 22) C. Barbiturates are rapidly transferred across the placental barrier, and lack of an antagonist makes them generally inappropriate during active labor. Neonatal side effects of barbiturates include central nervous system depression, prolonged drowsiness, delayed establishment of feeding (e.g. due to poor sucking reflex or poor sucking pressure). Tranquilizers are associated with neonatal effects such as hypotonia, hypothermia, generalized drowsiness, and reluctance to feed for the first few days. Narcotic analgesic readily cross the placental barrier, causing depressive effects in the newborn 2 to 3 hours after intramuscular injection. Regional anesthesia is associated with adverse reactions such

as maternal hypotension, allergic or toxic reaction, or partial or total respiratory failure.

- 23) D. During the third stage of labor, which begins with the delivery of the newborn, the nurse would promote parent-newborn interaction by placing the newborn on the mother's abdomen and encouraging the parents to touch the newborn. Collecting a urine specimen and other laboratory tests is done on admission during the first stage of labor. Assessing uterine contractions every 30 minutes is performed during the latent phase of the first stage of labor. Coaching the client to push effectively is appropriate during the second stage of labor.
- 24) The newborn's ability to regulate body temperature is poor. Therefore, placing the newborn under a radiant warmer aids in maintaining his or her body temperature. Suctioning with a bulb syringe helps maintain a patent airway. Obtaining an Apgar score measures the newborn's immediate adjustment to extrauterine life. Inspecting the umbilical cord aids in detecting cord anomalies.
- 25) D. Immediately before expulsion or birth of the rest of the body, the cardinal movement of external rotation occurs. Descent flexion, internal rotation, extension, and restitution (in this order) occur before external rotation.
- 26) B. The foramen ovale is an opening between the right and left auricles (atria) that should close shortly after birth so the newborn will not have a murmur or mixed blood traveling through the vascular system. The umbilical vein, ductus arteriosus, and ductus venosus are obliterated at birth.
- 27) B. Uric acid crystals in the urine may produce the reddish "brick dust" stain on the diaper. Mucus would not produce a stain. Bilirubin and iron are from hepatic adaptation.
- 28) B. The normal heart rate for a newborn that is sleeping is approximately 100 beats per minute. If the newborn was awake, the normal heart rate would range from 120 to 160 beats per minute.
- 29) C. The anterior fontanel is larger in size than the posterior fontanel. Additionally, the anterior fontanel, which is diamond shaped, closes at 18 months, whereas the posterior fontanel, which is triangular shaped, closes at 8 to 12 weeks. Neither fontanel should appear bulging, which may indicate increased intracranial pressure, or sunken, which may indicate dehydration.
- 30) B. Blink, cough, sneeze, swallowing and gag reflexes are all present at birth and remain unchanged through adulthood. Reflexes such as rooting and stepping subside within the first year.
- 31) With the babinski reflex, the newborn's toes hyperextend and fan apart from dorsiflexion of the big toe when one side of foot is stroked upward from the heel and across the ball of the foot. With the startle reflex, the newborn abducts and flexes all extremities and may begin to cry when

exposed to sudden movement of loud noise. With the rooting and sucking reflex, the newborn turns his head in the direction of stimulus, opens the mouth, and begins to suck when the cheeks, lip, or corner of mouth is touched. With the crawl reflex, the newborn will attempt to crawl forward with both arms and legs when he is placed on his abdomen on a flat surface.

- 32) The description of hyperemesis gravidarum includes severe nausea and vomiting, leading to electrolyte, metabolic, and nutritional imbalances in the absence of other medical problems. Hyperemesis is not a form of anemia. Loss of appetite may occur secondary to the nausea and vomiting of hyperemesis, which, if it continues, can deplete the nutrients transported to the fetus. Diarrhea does not occur with hyperemesis.
- 33) Edema of the hands and face is a classic sign of PIH. Many healthy pregnant woman experience foot and ankle edema. A weight gain of 2 lb or more per week indicates a problem. Early morning headache is not a classic sign of PIH.
- 34) In a missed abortion, there is early fetal intrauterine death, and products of conception are not expelled. The cervix remains closed; there may be a dark brown vaginal discharge, negative pregnancy test, and cessation of uterine growth and breast tenderness. A threatened abortion is evidenced with cramping and vaginal bleeding in early pregnancy, with no cervical dilation. An incomplete abortion presents with bleeding, cramping, and cervical dilation. An incomplete abortion involves only expulsion of part of the products of conception and bleeding occurs with cervical dilation.
- 35) Multiple gestation is one of the predisposing factors that may cause placenta previa. Uterine anomalies abdominal trauma, and renal or vascular disease may predispose a client to abruptio placentae.
- 36) A client with abruptio placentae may exhibit concealed or dark red bleeding, possibly reporting sudden intense localized uterine pain. The uterus is typically firm to boardlike, and the fetal presenting part may be engaged. Bright red, painless vaginal bleeding, a palpable fetal outline and a soft nontender abdomen are manifestations of placenta previa.
- 37) Abruptio placentae is described as premature separation of a normally implanted placenta during the second half of pregnancy, usually with severe hemorrhage. Placenta previa refers to implantation of the placenta in the lower uterine segment, causing painless bleeding in the third trimester of pregnancy. Ectopic pregnancy refers to the implantation of the products of conception in a site other than the endometrium. Incompetent cervix is a condition characterized by painful dilation of the cervical os without uterine contractions.
- 38) B. Hyperstimulation of the uterus such as with oxytocin during the induction of labor may result in tetanic contractions prolonged to more than 90seconds, which could lead to such complications as fetal distress,

abruptio placentae, amniotic fluid embolism, laceration of the cervix, and uterine rupture. Weak contractions would not occur. Pain, bright red vaginal bleeding, and increased restlessness and anxiety are not associated with hyperstimulation.

- 39) A key point to consider when preparing the client for a cesarean delivery is to modify the preoperative teaching to meet the needs of either a planned or emergency cesarean birth, the depth and breadth of instruction will depend on circumstances and time available. Allowing the mother's support person to remain with her as much as possible is an important concept, although doing so depends on many variables. Arranging for necessary explanations by various staff members to be involved with the client's care is a nursing responsibility. The nurse is responsible for reinforcing the explanations about the surgery, expected outcome, and type of anesthetic to be used. The obstetrician is responsible for explaining about the surgery and outcome and the anesthesiology staff is responsible for explanations about the type of anesthesia to be used.
- 40) Preterm labor is best described as labor that begins after 20 weeks' gestation and before 37 weeks' gestation. The other time periods are inaccurate.
- 41) PROM can precipitate many potential and actual problems; one of the most serious is the fetus loss of an effective defense against infection. This is the client's most immediate need at this time. Typically, PROM occurs about 1 hour, not 4 hours, before labor begins. Fetal viability and gestational age are less immediate considerations that affect the plan of care. Malpresentation and an incompetent cervix may be causes of PROM.
- 42) Dystocia is difficult, painful, prolonged labor due to mechanical factors involving the fetus (passenger), uterus (powers), pelvis (passage), or psyche. Nutritional, environment, and medical factors may contribute to the mechanical factors that cause dystocia.
- 43) With uterine rupture, the client is at risk for hypovolemic shock. Therefore, the priority is to prevent and limit hypovolemic shock. Immediate steps should include giving oxygen, replacing lost fluids, providing drug therapy as needed, evaluating fetal responses and preparing for surgery. Obtaining blood specimens, instituting complete bed rest, and inserting a urinary catheter are necessary in preparation for surgery to remedy the rupture.
- 44) The immediate priority is to minimize pressure on the cord. Thus the nurse's initial action involves placing the client on bed rest and then placing the client in a knee-chest position or lowering the head of the bed, and elevating the maternal hips on a pillow to minimize the pressure on the cord. Monitoring maternal vital signs and FHR, notifying the physician and preparing the client for delivery, and wrapping the cord with sterile

saline soaked warm gauze are important. But these actions have no effect on minimizing the pressure on the cord.

- 45) Postpartum hemorrhage is defined as blood loss of more than 500 ml following birth. Any amount less than this not considered postpartum hemorrhage.
- 46) With mastitis, injury to the breast, such as overdistention, stasis, and cracking of the nipples, is the primary predisposing factor. Epidemic and endemic infections are probable sources of infection for mastitis. Temporary urinary retention due to decreased perception of the urge to void is a contributory factor to the development of urinary tract infection, not mastitis.
- 47) Thrombophlebitis refers to an inflammation of the vascular endothelium with clot formation on the wall of the vessel. Blood components combining to form an aggregate body describe a thrombus or thrombosis. Clots lodging in the pulmonary vasculature refers to pulmonary embolism; in the femoral vein, femoral thrombophlebitis.
- 48) Classic symptoms of DVT include muscle pain, the presence of Homans sign, and swelling of the affected limb. Midcalf pain, tenderness, and redness, along the vein reflect superficial thrombophlebitis. Chills, fever and malaise occurring 2 weeks after delivery reflect pelvic thrombophlebitis. Chills, fever, stiffness and pain occurring 10 to 14 days after delivery suggest femoral thrombophlebitis.
- 49) B. Manifestations of cystitis include, frequency, urgency, dysuria, hematuria nocturia, fever, and suprapubic pain. Dehydration, hypertension, and chills are not typically associated with cystitis. High fever chills, flank pain, nausea, vomiting, dysuria, and frequency are associated with pvelonephritis.
- 50) C. According to statistical reports, between 50% and 80% of all new mothers report some form of postpartum blues. The ranges of 10% to 40%, 30% to 50%, and 25% to 70% are incorrect.

## MIDWIFERY 2

1. For the client who is using oral contraceptives, the nurse informs the client about the need to take the pill at the same time each day to accomplish which of the following?

- A. Decrease the incidence of nausea
- B. Maintain hormonal levels
- C. Reduce side effects
- D. Prevent drug interactions

2. When teaching a client about contraception. Which of the following would the nurse include as the most effective method for preventing sexually transmitted infections?

- A. Spermicides
- B. Diaphragm
- C. Condoms
- D. Vasectomy

3. When preparing a woman who is 2 days postpartum for discharge, recommendations for which of the following contraceptive methods would be avoided?

- A. Diaphragm
- B. Female condom
- C. Oral contraceptives
- D. Rhythm method

4. For which of the following clients would the nurse expect that an intrauterine device would not be recommended?

- A. Woman over age 35
- B. Nulliparous woman
- C. Promiscuous young adult
- D. Postpartum client

5. A client in her third trimester tells the nurse, "I'm constipated all the time!" Which of the following should the nurse recommend?

- A. Daily enemas
- B. Laxatives
- C. Increased fiber intake
- D. Decreased fluid intake

6. Which of the following would the nurse use as the basis for the teaching plan when caring for a pregnant teenager concerned about gaining too much weight during pregnancy?

- A. 10 pounds per trimester
- B. 1 pound per week for 40 weeks
- C. ½ pound per week for 40 weeks
- D. A total gain of 25 to 30 pounds

7. The client tells the nurse that her last menstrual period started on January 14 and ended on January 20. Using Nagele's rule, the nurse determines her EDD to be which of the following?

- A. September 27
- B. October 21
- C. November 7
- D. December 27

8. When taking an obstetrical history on a pregnant client who states, "I had a son born at 38 weeks gestation, a daughter born at 30 weeks gestation and I lost a baby at about 8 weeks," the nurse should record her obstetrical history as which of the following?

- A. G2 T2 P0 A0 L2
- B. G3 T1 P1 A0 L2
- C. G3 T2 P0 A0 L2
- D. G4 T1 P1 A1 L2

9. When preparing to listen to the fetal heart rate at 12 weeks' gestation, the nurse would use which of the following?

- A. Stethoscope placed midline at the umbilicus
- B. Doppler placed midline at the suprapubic region
- C. Fetoscope placed midway between the umbilicus and the xiphoid process
- D. External electronic fetal monitor placed at the umbilicus

10. When developing a plan of care for a client newly diagnosed with gestational diabetes, which of the following instructions would be the priority?

- A. Dietary intake
- B. Medication
- C. Exercise
- D. Glucose monitoring

11. A client at 24 weeks gestation has gained 6 pounds in 4 weeks. Which of the following would be the priority when assessing the client?

- A. Glucosuria
- B. Depression
- C. Hand/face edema
- D. Dietary intake

12. A client 12 weeks' pregnant come to the emergency department with abdominal cramping and moderate vaginal bleeding. Speculum examination reveals 2 to 3 cms cervical dilation. The nurse would document these findings as which of the following?

- A. Threatened abortion
- B. Imminent abortion
- C. Complete abortion
- D. Missed abortion

13. Which of the following would be the priority nursing diagnosis for a client with an ectopic pregnancy?

- A. Risk for infection
- B. Pain
- C. Knowledge Deficit
- D. Anticipatory Grieving

14. Before assessing the postpartum client's uterus for firmness and position in relation to the umbilicus and midline, which of the following should the nurse do first?

- A. Assess the vital signs
- B. Administer analgesia
- C. Ambulate her in the hall
- D. Assist her to urinate

15. Which of the following should the nurse do when a primipara who is lactating tells the nurse that she has sore nipples?

- A. Tell her to breast feed more frequently
- B. Administer a narcotic before breast feeding
- C. Encourage her to wear a nursing brassiere
- D. Use soap and water to clean the nipples

16. The nurse assesses the vital signs of a client, 4 hours' postpartum that are as follows: BP 90/60; temperature 100.4°F; pulse 100 weak, thready; R 20 per minute. Which of the following should the nurse do first?

- A. Report the temperature to the physician
- B. Recheck the blood pressure with another cuff
- C. Assess the uterus for firmness and position
- D. Determine the amount of lochia

17. The nurse assesses the postpartum vaginal discharge (lochia) on four clients. Which of the following assessments would warrant notification of the physician?

- A. A dark red discharge on a 2-day postpartum client
- B. A pink to brownish discharge on a client who is 5 days postpartum
- C. Almost colorless to creamy discharge on a client 2 weeks after delivery
- D. A bright red discharge 5 days after delivery

18. A postpartum client has a temperature of 101.4°F, with a uterus that is tender when palpated, remains unusually large, and not descending as normally expected. Which of the following should the nurse assess next?

- A. Lochia
- B. Breasts
- C. Incision
- D. Urine

19. Which of the following is the priority focus of nursing practice with the current early postpartum discharge?

- A. Promoting comfort and restoration of health
- B. Exploring the emotional status of the family
- C. Facilitating safe and effective self-and newborn care
- D. Teaching about the importance of family planning

20. Which of the following actions would be least effective in maintaining a neutral thermal environment for the newborn?

- A. Placing infant under radiant warmer after bathing
- B. Covering the scale with a warmed blanket prior to weighing
- C. Placing crib close to nursery window for family viewing
- D. Covering the infant's head with a knit stockinette

21. A newborn who has an asymmetrical Moro reflex response should be further assessed for which of the following?

- A. Talipes equinovarus
- B. Fractured clavicle
- C. Congenital hypothyroidism
- D. Increased intracranial pressure

22. During the first 4 hours after a male circumcision, assessing for which of the following is the priority?

- A. Infection
- B. Hemorrhage
- C. Discomfort
- D. Dehydration

23. The mother asks the nurse. "What's wrong with my son's breasts? Why are they so enlarged?" Which of the following would be the best response by the nurse?

- A. "The breast tissue is inflamed from the trauma experienced with birth"
- B. "A decrease in maternal hormones present before birth causes enlargement,"
- C. "You should discuss this with your doctor. It could be a malignancy"
- D. "The tissue has hypertrophied while the baby was in the uterus"

24. Immediately after birth the nurse notes the following on a male newborn: respirations 78; apical heart rate 160 BPM, nostril flaring; mild intercostal retractions; and grunting at the end of expiration. Which of the following should the nurse do?

- A. Call the assessment data to the physician's attention
- B. Start oxygen per nasal cannula at 2 L/min.
- C. Suction the infant's mouth and nares
- D. Recognize this as normal first period of reactivity

25. The nurse hears a mother telling a friend on the telephone about umbilical cord care. Which of the following statements by the mother indicates effective teaching?

- A. "Daily soap and water cleansing is best"
- B. "Alcohol helps it dry and kills germs"
- C. "An antibiotic ointment applied daily prevents infection"
- D. "He can have a tub bath each day"

26. A newborn weighing 3000 grams and feeding every 4 hours needs 120 calories/kg of body weight every 24 hours for proper growth and development. How many ounces of 20 cal/oz formula should this newborn receive at each feeding to meet nutritional needs?

- A. 2 ounces
- B. 3 ounces
- C. 4 ounces
- D. 6 ounces

27. The postterm neonate with meconium-stained amniotic fluid needs care designed to especially monitor for which of the following?

- A. Respiratory problems
- B. Gastrointestinal problems
- C. Integumentary problems
- D. Elimination problems

28. When measuring a client's fundal height, which of the following techniques denotes the correct method of measurement used by the nurse?

- A. From the xiphoid process to the umbilicus
- B. From the symphysis pubis to the xiphoid process
- C. From the symphysis pubis to the fundus
- D. From the fundus to the umbilicus

29. A client with severe preeclampsia is admitted with of BP 160/110, proteinuria, and severe pitting edema. Which of the following would be most important to include in the client's plan of care?

- A. Daily weights
- B. Seizure precautions
- C. Right lateral positioning

**D. Stress reduction**

**30. A postpartum primipara asks the nurse, "When can we have sexual intercourse again?" Which of the following would be the nurse's best response?**

- A. "Anytime you both want to."**
- B. "As soon as choose a contraceptive method."**
- C. "When the discharge has stopped and the incision is healed."**
- D. "After your 6 weeks examination."**

**31. When preparing to administer the vitamin K injection to a neonate, the nurse would select which of the following sites as appropriate for the injection?**

- A. Deltoid muscle**
- B. Anterior femoris muscle**
- C. Vastus lateralis muscle**
- D. Gluteus maximus muscle**

**32. When performing a pelvic examination, the nurse observes a red swollen area on the right side of the vaginal orifice. The nurse would document this as enlargement of which of the following?**

- A. Clitoris**
- B. Parotid gland**
- C. Skene's gland**
- D. Bartholin's gland**

**33. To differentiate as a female, the hormonal stimulation of the embryo that must occur involves which of the following?**

- A. Increase in maternal estrogen secretion**
- B. Decrease in maternal androgen secretion**
- C. Secretion of androgen by the fetal gonad**
- D. Secretion of estrogen by the fetal gonad**

**34. A client at 8 weeks' gestation calls complaining of slight nausea in the morning hours. Which of the following client interventions should the nurse question?**

- A. Taking 1 teaspoon of bicarbonate of soda in an 8-ounce glass of water**
- B. Eating a few low-sodium crackers before getting out of bed**
- C. Avoiding the intake of liquids in the morning hours**

**D. Eating six small meals a day instead of three large meals**

**35. The nurse documents positive ballottement in the client's prenatal record. The nurse understands that this indicates which of the following?**

- A. Palpable contractions on the abdomen**
- B. Passive movement of the unengaged fetus**
- C. Fetal kicking felt by the client**
- D. Enlargement and softening of the uterus**

**36. During a pelvic exam the nurse notes a purple-blue tinge of the cervix. The nurse documents this as which of the following?**

- A. Braxton-Hicks sign**
- B. Chadwick's sign**
- C. Goodell's sign**
- D. McDonald's sign**

**37. During a prenatal class, the nurse explains the rationale for breathing techniques during preparation for labor based on the understanding that breathing techniques are most important in achieving which of the following?**

- A. Eliminate pain and give the expectant parents something to do**
- B. Reduce the risk of fetal distress by increasing uteroplacental perfusion**
- C. Facilitate relaxation, possibly reducing the perception of pain**
- D. Eliminate pain so that less analgesia and anesthesia are needed**

**38. After 4 hours of active labor, the nurse notes that the contractions of a primigravida client are not strong enough to dilate the cervix. Which of the following would the nurse anticipate doing?**

- A. Obtaining an order to begin IV oxytocin infusion**
- B. Administering a light sedative to allow the patient to rest for several hours**
- C. Preparing for a cesarean section for failure to progress**
- D. Increasing the encouragement to the patient when pushing begins**

**39. A multigravida at 38 weeks' gestation is admitted with painless, bright red bleeding and mild contractions every 7 to 10 minutes. Which of the following assessments should be avoided?**

- A. Maternal vital signs**

- B. Fetal heart rate
- C. Contraction monitoring
- D. Cervical dilation

40. Which of the following would be the nurse's most appropriate response to a client who asks why she must have a cesarean delivery if she has a complete placenta previa?

- A. "You will have to ask your physician when he returns."
- B. "You need a cesarean to prevent hemorrhage."
- C. "The placenta is covering most of your cervix."
- D. "The placenta is covering the opening of the uterus and blocking your baby."

41. The nurse understands that the fetal head is in which of the following positions with a face presentation?

- A. Completely flexed
- B. Completely extended
- C. Partially extended
- D. Partially flexed

42. With a fetus in the left-anterior breech presentation, the nurse would expect the fetal heart rate would be most audible in which of the following areas?

- A. Above the maternal umbilicus and to the right of midline
- B. In the lower-left maternal abdominal quadrant
- C. In the lower-right maternal abdominal quadrant
- D. Above the maternal umbilicus and to the left of midline

43. The amniotic fluid of a client has a greenish tint. The nurse interprets this to be the result of which of the following?

- A. Lanugo
- B. Hydramnio
- C. Meconium
- D. Vernix

44. A patient is in labor and has just been told she has a breech presentation. The nurse should be particularly alert for which of the following?

- A. Quickening

- B. Ophthalmia neonatorum
- C. Pica
- D. Prolapsed umbilical cord

45. When describing dizygotic twins to a couple, on which of the following would the nurse base the explanation?

- A. Two ova fertilized by separate sperm
- B. Sharing of a common placenta
- C. Each ova with the same genotype
- D. Sharing of a common chorion

46. Which of the following refers to the single cell that reproduces itself after conception?

- A. Chromosome
- B. Blastocyst
- C. Zygote
- D. Trophoblast

47. In the late 1950s, consumers and health care professionals began challenging the routine use of analgesics and anesthetics during childbirth. Which of the following was an outgrowth of this concept?

- A. Labor, delivery, recovery, postpartum (LDRP)
- B. Nurse-midwifery
- C. Clinical nurse specialist
- D. Prepared childbirth

48. A client has a midpelvic contracture from a previous pelvic injury due to a motor vehicle accident as a teenager. The nurse is aware that this could prevent a fetus from passing through or around which structure during childbirth?

- A. Symphysis pubis
- B. Sacral promontory
- C. Ischial spines
- D. Pubic arch

49. When teaching a group of adolescents about variations in the length of the menstrual cycle, the nurse understands that the underlying mechanism is due to variations in which of the following phases?

- A. Menstrual phase
- B. Proliferative phase
- C. Secretory phase
- D. Ischemic phase

50. When teaching a group of adolescents about male hormone production, which of the following would the nurse include as being produced by the Leydig cells?

- A. Follicle-stimulating hormone
- B. Testosterone
- C. Leuteinizing hormone
- D. Gonadotropin releasing hormone

Answers and Rationales

1. B. Regular timely ingestion of oral contraceptives is necessary to maintain hormonal levels of the drugs to suppress the action of the hypothalamus and anterior pituitary leading to inappropriate secretion of FSH and LH. Therefore, follicles do not mature, ovulation is inhibited, and pregnancy is prevented. The estrogen content of the oral site contraceptive may cause the nausea, regardless of when the pill is taken. Side effects and drug interactions may occur with oral contraceptives regardless of the time the pill is taken.

2. C. Condoms, when used correctly and consistently, are the most effective contraceptive method or barrier against bacterial and viral sexually transmitted infections. Although spermicides kill sperm, they do not provide reliable protection against the spread of sexually transmitted infections, especially intracellular organisms such as HIV. Insertion and removal of the diaphragm along with the use of the spermicides may cause vaginal irritations, which could place the client at risk for infection transmission. Male sterilization eliminates spermatozoa from the ejaculate, but it does not eliminate bacterial and/or viral microorganisms that can cause sexually transmitted infections.

3. A. The diaphragm must be fitted individually to ensure effectiveness. Because of the changes to the reproductive structures during pregnancy and following delivery, the diaphragm must be refitted, usually at the 6 weeks' examination following childbirth or after a weight loss of 15 lbs or more. In addition, for maximum effectiveness, spermicidal jelly should be placed in the dome and around the rim. However, spermicidal jelly should not be inserted into the vagina until involution is completed at approximately 6 weeks. Use of a female condom protects the reproductive system from the introduction of semen or spermicides into the vagina and may be used after childbirth. Oral contraceptives may be started within the first postpartum week to ensure suppression of ovulation . For the couple who

has determined the female's fertile period, using the rhythm method, avoidance of intercourse during this period, is safe and effective.

4. C. An IUD may increase the risk of pelvic inflammatory disease, especially in women with more than one sexual partner, because of the increased risk of sexually transmitted infections. An IUD should not be used if the woman has an active or chronic pelvic infection, postpartum infection, endometrial hyperplasia or carcinoma, or uterine abnormalities. Age is not a factor in determining the risks associated with IUD use. Most IUD users are over the age of 30. Although there is a slightly higher risk for infertility in women who have never been pregnant, the IUD is an acceptable option as long as the risk-benefit ratio is discussed. IUDs may be inserted immediately after delivery, but this is not recommended because of the increased risk and rate of expulsion at this time.

5. C. During the third trimester, the enlarging uterus places pressure on the intestines. This coupled with the effect of hormones on smooth muscle relaxation causes decreased intestinal motility (peristalsis). Increasing fiber in the diet will help fecal matter pass more quickly through the intestinal tract, thus decreasing the amount of water that is absorbed. As a result, stool is softer and easier to pass. Enemas could precipitate preterm labor and/or electrolyte loss and should be avoided. Laxatives may cause preterm labor by stimulating peristalsis and may interfere with the absorption of nutrients. Use for more than 1 week can also lead to laxative dependency. Liquid in the diet helps provide a semisolid, soft consistency to the stool. Eight to ten glasses of fluid per day are essential to maintain hydration and promote stool evacuation.

6. D. To ensure adequate fetal growth and development during the 40 weeks of a pregnancy, a total weight gain 25 to 30 pounds is recommended: 1.5 pounds in the first 10 weeks; 9 pounds by 30 weeks; and 27.5 pounds by 40 weeks. The pregnant woman should gain less weight in the first and second trimester than in the third. During the first trimester, the client should only gain 1.5 pounds in the first 10 weeks, not 1 pound per week. A weight gain of  $\frac{1}{2}$  pound per week would be 20 pounds for the total pregnancy, less than the recommended amount.

8. count back 3 months, changing the year appropriately. To obtain a date of September 27, 7 days have been added to the last day of the LMP (rather than the first day of the LMP), plus 4 months (instead of 3 months) were counted back. To obtain the date of November 7, 7 days have been subtracted (instead of added) from the first day of LMP plus November indicates counting back 2 months (instead of 3 months) from January. To obtain the date of December 27, 7 days were added to the last day of the LMP (rather than the first day of the LMP) and December indicates counting back only 1 month (instead of 3 months) from January.

9. D. The client has been pregnant four times, including current pregnancy (G). Birth at 38 weeks' gestation is considered full term (T), while birth from 20 weeks to 38

weeks is considered preterm (P). A spontaneous abortion occurred at 8 weeks (A). She has two living children (L).

10. B. At 12 weeks gestation, the uterus rises out of the pelvis and is palpable above the symphysis pubis. The Doppler intensifies the sound of the fetal pulse rate so it is audible. The uterus has merely risen out of the pelvis into the abdominal cavity and is not at the level of the umbilicus. The fetal heart rate at this age is not audible with a stethoscope. The uterus at 12 weeks is just above the symphysis pubis in the abdominal cavity, not midway between the umbilicus and the xiphoid process. At 12 weeks the FHR would be difficult to auscultate with a fetoscope. Although the external electronic fetal monitor would project the FHR, the uterus has not risen to the umbilicus at 12 weeks.

11. A. Although all of the choices are important in the management of diabetes, diet therapy is the mainstay of the treatment plan and should always be the priority. Women diagnosed with gestational diabetes generally need only diet therapy without medication to control their blood sugar levels. Exercise, is important for all pregnant women and especially for diabetic women, because it burns up glucose, thus decreasing blood sugar. However, dietary intake, not exercise, is the priority. All pregnant women with diabetes should have periodic monitoring of serum glucose. However, those with gestational diabetes generally do not need daily glucose monitoring. The standard of care recommends a fasting and 2-hour postprandial blood sugar level every 2 weeks.

12. C. After 20 weeks' gestation, when there is a rapid weight gain, preeclampsia should be suspected, which may be caused by fluid retention manifested by edema, especially of the hands and face. The three classic signs of preeclampsia are hypertension, edema, and proteinuria. Although urine is checked for glucose at each clinic visit, this is not the priority. Depression may cause either anorexia or excessive food intake, leading to excessive weight gain or loss. This is not, however, the priority consideration at this time. Weight gain thought to be caused by excessive food intake would require a 24-hour diet recall. However, excessive intake would not be the primary consideration for this client at this time.

13. B. Cramping and vaginal bleeding coupled with cervical dilation signifies that termination of the pregnancy is inevitable and cannot be prevented. Thus, the nurse would document an imminent abortion. In a threatened abortion, cramping and vaginal bleeding are present, but there is no cervical dilation. The symptoms may subside or progress to abortion. In a complete abortion all the products of conception are expelled. A missed abortion is early fetal intrauterine death without expulsion of the products of conception.

14. B. For the client with an ectopic pregnancy, lower abdominal pain, usually unilateral, is the primary symptom. Thus, pain is the priority. Although the potential for infection is always present, the risk is low in ectopic pregnancy because pathogenic microorganisms have not been introduced from external sources. The

client may have a limited knowledge of the pathology and treatment of the condition and will most likely experience grieving, but this is not the priority at this time.

15. D. Before uterine assessment is performed, it is essential that the woman empty her bladder. A full bladder will interfere with the accuracy of the assessment by elevating the uterus and displacing to the side of the midline. Vital sign assessment is not necessary unless an abnormality in uterine assessment is identified. Uterine assessment should not cause acute pain that requires administration of analgesia. Ambulating the client is an essential component of postpartum care, but is not necessary prior to assessment of the uterus.

16. A. Feeding more frequently, about every 2 hours, will decrease the infant's frantic, vigorous sucking from hunger and will decrease breast engorgement, soften the breast, and promote ease of correct latching-on for feeding. Narcotics administered prior to breast feeding are passed through the breast milk to the infant, causing excessive sleepiness. Nipple soreness is not severe enough to warrant narcotic analgesia. All postpartum clients, especially lactating mothers, should wear a supportive brassiere with wide cotton straps. This does not, however, prevent or reduce nipple soreness. Soaps are drying to the skin of the nipples and should not be used on the breasts of lactating mothers. Dry nipple skin predisposes to cracks and fissures, which can become sore and painful.

17. D. A weak, thready pulse elevated to 100 BPM may indicate impending hemorrhagic shock. An increased pulse is a compensatory mechanism of the body in response to decreased fluid volume. Thus, the nurse should check the amount of lochia present. Temperatures up to 100.48F in the first 24 hours after birth are related to the dehydrating effects of labor and are considered normal. Although rechecking the blood pressure may be a correct choice of action, it is not the first action that should be implemented in light of the other data. The data indicate a potential impending hemorrhage. Assessing the uterus for firmness and position in relation to the umbilicus and midline is important, but the nurse should check the extent of vaginal bleeding first. Then it would be appropriate to check the uterus, which may be a possible cause of the hemorrhage.

18. D. Any bright red vaginal discharge would be considered abnormal, but especially 5 days after delivery, when the lochia is typically pink to brownish. Lochia rubra, a dark red discharge, is present for 2 to 3 days after delivery. Bright red vaginal bleeding at this time suggests late postpartum hemorrhage, which occurs after the first 24 hours following delivery and is generally caused by retained placental fragments or bleeding disorders. Lochia rubra is the normal dark red discharge occurring in the first 2 to 3 days after delivery, containing epithelial cells, erythrocytes, leukocytes and decidua. Lochia serosa is a pink to brownish serosanguineous discharge occurring from 3 to 10 days after delivery that contains decidua, erythrocytes, leukocytes, cervical mucus, and microorganisms. Lochia alba is an almost colorless to yellowish discharge occurring from 10 days to 3 weeks after

delivery and containing leukocytes, decidua, epithelial cells, fat, cervical mucus, cholesterol crystals, and bacteria.

19. A. The data suggests an infection of the endometrial lining of the uterus. The lochia may be decreased or copious, dark brown in appearance, and foul smelling, providing further evidence of a possible infection. All the client's data indicate a uterine problem, not a breast problem. Typically, transient fever, usually 101°F, may be present with breast engorgement. Symptoms of mastitis include influenza-like manifestations. Localized infection of an episiotomy or C-section incision rarely causes systemic symptoms, and uterine involution would not be affected. The client data do not include dysuria, frequency, or urgency, symptoms of urinary tract infections, which would necessitate assessing the client's urine.

20. C. Because of early postpartum discharge and limited time for teaching, the nurse's priority is to facilitate the safe and effective care of the client and newborn. Although promoting comfort and restoration of health, exploring the family's emotional status, and teaching about family planning are important in postpartum/newborn nursing care, they are not the priority focus in the limited time presented by early post-partum discharge.

21. C. Heat loss by radiation occurs when the infant's crib is placed too near cold walls or windows. Thus placing the newborn's crib close to the viewing window would be least effective. Body heat is lost through evaporation during bathing. Placing the infant under the radiant warmer after bathing will assist the infant to be rewarmed. Covering the scale with a warmed blanket prior to weighing prevents heat loss through conduction. A knit cap prevents heat loss from the head a large head, a large body surface area of the newborn's body.

22. B. A fractured clavicle would prevent the normal Moro response of symmetrical sequential extension and abduction of the arms followed by flexion and adduction. In talipes equinovarus (clubfoot) the foot is turned medially, and in plantar flexion, with the heel elevated. The feet are not involved with the Moro reflex. Hypothyroidism has no effect on the primitive reflexes. Absence of the Moro reflex is the most significant single indicator of central nervous system status, but it is not a sign of increased intracranial pressure.

23. B. Hemorrhage is a potential risk following any surgical procedure. Although the infant has been given vitamin K to facilitate clotting, the prophylactic dose is often not sufficient to prevent bleeding. Although infection is a possibility, signs will not appear within 4 hours after the surgical procedure. The primary discomfort of circumcision occurs during the surgical procedure, not afterward. Although feedings are withheld prior to the circumcision, the chances of dehydration are minimal.

24. B. The presence of excessive estrogen and progesterone in the maternal-fetal blood followed by prompt withdrawal at birth precipitates breast engorgement, which will spontaneously resolve in 4 to 5 days after birth. The trauma of the birth process does not cause inflammation of the newborn's breast tissue. Newborns do

not have breast malignancy. This reply by the nurse would cause the mother to have undue anxiety. Breast tissue does not hypertrophy in the fetus or newborns.

25. D. The first 15 minutes to 1 hour after birth is the first period of reactivity involving respiratory and circulatory adaptation to extrauterine life. The data given reflect the normal changes during this time period. The infant's assessment data reflect normal adaptation. Thus, the physician does not need to be notified and oxygen is not needed. The data do not indicate the presence of choking, gagging or coughing, which are signs of excessive secretions. Suctioning is not necessary.

26. B. Application of 70% isopropyl alcohol to the cord minimizes microorganisms (germicidal) and promotes drying. The cord should be kept dry until it falls off and the stump has healed. Antibiotic ointment should only be used to treat an infection, not as a prophylaxis. Infants should not be submerged in a tub of water until the cord falls off and the stump has completely healed.

27. B. To determine the amount of formula needed, do the following mathematical calculation.  $3 \text{ kg} \times 120 \text{ cal/kg per day} = 360 \text{ calories/day}$  feeding q 4 hours = 6 feedings per day = 60 calories per feeding; 60 calories per feeding; 60 calories per feeding with formula 20 cal/oz = 3 ounces per feeding. Based on the calculation. 2, 4 or 6 ounces are incorrect.

28. A. Intrauterine anoxia may cause relaxation of the anal sphincter and emptying of meconium into the amniotic fluid. At birth some of the meconium fluid may be aspirated, causing mechanical obstruction or chemical pneumonitis. The infant is not at increased risk for gastrointestinal problems. Even though the skin is stained with meconium, it is noninfectious (sterile) and nonirritating. The postterm meconium-stained infant is not at additional risk for bowel or urinary problems.

29. C. The nurse should use a nonelastic, flexible, paper measuring tape, placing the zero point on the superior border of the symphysis pubis and stretching the tape across the abdomen at the midline to the top of the fundus. The xiphoid and umbilicus are not appropriate landmarks to use when measuring the height of the fundus (McDonald's measurement).

30. B. Women hospitalized with severe preeclampsia need decreased CNS stimulation to prevent a seizure. Seizure precautions provide environmental safety should a seizure occur. Because of edema, daily weight is important but not the priority. Preeclampsia causes vasospasm and therefore can reduce utero-placental perfusion. The client should be placed on her left side to maximize blood flow, reduce blood pressure, and promote diuresis. Interventions to reduce stress and anxiety are very important to facilitate coping and a sense of control, but seizure precautions are the priority.

31. C. Cessation of the lochial discharge signifies healing of the endometrium. Risk of hemorrhage and infection are minimal 3 weeks after a normal vaginal delivery. Telling the client anytime is inappropriate because this response does not provide

the client with the specific information she is requesting. Choice of a contraceptive method is important, but not the specific criteria for safe resumption of sexual activity. Culturally, the 6-weeks' examination has been used as the time frame for resuming sexual activity, but it may be resumed earlier.

32. C. The middle third of the vastus lateralis is the preferred injection site for vitamin K administration because it is free of blood vessels and nerves and is large enough to absorb the medication. The deltoid muscle of a newborn is not large enough for a newborn IM injection. Injections into this muscle in a small child might cause damage to the radial nerve. The anterior femoris muscle is the next safest muscle to use in a newborn but is not the safest. Because of the proximity of the sciatic nerve, the gluteus maximus muscle should not be until the child has been walking 2 years.

32. D. Bartholin's glands are the glands on either side of the vaginal orifice. The clitoris is female erectile tissue found in the perineal area above the urethra. The parotid glands are open into the mouth. Skene's glands open into the posterior wall of the female urinary meatus.

33. D. The fetal gonad must secrete estrogen for the embryo to differentiate as a female. An increase in maternal estrogen secretion does not effect differentiation of the embryo, and maternal estrogen secretion occurs in every pregnancy. Maternal androgen secretion remains the same as before pregnancy and does not effect differentiation. Secretion of androgen by the fetal gonad would produce a male fetus.

34. A. Using bicarbonate would increase the amount of sodium ingested, which can cause complications. Eating low-sodium crackers would be appropriate. Since liquids can increase nausea avoiding them in the morning hours when nausea is usually the strongest is appropriate. Eating six small meals a day would keep the stomach full, which often decrease nausea.

35. B. Ballottement indicates passive movement of the unengaged fetus. Ballottement is not a contraction. Fetal kicking felt by the client represents quickening. Enlargement and softening of the uterus is known as Piskacek's sign.

36. B. Chadwick's sign refers to the purple-blue tinge of the cervix. Braxton Hicks contractions are painless contractions beginning around the 4th month. Goodell's sign indicates softening of the cervix. Flexibility of the uterus against the cervix is known as McDonald's sign.

37. C. Breathing techniques can raise the pain threshold and reduce the perception of pain. They also promote relaxation. Breathing techniques do not eliminate pain, but they can reduce it. Positioning, not breathing, increases uteroplacental perfusion.

38. A. The client's labor is hypotonic. The nurse should call the physical and obtain an order for an infusion of oxytocin, which will assist the uterus to contract more forcefully in an attempt to dilate the cervix. Administering light sedative would be

done for hypertonic uterine contractions. Preparing for cesarean section is unnecessary at this time. Oxytocin would increase the uterine contractions and hopefully progress labor before a cesarean would be necessary. It is too early to anticipate client pushing with contractions.

39. D. The signs indicate placenta previa and vaginal exam to determine cervical dilation would not be done because it could cause hemorrhage. Assessing maternal vital signs can help determine maternal physiologic status. Fetal heart rate is important to assess fetal well-being and should be done. Monitoring the contractions will help evaluate the progress of labor.

40. D. A complete placenta previa occurs when the placenta covers the opening of the uterus, thus blocking the passageway for the baby. This response explains what a complete previa is and the reason the baby cannot come out except by cesarean delivery. Telling the client to ask the physician is a poor response and would increase the patient's anxiety. Although a cesarean would help to prevent hemorrhage, the statement does not explain why the hemorrhage could occur. With a complete previa, the placenta is covering all the cervix, not just most of it.

41. B. With a face presentation, the head is completely extended. With a vertex presentation, the head is completely or partially flexed. With a brow (forehead) presentation, the head would be partially extended.

42. D. With this presentation, the fetal upper torso and back face the left upper maternal abdominal wall. The fetal heart rate would be most audible above the maternal umbilicus and to the left of the middle. The other positions would be incorrect.

43. C. The greenish tint is due to the presence of meconium. Lanugo is the soft, downy hair on the shoulders and back of the fetus. Hydramnios represents excessive amniotic fluid. Vernix is the white, cheesy substance covering the fetus.

44. D. In a breech position, because of the space between the presenting part and the cervix, prolapse of the umbilical cord is common. Quickening is the woman's first perception of fetal movement. Ophthalmia neonatorum usually results from maternal gonorrhea and is conjunctivitis. Pica refers to the oral intake of nonfood substances.

45. A. Dizygotic (fraternal) twins involve two ova fertilized by separate sperm. Monozygotic (identical) twins involve a common placenta, same genotype, and common chorion.

46. C. The zygote is the single cell that reproduces itself after conception. The chromosome is the material that makes up the cell and is gained from each parent. Blastocyst and trophoblast are later terms for the embryo after zygote.

47. D. Prepared childbirth was the direct result of the 1950's challenging of the routine use of analgesic and anesthetics during childbirth. The LDRP was a much later

concept and was not a direct result of the challenging of routine use of analgesics and anesthetics during childbirth. Roles for nurse midwives and clinical nurse specialists did not develop from this challenge.

48. C. The ischial spines are located in the mid-pelvic region and could be narrowed due to the previous pelvic injury. The symphysis pubis, sacral promontory, and pubic arch are not part of the mid-pelvis.

49. B. Variations in the length of the menstrual cycle are due to variations in the proliferative phase. The menstrual, secretory and ischemic phases do not contribute to this variation.

50. B. Testosterone is produced by the Leyding cells in the seminiferous tubules. Follicle-stimulating hormone and leuteinzing hormone are released by the anterior pituitary gland. The hypothalamus is responsible for releasing gonadotropin-releasing hormone.

1. While performing physical assessment of a 12 month-old, the nurse notes that the infant's anterior fontanelle is still slightly open. Which of the following is the nurse's most appropriate action?

- A. Notify the physician immediately because there is a problem.
- B. Perform an intensive neurologic examination.
- C. Perform an intensive developmental examination.
- D. Do nothing because this is a normal finding for the age.

2. When teaching a mother about introducing solid foods to her child, which of the following indicates the earliest age at which this should be done?

- A. 1 month
- B. 2 months
- C. 3 months
- D. 4 months

3. The infant of a substance-abusing mother is at risk for developing a sense of which of the following?

- A. Mistrust
- B. Shame
- C. Guilt
- D. Inferiority

4. Which of the following toys should the nurse recommend for a 5-month-old?

- A. A big red balloon
- B. A teddy bear with button eyes
- C. A push-pull wooden truck
- D. A colorful busy box

5. The mother of a 2-month-old is concerned that she may be spoiling her baby by picking her up when she cries. Which of the following would be the nurse's best response?

- A. "Let her cry for a while before picking her up, so you don't spoil her"
- B. "Babies need to be held and cuddled; you won't spoil her this way"
- C. "Crying at this age means the baby is hungry; give her a bottle"
- D. "If you leave her alone she will learn how to cry herself to sleep"

6. When assessing an 18-month-old, the nurse notes a characteristic protruding abdomen. Which of the following would explain the rationale for this finding?

- A. Increased food intake owing to age
- B. Underdeveloped abdominal muscles
- C. Bowlegged posture
- D. Linear growth curve

7. If parents keep a toddler dependent in areas where he is capable of using skills, the toddler will develop a sense of which of the following?

- A. Mistrust
- B. Shame
- C. Guilt
- D. Inferiority

8. Which of the following is an appropriate toy for an 18-month-old?

- A. Multiple-piece puzzle
- B. Miniature cars
- C. Finger paints
- D. Comic book

9. When teaching parents about the child's readiness for toilet training, which of the following signs should the nurse instruct them to watch for in the toddler?

- A. Demonstrates dryness for 4 hours
- B. Demonstrates ability to sit and walk
- C. Has a new sibling for stimulation
- D. Verbalizes desire to go to the bathroom

10. When teaching parents about typical toddler eating patterns, which of the following should be included?

- A. Food "jags"
- B. Preference to eat alone
- C. Consistent table manners
- D. Increase in appetite

11. Which of the following suggestions should the nurse offer the parents of a 4-year-old boy who resists going to bed at night?

- A. "Allow him to fall asleep in your room, then move him to his own bed."
- B. "Tell him that you will lock him in his room if he gets out of bed one more time."
- C. "Encourage active play at bedtime to tire him out so he will fall asleep faster."
- D. "Read him a story and allow him to play quietly in his bed until he falls asleep."

12. When providing therapeutic play, which of the following toys would best promote imaginative play in a 4-year-old?

- A. Large blocks
- B. Dress-up clothes
- C. Wooden puzzle
- D. Big wheels

13. Which of the following activities, when voiced by the parents following a teaching session about the characteristics of school-age cognitive development would indicate the need for additional teaching?

- A. Collecting baseball cards and marbles
- B. Ordering dolls according to size
- C. Considering simple problem-solving options
- D. Developing plans for the future

14. A hospitalized schoolager states: "I'm not afraid of this place, I'm not afraid of anything." This statement is most likely an example of which of the following?

- A. Regression
- B. Repression
- C. Reaction formation
- D. Rationalization

15. After teaching a group of parents about accident prevention for schoolagers, which of the following statements by the group would indicate the need for more teaching?

- A. "Schoolagers are more active and adventurous than are younger children."
- B. "Schoolagers are more susceptible to home hazards than are younger children."
- C. "Schoolagers are unable to understand potential dangers around them."

D. "Schoolagers are less subject to parental control than are younger children."

16. Which of the following skills is the most significant one learned during the schoolage period?

- A. Collecting
- B. Ordering
- C. Reading
- D. Sorting

17. A child age 7 was unable to receive the measles, mumps, and rubella (MMR) vaccine at the recommended scheduled time. When would the nurse expect to administer MMR vaccine?

- A. In a month from now
- B. In a year from now
- C. At age 10
- D. At age 13

18. The adolescent's inability to develop a sense of who he is and what he can become results in a sense of which of the following?

- A. Shame
- B. Guilt
- C. Inferiority
- D. Role diffusion

19. Which of the following would be most appropriate for a nurse to use when describing menarche to a 13-year-old?

- A. A female's first menstruation or menstrual "periods"
- B. The first year of menstruation or "period"
- C. The entire menstrual cycle or from one "period" to another
- D. The onset of uterine maturation or peak growth

20. A 14-year-old boy has acne and according to his parents, dominates the bathroom by using the mirror all the time. Which of the following remarks by the nurse would be least helpful in talking to the boy and his parents?

- A. "This is probably the only concern he has about his body. So don't worry about it or the time he spends on it."

- B. "Teenagers are anxious about how their peers perceive them. So they spend a lot of time grooming."
- C. "A teen may develop a poor self-image when experiencing acne. Do you feel this way sometimes?"
- D. "You appear to be keeping your face well washed. Would you feel comfortable discussing your cleansing method?"

21. Which of the following should the nurse suspect when noting that a 3-year-old is engaging in explicit sexual behavior during doll play?

- A. The child is exhibiting normal pre-school curiosity
- B. The child is acting out personal experiences
- C. The child does not know how to play with dolls
- D. The child is probably developmentally delayed.

22. Which of the following statements by the parents of a child with school phobia would indicate the need for further teaching?

- A. "We'll keep him at home until phobia subsides."
- B. "We'll work with his teachers and counselors at school."
- C. "We'll try to encourage him to talk about his problem."
- D. "We'll discuss possible solutions with him and his counselor."

23. When developing a teaching plan for a group of high school students about teenage pregnancy, the nurse would keep in mind which of the following?

- A. The incidence of teenage pregnancies is increasing.
- B. Most teenage pregnancies are planned.
- C. Denial of the pregnancy is common early on.
- D. The risk for complications during pregnancy is rare.

24. When assessing a child with a cleft palate, the nurse is aware that the child is at risk for more frequent episodes of otitis media due to which of the following?

- A. Lowered resistance from malnutrition
- B. Ineffective functioning of the Eustachian tubes
- C. Plugging of the Eustachian tubes with food particles
- D. Associated congenital defects of the middle ear.

25. While performing a neurodevelopmental assessment on a 3-month-old infant, which of the following characteristics would be expected?

- A. A strong Moro reflex
- B. A strong parachute reflex
- C. Rolling from front to back
- D. Lifting of head and chest when prone

26. By the end of which of the following would the nurse most commonly expect a child's birth weight to triple?

- A. 4 months
- B. 7 months
- C. 9 months
- D. 12 months

27. Which of the following best describes parallel play between two toddlers?

- A. Sharing crayons to color separate pictures
- B. Playing a board game with a nurse
- C. Sitting near each other while playing with separate dolls
- D. Sharing their dolls with two different nurses

28. Which of the following would the nurse identify as the initial priority for a child with acute lymphocytic leukemia?

- A. Instituting infection control precautions
- B. Encouraging adequate intake of iron-rich foods
- C. Assisting with coping with chronic illness
- D. Administering medications via IM injections

29. Which of the following information, when voiced by the mother, would indicate to the nurse that she understands home care instructions following the administration of a diphtheria, tetanus, and pertussis injection?

- A. Measures to reduce fever
- B. Need for dietary restrictions
- C. Reasons for subsequent rash
- D. Measures to control subsequent diarrhea

30. Which of the following actions by a community health nurse is most appropriate when noting multiple bruises and burns on the posterior trunk of an 18-month-old child during a home visit?

- A. Report the child's condition to Protective Services immediately.
- B. Schedule a follow-up visit to check for more bruises.
- C. Notify the child's physician immediately.
- D. Do nothing because this is a normal finding in a toddler.

31. Which of the following is being used when the mother of a hospitalized child calls the student nurse and states, "You idiot, you have no idea how to care for my sick child"?

Displacement

Projection

Repression

Psychosis

32. Which of the following should the nurse expect to note as a frequent complication for a child with congenital heart disease?

Susceptibility to respiratory infection

Bleeding tendencies

Frequent vomiting and diarrhea

Seizure disorder

33. Which of the following would the nurse do first for a 3-year-old boy who arrives in the emergency room with a temperature of 105 degrees, inspiratory stridor, and restlessness, who is leaning forward and drooling?

- A. Auscultate his lungs and place him in a mist tent.
- B. Have him lie down and rest after encouraging fluids.
- C. Examine his throat and perform a throat culture
- D. Notify the physician immediately and prepare for intubation.

34. Which of the following would the nurse need to keep in mind as a predisposing factor when formulating a teaching plan for child with a urinary tract infection?

- A. A shorter urethra in females
- B. Frequent emptying of the bladder
- C. Increased fluid intake
- D. Ingestion of acidic juices

**35. Which of the following should the nurse do first for a 15-year-old boy with a full leg cast who is screaming in unrelenting pain and exhibiting right foot pallor signifying compartment syndrome?**

- A. Medicate him with acetaminophen.
- B. Notify the physician immediately
- C. Release the traction
- D. Monitor him every 5 minutes

**36. At which of the following ages would the nurse expect to administer the varicella zoster vaccine to child?**

- A. At birth
- B. 2 months
- C. 6 months
- D. 12 months

**37. When discussing normal infant growth and development with parents, which of the following toys would the nurse suggest as most appropriate for an 8-month-old?**

- A. Push-pull toys
- B. Rattle
- C. Large blocks
- D. Mobile

**38. Which of the following aspects of psychosocial development is necessary for the nurse to keep in mind when providing care for the preschool child?**

- A. The child can use complex reasoning to think out situations.
- B. Fear of body mutilation is a common preschool fear
- C. The child engages in competitive types of play
- D. Immediate gratification is necessary to develop initiative.

**39. Which of the following is characteristic of a preschooler with mid mental retardation?**

- A. Slow to feed self
- B. Lack of speech
- C. Marked motor delays
- D. Gait disability

**40. Which of the following assessment findings would lead the nurse to suspect Down syndrome in an infant?**

- A. Small tongue
- B. Transverse palmar crease
- C. Large nose
- D. Restricted joint movement

**41. While assessing a newborn with cleft lip, the nurse would be alert that which of the following will most likely be compromised?**

- A. Sucking ability
- B. Respiratory status
- C. Locomotion
- D. GI function

**42. When providing postoperative care for the child with a cleft palate, the nurse should position the child in which of the following positions?**

- A. Supine
- B. Prone
- C. In an infant seat
- D. On the side

**43. While assessing a child with pyloric stenosis, the nurse is likely to note which of the following?**

- A. Regurgitation
- B. Steatorrhea
- C. Projectile vomiting
- D. Currant jelly" stools

**44. Which of the following nursing diagnoses would be inappropriate for the infant with gastroesophageal reflux (GER)?**

- A. Fluid volume deficit
- B. Risk for aspiration
- C. Altered nutrition: less than body requirements
- D. Altered oral mucous membranes

45. Which of the following parameters would the nurse monitor to evaluate the effectiveness of thickened feedings for an infant with gastroesophageal reflux (GER)?

- A. Vomiting
- B. Stools
- C. Uterine
- D. Weight

46. Discharge teaching for a child with celiac disease would include instructions about avoiding which of the following?

- A. Rice
- B. Milk
- C. Wheat
- D. Chicken

47. Which of the following would the nurse expect to assess in a child with celiac disease having a celiac crisis secondary to an upper respiratory infection?

- A. Respiratory distress
- B. Lethargy
- C. Watery diarrhea
- D. Weight gain

48. Which of the following should the nurse do first after noting that a child with Hirschsprung disease has a fever and watery explosive diarrhea?

- A. Notify the physician immediately
- B. Administer antidiarrheal medications
- C. Monitor child every 30 minutes
- D. Nothing, this is characteristic of Hirschsprung disease

49. A newborn's failure to pass meconium within the first 24 hours after birth may indicate which of the following?

- A. Hirschsprung disease
- B. Celiac disease
- C. Intussusception
- D. Abdominal wall defect

50. When assessing a child for possible intussusception, which of the following would be least likely to provide valuable information?

- A. Stool inspection
- B. Pain pattern
- C. Family history
- D. Abdominal palpation

Answers and Rationales

1. D. The anterior fontanelle typically closes anywhere between 12 to 18 months of age. Thus, assessing the anterior fontanelle as still being slightly open is a normal finding requiring no further action. Because it is normal finding for this age, notifying the physician or performing additional examinations are inappropriate.

2. D. Solid foods are not recommended before age 4 to 6 months because of the sucking reflex and the immaturity of the gastrointestinal tract and immune system. Therefore, the earliest age at which to introduce foods is 4 months. Any time earlier would be inappropriate.

3. A. According to Erikson, infants need to have their needs met consistently and effectively to develop a sense of trust. An infant whose needs are consistently unmet or who experiences significant delays in having them met, such as in the case of the infant of a substance-abusing mother, will develop a sense of uncertainty, leading to mistrust of caregivers and the environment. Toddlers develop a sense of shame when their autonomy needs are not met consistently. Preschoolers develop a sense of guilt when their sense of initiative is thwarted. Schoolagers develop a sense of inferiority when they do not develop a sense of industry.

4. D. A busy box facilitates the fine motor development that occurs between 4 and 6 months. Balloons are contraindicated because small children may aspirate balloons. Because the button eyes of a teddy bear may detach and be aspirated, this toy is unsafe for children younger than 3 years. A 5-month-old is too young to use a push-pull toy.

5. B. Infants need to have their security needs met by being held and cuddled. At 2 months of age, they are unable to make the connection between crying and attention. This association does not occur until late infancy or early toddlerhood. Letting the infant cry for a time before picking up the infant or leaving the infant alone to cry herself to sleep interferes with meeting the infant's need for security at this very young age. Infants cry for many reasons. Assuming that the child is hungry may cause overfeeding problems such as obesity.

6. B. Underdeveloped abdominal musculature gives the toddler a characteristically protruding abdomen. During toddlerhood, food intake decreases, not increases. Toddlers are characteristically bowlegged because the leg muscles must bear the weight of the relatively large trunk. Toddler growth patterns occur in a steplike, not linear pattern.

7. B. According to Erikson, toddlers experience a sense of shame when they are not allowed to develop appropriate independence and autonomy. Infants develop mistrust when their needs are not consistently gratified. Preschoolers develop guilt when their initiative needs are not met while schoolagers develop a sense of inferiority when their industry needs are not met.

8. C. Young toddlers are still sensorimotor learners and they enjoy the experience of feeling different textures. Thus, finger paints would be an appropriate toy choice. Multiple-piece toys, such as puzzle, are too difficult to manipulate and may be hazardous if the pieces are small enough to be aspirated. Miniature cars also have a high potential for aspiration. Comic books are on too high a level for toddlers. Although they may enjoy looking at some of the pictures, toddlers are more likely to rip a comic book apart.

9. D. The child must be able to sate the need to go to the bathroom to initiate toilet training. Usually, a child needs to be dry for only 2 hours, not 4 hours. The child also must be able to sit, walk, and squat. A new sibling would most likely hinder toilet training.

10.A. Toddlers become picky eaters, experiencing food jags and eating large amounts one day and very little the next. A toddler's food jags express a preference for the ritualism of eating one type of food for several days at a time. Toddlers typically enjoy socialization and limiting others at meal time. Toddlers prefer to feed themselves and thus are too young to have table manners. A toddler's appetite and need for calories, protein, and fluid decrease due to the dramatic slowing of growth rate.

11. D. Preschoolers commonly have fears of the dark, being left alone especially at bedtime, and ghosts, which may affect the child's going to bed at night. Quiet play and time with parents is a positive bedtime routine that provides security and also readies the child for sleep. The child should sleep in his own bed. Telling the child about locking him in his room will be viewed by the child as a threat. Additionally, a locked door is frightening and potentially hazardous. Vigorous activity at bedtime stirs up the child and makes more difficult to fall asleep.

12. B. Dress-up clothes enhance imaginative play and imagination, allowing preschoolers to engage in rich fantasy play. Building blocks and wooden puzzles are appropriate for encouraging fine motor development. Big wheels and tricycles encourage gross motor development.

13. D. The school-aged child is in the stage of concrete operations, marked by inductive reasoning, logical operations, and reversible concrete thought. The ability to consider the future requires formal thought operations, which are not developed until adolescence. Collecting baseball cards and marbles, ordering dolls by size, and simple problem-solving options are examples of the concrete operational thinking of the schoolager.

14. C. Reaction formation is the schoolager's typical defensive response when hospitalized. In reaction formation, expression of unacceptable thoughts or behaviors is prevented (or overridden) by the exaggerated expression of opposite thoughts or types of behaviors. Regression is seen in toddlers and preschoolers when they retreat or return to an earlier level of development. Repression refers to the involuntary blocking of unpleasant feelings and experiences from one's awareness. Rationalization is the attempt to make excuses to justify unacceptable feelings or behaviors.

15. C. The schoolager's cognitive level is sufficiently developed to enable good understanding of and adherence to rules. Thus, schoolagers should be able to understand the potential dangers around them. With growth comes greater freedom and children become more adventurous and daring. The school-aged child is also still prone to accidents and home hazards, especially because of increased motor abilities and independence. Plus the home hazards differ from other age groups. These hazards, which are potentially lethal but tempting, may include firearms, alcohol, and medications. School-age children begin to internalize their own controls and need less outside direction. Plus the child is away from home more often. Some parental or caregiver assistance is still needed to answer questions and provide guidance for decisions and responsibilities.

16. C. The most significant skill learned during the school-age period is reading. During this time the child develops formal adult articulation patterns and learns that words can be arranged in structure. Collective, ordering, and sorting, although important, are not most significant skills learned.

17. C. Based on the recommendations of the American Academy of Family Physicians and the American Academy of Pediatrics, the MMR vaccine should be given at the age of 10 if the child did not receive it between the ages of 4 to 6 years as recommended. Immunization for diphtheria and tetanus is required at age 13.

18. D. According to Erikson, role diffusion develops when the adolescent does not develop a sense of identity and a sense of where he fits in. Toddlers develop a sense of shame when they do not achieve autonomy. Preschoolers develop a sense of guilt when they do not develop a sense of initiative. School-age children develop a sense of inferiority when they do not develop a sense of industry.

19. A. Menarche refers to the onset of the first menstruation or menstrual period and refers only to the first cycle. Uterine growth and broadening of the pelvic girdle occurs before menarche.

20. A. Stating that this is probably the only concern the adolescent has and telling the parents not to worry about it or the time her spends on it shuts off further investigation and is likely to make the adolescent and his parents feel defensive. The statement about peer acceptance and time spent in front of the mirror for the development of self image provides information about the adolescent's needs to the parents and may help to gain trust with the adolescent. Asking the adolescent how he feels about the acne will encourage the adolescent to share his feelings. Discussing the cleansing method shows interest and concern for the adolescent and also can help to identify any patient-teaching needs for the adolescent regarding cleansing.

21. B. Preschoolers should be developmentally incapable of demonstrating explicit sexual behavior. If a child does so, the child has been exposed to such behavior, and sexual abuse should be suspected. Explicit sexual behavior during doll play is not a characteristic of preschool development nor symptomatic of developmental delay. Whether or nor the child knows how to play with dolls is irrelevant.

22. A. The parents need more teaching if they state that they will keep the child home until the phobia subsides. Doing so reinforces the child's feelings of worthlessness and dependency. The child should attend school even during resolution of the problem. Allowing the child to verbalize helps the child to ventilate feelings and may help to uncover causes and solutions. Collaboration with the teachers and counselors at school may lead to uncovering the cause of the phobia and to the development of solutions. The child should participate and play an active role in developing possible solutions.

23. C. The adolescent who becomes pregnant typically denies the pregnancy early on. Early recognition by a parent or health care provider may be crucial to timely initiation of prenatal care. The incidence of adolescent pregnancy has declined since 1991, yet morbidity remains high. Most teenage pregnancies are unplanned and occur out of wedlock. The pregnant adolescent is at high risk for physical complications including premature labor and low-birth-weight infants, high neonatal mortality, iron deficiency anemia, prolonged labor, and fetopelvic disproportion as well as numerous psychological crises.

24. B. Because of the structural defect, children with cleft palate may have ineffective functioning of their Eustachian tubes creating frequent bouts of otitis media. Most children with cleft palate remain well-nourished and maintain adequate nutrition through the use of proper feeding techniques. Food particles do not pass through the cleft and into the Eustachian tubes. There is no association between cleft palate and congenial ear deformities.

25. D. A 3-month-old infant should be able to lift the head and chest when prone. The Moro reflex typically diminishes or subsides by 3 months. The parachute reflex appears at 9 months. Rolling from front to back usually is accomplished at about 5 months.

26. D. A child's birth weight usually triples by 12 months and doubles by 4 months. No specific birth weight parameters are established for 7 or 9 months.

27. C. Toddlers engaging in parallel play will play near each other, but not with each other. Thus, when two toddlers sit near each other but play with separate dolls, they are exhibiting parallel play. Sharing crayons, playing a board game with a nurse, or sharing dolls with two different nurses are all examples of cooperative play.

28. A. Acute lymphocytic leukemia (ALL) causes leukopenia, resulting in immunosuppression and increasing the risk of infection, a leading cause of death in children with ALL. Therefore, the initial priority nursing intervention would be to institute infection control precautions to decrease the risk of infection. Iron-rich foods help with anemia, but dietary iron is not an initial intervention. The prognosis of ALL usually is good. However, later on, the nurse may need to assist the child and family with coping since death and dying may still be an issue in need of discussion. Injections should be discouraged, owing to increased risk from bleeding due to thrombocytopenia.

29. A. The pertussis component may result in fever and the tetanus component may result in injection soreness. Therefore, the mother's verbalization of information about measures to reduce fever indicates understanding. No dietary restrictions are necessary after this injection is given. A subsequent rash is more likely to be seen 5 to 10 days after receiving the MMR vaccine, not the diphtheria, pertussis, and tetanus vaccine. Diarrhea is not associated with this vaccine.

30. A. Multiple bruises and burns on a toddler are signs child abuse. Therefore, the nurse is responsible for reporting the case to Protective Services immediately to protect the child from further harm. Scheduling a follow-up visit is inappropriate because additional harm may come to the child if the nurse waits for further assessment data. Although the nurse should notify the physician, the goal is to initiate measures to protect the child's safety. Notifying the physician immediately does not initiate the removal of the child from harm nor does it absolve the nurse from responsibility. Multiple bruises and burns are not normal toddler injuries.

31. B. The mother is using projection, the defense mechanism used when a person attributes his or her own undesirable traits to another. Displacement is the transfer of emotion onto an unrelated object, such as when the mother would kick a chair or bang the door shut. Repression is the submerging of painful ideas into the unconscious. Psychosis is a state of being out of touch with reality.

32. A. Children with congenital heart disease are more prone to respiratory infections. Bleeding tendencies, frequent vomiting, and diarrhea and seizure disorders are not associated with congenital heart disease.

33. D. The child is exhibiting classic signs of epiglottitis, always a pediatric emergency. The physician must be notified immediately and the nurse must be prepared for an emergency intubation or tracheostomy. Further assessment with auscultating lungs

and placing the child in a mist tent wastes valuable time. The situation is a possible life-threatening emergency. Having the child lie down would cause additional distress and may result in respiratory arrest. Throat examination may result in laryngospasm that could be fatal.

34. A. In females, the urethra is shorter than in males. This decreases the distance for organisms to travel, thereby increasing the chance of the child developing a urinary tract infection. Frequent emptying of the bladder would help to decrease urinary tract infections by avoiding sphincter stress. Increased fluid intake enables the bladder to be cleared more frequently, thus helping to prevent urinary tract infections. The intake of acidic juices helps to keep the urine pH acidic and thus decrease the chance of flora development.

35. B. Compartment syndrome is an emergent situation and the physician needs to be notified immediately so that interventions can be initiated to relieve the increasing pressure and restore circulation. Acetaminophen (Tylenol) will be ineffective since the pain is related to the increasing pressure and tissue ischemia. The cast, not traction, is being used in this situation for immobilization, so releasing the traction would be inappropriate. In this situation, specific action not continued monitoring is indicated.

36. D. The varicella zoster vaccine (VZV) is a live vaccine given after age 12 months. The first dose of hepatitis B vaccine is given at birth to 2 months, then at 1 to 4 months, and then again at 6 to 18 months. DtaP is routinely given at 2, 4, 6, and 15 to 18 months and a booster at 4 to 6 years.

37. C. Because the 8-month-old is refining his gross motor skills, being able to sit unsupported and also improving his fine motor skills, probably capable of making hand-to-hand transfers, large blocks would be the most appropriate toy selection. Push-pull toys would be more appropriate for the 10 to 12-month-old as he or she begins to cruise the environment. Rattles and mobiles are more appropriate for infants in the 1 to 3 month age range. Mobiles pose a danger to older infants because of possible strangulation.

38. B. During the preschool period, the child has mastered a sense of autonomy and goes on to master a sense of initiative. During this period, the child commonly experiences more fears than at any other time. One common fear is fear of the body mutilation, especially associated with painful experiences. The preschool child uses simple, not complex, reasoning, engages in associative, not competitive, play (interactive and cooperative play with sharing), and is able to tolerate longer periods of delayed gratification.

39. A. Mild mental retardation refers to development disability involving an IQ 50 to 70. Typically, the child is not noted as being retarded, but exhibits slowness in performing tasks, such as self-feeding, walking, and talking. Little or no speech, marked motor delays, and gait disabilities would be seen in more severe forms mental retardation.

40. B. Down syndrome is characterized by the following a transverse palmar crease (simian crease), separated sagittal suture, oblique palpebral fissures, small nose, depressed nasal bridge, high-arched palate, excess and lax skin, wide spacing and plantar crease between the second and big toes, hyperextensible and lax joints, large protruding tongue, and muscle weakness.

41. A. Because of the defect, the child will be unable to form the mouth adequately around nipple, thereby requiring special devices to allow for feeding and sucking gratification. Respiratory status may be compromised if the child is fed improperly or during postoperative period, Locomotion would be a problem for the older infant because of the use of restraints. GI functioning is not compromised in the child with a cleft lip.

42. B. Postoperatively children with cleft palate should be placed on their abdomens to facilitate drainage. If the child is placed in the supine position, he or she may aspirate. Using an infant seat does not facilitate drainage. Side-lying does not facilitate drainage as well as the prone position.

43. C. Projectile vomiting is a key symptom of pyloric stenosis. Regurgitation is seen more commonly with GER. Steatorrhea occurs in malabsorption disorders such as celiac disease. "Currant jelly" stools are characteristic of intussusception.

44. D. GER is the backflow of gastric contents into the esophagus resulting from relaxation or incompetence of the lower esophageal (cardiac) sphincter. No alteration in the oral mucous membranes occurs with this disorder. Fluid volume deficit, risk for aspiration, and altered nutrition are appropriate nursing diagnoses.

45. A. Thickened feedings are used with GER to stop the vomiting. Therefore, the nurse would monitor the child's vomiting to evaluate the effectiveness of using the thickened feedings. No relationship exists between feedings and characteristics of stools and uterine. If feedings are ineffective, this should be noted before there is any change in the child's weight.

46. C. Children with celiac disease cannot tolerate or digest gluten. Therefore, because of its gluten content, wheat and wheat-containing products must be avoided. Rice, milk, and chicken do not contain gluten and need not be avoided.

47. C. Episodes of celiac crises are precipitated by infections, ingestion of gluten, prolonged fasting, or exposure to anticholinergic drugs. Celiac crisis is typically characterized by severe watery diarrhea. Respiratory distress is unlikely in a routine upper respiratory infection. Irritability, rather than lethargy, is more likely. Because of the fluid loss associated with the severe watery diarrhea, the child's weight is more likely to be decreased.

48. A. For the child with Hirschsprung disease, fever and explosive diarrhea indicate enterocolitis, a life-threatening situation. Therefore, the physician should be notified immediately. Generally, because of the intestinal obstruction and inadequate propulsive intestinal movement, antidiarrheals are not used to treat Hirschsprung

disease. The child is acutely ill and requires intervention, with monitoring more frequently than every 30 minutes. Hirschsprung disease typically presents with chronic constipation.

49. A. Failure to pass meconium within the first 24 hours after birth may be an indication of Hirschsprung disease, a congenital anomaly resulting in mechanical obstruction due to inadequate motility in an intestinal segment. Failure to pass meconium is not associated with celiac disease, intussusception, or abdominal wall defect.

50. C. Because intussusception is not believed to have a familial tendency, obtaining a family history would provide the least amount of information. Stool inspection, pain pattern, and abdominal palpation would reveal possible indicators of intussusception. Current, jelly-like stools containing blood and mucus are an indication of intussusception. Acute, episodic abdominal pain is characteristic of intussusception. A sausage-shaped mass may be palpated in the right upper quadrant.

#### MIDWIFERY 4

1. Which of the following conditions will lead to a small-for-gestational age fetus due to less blood supply to the fetus?

- A. Diabetes in the mother
- B. Maternal cardiac condition
- C. Premature labor

**D. Abruptio placenta**

**2. The lower limit of viability for infants in terms of age of gestation is:**

- A. 21-24 weeks**
- B. 25-27 weeks**
- C. 28-30 weeks**
- D. 38-40 weeks**

**3. Which provision of our 1987 constitution guarantees the right of the unborn child to life from conception is**

- A. Article II section 12**
- B. Article II section 15**
- C. Article XIII section 11**
- D. Article XIII section 15**

**4. In the Philippines, if a nurse performs abortion on the mother who wants it done and she gets paid for doing it, she will be held liable because**

- A. Abortion is immoral and is prohibited by the church**
- B. Abortion is both immoral and illegal in our country**
- C. Abortion is considered illegal because you got paid for doing it**
- D. Abortion is illegal because majority in our country are catholics and it is prohibited by the church**

**5. The preferred manner of delivering the baby in a gravido-cardiac is vaginal delivery assisted by forceps under epidural anesthesia. The main rationale for this is:**

- A. To allow atraumatic delivery of the baby**
- B. To allow a gradual shifting of the blood into the maternal circulation**
- C. To make the delivery effort free and the mother does not need to push with contractions**
- D. To prevent perineal laceration with the expulsion of the fetal head**

**6. When giving narcotic analgesics to mother in labor, the special consideration to follow is:**

- A. The progress of labor is well established reaching the transitional stage**
- B. Uterine contraction is progressing well and delivery of the baby is imminent**

- C. Cervical dilatation has already reached at least 8 cm. and the station is at least (+)2
- D. Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.

7. 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:

- A. Labor is progressing as expected
- B. The latent phase of Stage 1 is prolonged
- C. The active phase of Stage 1 is protracted
- D. The duration of labor is normal

8. Which of the following techniques during labor and delivery can lead to uterine inversion?

- A. Fundal pressure applied to assist the mother in bearing down during delivery of the fetal head
- B. Strongly tugging on the umbilical cord to deliver the placenta and hasten placental separation
- C. Massaging the fundus to encourage the uterus to contract
- D. Applying light traction when delivering the placenta that has already detached from the uterine wall

9. The fetal heart rate is checked following rupture of the bag of waters in order to:

- A. Check if the fetus is suffering from head compression
- B. Determine if cord compression followed the rupture
- C. Determine if there is utero-placental insufficiency
- D. Check if fetal presenting part has adequately descended following the rupture

10. Upon assessment, the nurse got the following findings: 2 perineal pads highly saturated with blood within 2 hours post partum, PR= 80 bpm, fundus soft and boundaries not well defined. The appropriate nursing diagnosis is:

- A. Normal blood loss
- B. Blood volume deficiency
- C. Inadequate tissue perfusion related to hemorrhage
- D. Hemorrhage secondary to uterine atony

11. The following are signs and symptoms of fetal distress EXCEPT:

- A. Fetal heart rate (FHR) decreased during a contraction and persists even after the uterine contraction ends
- B. The FHR is less than 120 bpm or over 160 bpm
- C. The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm and FHR after uterine contraction is 126 bpm
- D. FHR is 160 bpm, weak and irregular

12. If the labor period lasts only for 3 hours, the nurse should suspect that the following conditions may occur:

- 1. Laceration of cervix
  - 2. Laceration of perineum
  - 3. Cranial hematoma in the fetus
  - 4. Fetal anoxia
- A. 1 & 2
  - B. 2 & 4
  - C. 2,3,4
  - D. 1,2,3,4

13. The primary power involved in labor and delivery is

- A. Bearing down ability of mother
- B. Cervical effacement and dilatation
- C. Uterine contraction
- D. Valsalva technique

14. The proper technique to monitor the intensity of a uterine contraction is

- A. Place the palm of the hands on the abdomen and time the contraction
- B. Place the finger tips lightly on the suprapubic area and time the contraction
- C. Put the tip of the fingers lightly on the fundal area and try to indent the abdominal wall at the height of the contraction
- D. Put the palm of the hands on the fundal area and feel the contraction at the fundal area

15. To monitor the frequency of the uterine contraction during labor, the right technique is to time the contraction

- A. From the beginning of one contraction to the end of the same contraction

- B. From the beginning of one contraction to the beginning of the next contraction
- C. From the end of one contraction to the beginning of the next contraction
- D. From the deceleration of one contraction to the acme of the next contraction

16. The peak point of a uterine contraction is called the

- A. Acceleration
- B. Acme
- C. Deceleration
- D. Axiom

17. When determining the duration of a uterine contraction the right technique is to time it from

- A. The beginning of one contraction to the end of the same contraction
- B. The end of one contraction to the beginning of another contraction
- C. The acme point of one contraction to the acme point of another contraction
- D. The beginning of one contraction to the end of another contraction

18. When the bag of waters ruptures, the nurse should check the characteristic of the amniotic fluid. The normal color of amniotic fluid is

- A. Clear as water
- B. Bluish
- C. Greenish
- D. Yellowish

19. When the bag of waters ruptures spontaneously, the nurse should inspect the vaginal introitus for possible cord prolapse. If there is part of the cord that has prolapsed into the vaginal opening the correct nursing intervention is:

- A. Push back the prolapse cord into the vaginal canal
- B. Place the mother on semifowler's position to improve circulation
- C. Cover the prolapse cord with sterile gauze wet with sterile NSS and place the woman on trendellenberg position
- D. Push back the cord into the vagina and place the woman on sims position

20. 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

- A. The heart rate will decelerate during a contraction and then go back to its pre-contraction rate after the contraction
- B. The heart rate will accelerate during a contraction and remain slightly above the pre-contraction rate at the end of the contraction
- C. The rate should not be affected by the uterine contraction.
- D. The heart rate will decelerate at the middle of a contraction and remain so for about a minute after the contraction

21. The mechanisms involved in fetal delivery is

- A. Descent, extension, flexion, external rotation
- B. Descent, flexion, internal rotation, extension, external rotation
- C. Flexion, internal rotation, external rotation, extension
- D. Internal rotation, extension, external rotation, flexion

22. The first thing that a nurse must ensure when the baby's head comes out is

- A. The cord is intact
- B. No part of the cord is encircling the baby's neck
- C. The cord is still attached to the placenta
- D. The cord is still pulsating

23. To ensure that the baby will breathe as soon as the head is delivered, the nurse's priority action is to

- A. Suction the nose and mouth to remove mucous secretions
- B. Slap the baby's buttocks to make the baby cry
- C. Clamp the cord about 6 inches from the base
- D. Check the baby's color to make sure it is not cyanotic

24. When doing perineal care in preparation for delivery, the nurse should observe the following EXCEPT

- A. Use up-down technique with one stroke
- B. Clean from the mons veneris to the anus
- C. Use mild soap and warm water
- D. Paint the inner thighs going towards the perineal area

25. What are the important considerations that the nurse must remember after the placenta is delivered?

1. Check if the placenta is complete including the membranes
2. Check if the cord is long enough for the baby

3. Check if the umbilical cord has 3 blood vessels
  4. Check if the cord has a meaty portion and a shiny portion
    - A. 1 and 3
    - B. 2 and 4
    - C. 1, 3, and 4
    - D. 2 and 3
26. The following are correct statements about false labor EXCEPT
- A. The pain is irregular in intensity and frequency.
  - B. The duration of contraction progressively lengthens over time
  - C. There is no vaginal bloody discharge
  - D. The cervix is still closed.
27. The passageway in labor and deliver of the fetus include the following EXCEPT
- A. Distensibility of lower uterine segment
  - B. Cervical dilatation and effacement
  - C. Distensibility of vaginal canal and introitus
  - D. Flexibility of the pelvis
28. The normal umbilical cord is composed of:
- A. 2 arteries and 1 vein
  - B. 2 veins and 1 artery
  - C. 2 arteries and 2 veins
  - D. none of the above
29. At what stage of labor and delivery does a primigravida differ mainly from a multigravida?
- A. Stage 1
  - B. Stage 2
  - C. Stage 3
  - D. Stage 4
30. The second stage of labor begins with \_\_\_\_ and ends with \_\_\_?
- A. Begins with full dilatation of cervix and ends with delivery of placenta
  - B. Begins with true labor pains and ends with delivery of baby
  - C. Begins with complete dilatation and effacement of cervix and ends with delivery of baby

- D. Begins with passage of show and ends with full dilatation and effacement of cervix

31. The following are signs that the placenta has detached EXCEPT:

- A. Lengthening of the cord
- B. Uterus becomes more globular
- C. Sudden gush of blood
- D. Mother feels like bearing down

32. When the shiny portion of the placenta comes out first, this is called the \_\_\_\_ mechanism.

- A. Schultze
- B. Ritgens
- C. Duncan
- D. Marmets

33. When the baby's head is out, the immediate action of the nurse is

- A. Cut the umbilical cord
- B. Wipe the baby's face and suction mouth first
- C. Check if there is cord coiled around the neck
- D. Deliver the anterior shoulder

34. When delivering the baby's head the nurse supports the mother's perineum to prevent tear. This technique is called

- A. Marmet's technique
- B. Ritgen's technique
- C. Duncan maneuver
- D. Schultze maneuver

35. The basic delivery set for normal vaginal delivery includes the following instruments/articles EXCEPT:

- A. 2 clamps
- B. Pair of scissors
- C. Kidney basin
- D. Retractor

36. 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

37. 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:

- A. Oxytocin will prevent bleeding
- B. Oxytocin can make the cervix close and thus trap the placenta inside
- C. Oxytocin will facilitate placental delivery
- D. Giving oxytocin will ensure complete delivery of the placenta

38. In a gravido-cardiac mother, the first 2 hours postpartum (4th stage of labor and delivery) particularly in a cesarean section is a critical period because at this stage

- A. There is a fluid shift from the placental circulation to the maternal circulation which can overload the compromised heart.
- B. The maternal heart is already weak and the mother can die
- C. The delivery process is strenuous to the mother
- D. The mother is tired and weak which can distress the heart

39. The drug usually given parentally to enhance uterine contraction is:

- A. Terbutalline
- B. Pitocin
- C. Magnesium sulfate
- D. Lidocaine

40. The partograph is a tool used to monitor labor. The maternal parameters measured/monitored are the following EXCEPT:

- A. Vital signs
- B. Fluid intake and output
- C. Uterine contraction
- D. Cervical dilatation

41. The following are natural childbirth procedures EXCEPT:
- A. Lamaze method
  - B. Dick-Read method
  - C. Ritgen's maneuver
  - D. Psychoprophylactic method
42. The following are common causes of dysfunctional labor. Which of these can a nurse, on her own manage?
- A. Pelvic bone contraction
  - B. Full bladder
  - C. Extension rather than flexion of the head
  - D. Cervical rigidity
43. At what stage of labor is the mother is advised to bear down?
- A. When the mother feels the pressure at the rectal area
  - B. During a uterine contraction
  - C. In between uterine contraction to prevent uterine rupture
  - D. Anytime the mother feels like bearing down
44. The normal dilatation of the cervix during the first stage of labor in a nullipara is
- A. 1.2 cm./hr
  - B. 1.5 cm./hr.
  - C. 1.8 cm./hr
  - D. 2.0 cm./hr
45. When the fetal head is at the level of the ischial spine, it is said that the station of the head is
- A. Station -1
  - B. Station "0"
  - C. Station +1
  - D. Station +2
46. During an internal examination, the nurse palpated the posterior fontanel to be at the left side of the mother at the upper quadrant. The interpretation is that the position of the fetus is:

- A. LOA
- B. ROP
- C. LOP
- D. ROA

47. The following are types of breech presentation EXCEPT:

- A. Footling
- B. Frank
- C. Complete
- D. Incomplete

48. When the nurse palpates the suprapubic area of the mother and found that the presenting part is still movable, the right term for this observation that the fetus is

- A. Engaged
- B. Descended
- C. Floating
- D. Internal Rotation

49. The placenta should be delivered normally within \_\_\_ minutes after the delivery of the baby.

- A. 5 minutes
- B. 30 minutes
- C. 45 minutes
- D. 60 minutes

50. When shaving a woman in preparation for cesarean section, the area to be shaved should be from \_\_\_ to \_\_\_

- A. Under breast to mid-thigh including the pubic area
- B. The umbilicus to the mid-thigh
- C. Xyphoid process to the pubic area
- D. Above the umbilicus to the pubic area

Answers and Rationales

1. Answer: (B) Maternal cardiac condition. In general, when the heart is compromised such as in maternal cardiac condition, the condition can lead to less blood supply to the uterus consequently to the placenta which provides the fetus with the essential nutrients and oxygen. Thus if the blood

supply is less, the baby will suffer from chronic hypoxia leading to a small-for-gestational age condition.

2. Answer: (A) 21-24 weeks. Viability means the capability of the fetus to live/survive outside of the uterine environment. With the present technological and medical advances, 21 weeks AOG is considered as the minimum fetal age for viability.
3. Answer: (A) Article II section 12. The Philippine Constitution of 1987 guarantees the right of the unborn child from conception equal to the mother as stated in Article II State Policies, Section 12.
4. Answer: (B) Abortion is both immoral and illegal in our country. Induced Abortion is illegal in the country as stated in our Penal Code and any person who performs the act for a fee commits a grave offense punishable by 10-12 years of imprisonment.
5. Answer: (C) To make the delivery effort free and the mother does not need to push with contractions. Forceps delivery under epidural anesthesia will make the delivery process less painful and require less effort to push for the mother. Pushing requires more effort which a compromised heart may not be able to endure.
6. Answer: (D) Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.. Narcotic analgesics must be given when uterine contractions are already well established so that it will not cause stoppage of the contraction thus protracting labor. Also, it should be given when delivery of fetus is imminent or too close because the fetus may suffer respiratory depression as an effect of the drug that can pass through placental barrier.
7. Answer: (C) The active phase of Stage 1 is protracted. The active phase of Stage I starts from 4cm cervical dilatation and is expected that the uterus will dilate by 1cm every hour. Since the time lapsed is already 2 hours, the dilatation is expected to be already 8 cm. Hence, the active phase is protracted.
8. Answer: (B) Strongly tugging on the umbilical cord to deliver the placenta and hasten placental separation. When the placenta is still attached to the uterine wall, tugging on the cord while the uterus is relaxed can lead to inversion of the uterus. Light tugging on the cord when placenta has detached is alright in order to help deliver the placenta that is already detached.
9. Answer: (B) Determine if cord compression followed the rupture. After the rupture of the bag of waters, the cord may also go with the water because of the pressure of the rupture and flow. If the cord goes out of the cervical opening, before the head is delivered (cephalic presentation), the head can compress on the cord causing fetal distress. Fetal distress can be detected through the fetal heart tone. Thus, it is essential do check the FHB right after rupture of bag to ensure that the cord is not being compressed by the fetal head.

10. Answer: (D) Hemorrhage secondary to uterine atony. All the signs in the stem of the question are signs of hemorrhage. If the fundus is soft and boundaries not well defined, the cause of the hemorrhage could be uterine atony.
11. Answer: (C) The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm and FHR after uterine contraction is 126 bpm. The normal range of FHR is 120-160 bpm, strong and regular. During a contraction, the FHR usually goes down but must return to its pre-contraction rate after the contraction ends.
12. Answer: (D) 1,2,3,4. all the above conditions can occur following a precipitate labor and delivery of the fetus because there was little time for the baby to adapt to the passageway. If the presentation is cephalic, the fetal head serves as the main part of the fetus that pushes through the birth canal which can lead to cranial hematoma, and possible compression of cord may occur which can lead to less blood and oxygen to the fetus (hypoxia). Likewise the maternal passageway (cervix, vaginal canal and perineum) did not have enough time to stretch which can lead to laceration.
13. Answer: (C) Uterine contraction. Uterine contraction is the primary force that will expel the fetus out through the birth canal Maternal bearing down is considered the secondary power/force that will help push the fetus out.
14. Answer: (C) Put the tip of the fingers lightly on the fundal area and try to indent the abdominal wall at the height of the contraction. In monitoring the intensity of the contraction the best place is to place the fingertips at the fundal area. The fundus is the contractile part of the uterus and the fingertips are more sensitive than the palm of the hand.
15. Answer: (B) From the beginning of one contraction to the beginning of the next contraction. Frequency of the uterine contraction is defined as from the beginning of one contraction to the beginning of another contraction.
16. Answer: (B) Acme. Acme is the technical term for the highest point of intensity of a uterine contraction.
17. Answer: (A) The beginning of one contraction to the end of the same contraction. Duration of a uterine contraction refers to one contraction. Thus it is correctly measure from the beginning of one contraction to the end of the same contraction and not of another contraction.
18. Answer: (A) Clear as water. The normal color of amniotic fluid is clear like water. If it is yellowish, there is probably Rh incompatibility. If the color is greenish, it is probably meconium stained.
19. Answer: (C) Cover the prolapse cord with sterile gauze wet with sterile NSS and place the woman on trendellenberg position. The correct action of the nurse is to cover the cord with sterile gauze wet with sterile NSS. Observe strict asepsis in the care of the cord to prevent infection. The cord has to be kept moist to prevent it from drying. Don't attempt to put back the cord into the vagina but relieve pressure on the cord by positioning the mother either on trendellenberg or sims position

20. Answer: (A) The heart rate will decelerate during a contraction and then go back to its pre-contraction rate after the contraction. The normal fetal heart rate will decelerate (go down) slightly during a contraction because of the compression on the fetal head. However, the heart rate should go back to the pre-contraction rate as soon as the contraction is over since the compression on the head has also ended.
21. Answer: (B) Descent, flexion, internal rotation, extension, external rotation. The mechanism of fetal delivery begins with descent into the pelvic inlet which may occur several days before true labor sets in the primigravida. Flexion, internal rotation and extension are mechanisms that the fetus must perform as it accommodates through the passageway/birth canal. External rotation is done after the head is delivered so that the shoulders will be easily delivered through the vaginal introitus.
22. Answer: (B) No part of the cord is encircling the baby's neck. The nurse should check right away for possible cord coil around the neck because if it is present, the baby can be strangled by it and the fetal head will have difficulty being delivered.
23. Answer: (A) Suction the nose and mouth to remove mucous secretions. Suctioning the nose and mouth of the fetus as soon as the head is delivered will remove any obstruction that maybe present allowing for better breathing. Also, if mucus is in the nose and mouth, aspiration of the mucus is possible which can lead to aspiration pneumonia. (Remember that only the baby's head has come out as given in the situation.)
24. Answer: (D) Paint the inner thighs going towards the perineal area. Painting of the perineal area in preparation for delivery of the baby must always be done but the stroke should be from the perineum going outwards to the thighs. The perineal area is the one being prepared for the delivery and must be kept clean
25. Answer: (A) 1 and 3. The nurse after delivering the placenta must ensure that all the cotyledons and the membranes of the placenta are complete. Also, the nurse must check if the umbilical cord is normal which means it contains the 3 blood vessels, 2 veins and 1 artery.
26. Answer: (B) The duration of contraction progressively lengthens over time. In false labor, the contractions remain to be irregular in intensity and duration while in true labor, the contractions become stronger, longer and more frequent.
27. Answer: (D) Flexibility of the pelvis. The pelvis is a bony structure that is part of the passageway but is not flexible. The lower uterine segment including the cervix as well as the vaginal canal and introitus are all part of the passageway in the delivery of the fetus.
28. Answer: (A) 2 arteries and 1 vein. The umbilical cord is composed of 2 arteries and 1 vein.

29. Answer: (A) Stage 1. In stage 1 during a normal vaginal delivery of a vertex presentation, the multigravida may have about 8 hours labor while the primigravida may have up to 12 hours labor.
30. Answer: (C) Begins with complete dilatation and effacement of cervix and ends with delivery of baby. Stage 2 of labor and delivery process begins with full dilatation of the cervix and ends with the delivery of baby. Stage 1 begins with true labor pains and ends with full dilatation and effacement of the cervix.
31. Answer: (D) Mother feels like bearing down. Placental detachment does not require the mother to bear down. A normal placenta will detach by itself without any effort from the mother.
32. Answer: (A) Schultze. There are 2 mechanisms possible during the delivery of the placenta. If the shiny portion comes out first, it is called the Schultze mechanism; while if the meaty portion comes out first, it is called the Duncan mechanism.
33. Answer: (C) Check if there is cord coiled around the neck. The nurse should check if there is a cord coil because the baby will not be delivered safely if the cord is coiled around its neck. Wiping of the face should be done seconds after you have ensured that there is no cord coil but suctioning of the nose should be done after the mouth because the baby is a "nasal obligate" breather. If the nose is suctioned first before the mouth, the mucus plugging the mouth can be aspirated by the baby.
34. Answer: (B) Ritgen's technique. Ritgen's technique is done to prevent perineal tear. This is done by the nurse by support the perineum with a sterile towel and pushing the perineum downward with one hand while the other hand is supporting the baby's head as it goes out of the vaginal opening.
35. Answer: (D) Retractor. For normal vaginal delivery, the nurse needs only the instruments for cutting the umbilical cord such as: 2 clamps (straight or curve) and a pair of scissors as well as the kidney basin to receive the placenta. The retractor is not part of the basic set. In the hospital setting, needle holder and tissue forceps are added especially if the woman delivering the baby is a primigravida wherein episiotomy is generally done.
36. Answer: (A) Inspect the placenta for completeness including the membranes. The placenta must be inspected for completeness to include the membranes because an incomplete placenta could mean that there is retention of placental fragments which can lead to uterine atony. If the uterus does not contract adequately, hemorrhage can occur.
37. Answer: (B) Oxytocin can make the cervix close and thus trap the placenta inside. The action of oxytocin is to make the uterus contract as well make the cervix close. If it is given prior to placental delivery, the placenta will be trapped inside because the action of the drug is almost immediate if given parentally.
38. Answer: (A) There is a fluid shift from the placental circulation to the maternal circulation which can overload the compromised heart.. During the

pregnancy, there is an increase in maternal blood volume to accommodate the need of the fetus. When the baby and placenta have been delivered, there is a fluid shift back to the maternal circulation as part of physiologic adaptation during the postpartum period. In cesarean section, the fluid shift occurs faster because the placenta is taken out right after the baby is delivered giving it less time for the fluid shift to gradually occur.

39. Answer: (B) Pitocin. The common oxytocin given to enhance uterine contraction is pitocin. This is also the drug given to induce labor.
40. Answer: (B) Fluid intake and output. Partograph is a monitoring tool designed by the World Health Organization for use by health workers when attending to mothers in labor especially the high risk ones. For maternal parameters all of the above is placed in the partograph except the fluid intake since this is placed in a separate monitoring sheet.
41. Answer: (C) Ritgen's maneuver. Ritgen's method is used to prevent perineal tear/laceration during the delivery of the fetal head. Lamaze method is also known as psychoprophylactic method and Dick-Read method are commonly known natural childbirth procedures which advocate the use of non-pharmacologic measures to relieve labor pain.
42. Answer: (B) Full bladder. Full bladder can impede the descent of the fetal head. The nurse can readily manage this problem by doing a simple catheterization of the mother.
43. Answer: (B) During a uterine contraction. The primary power of labor and delivery is the uterine contraction. This should be augmented by the mother's bearing down during a contraction.
44. Answer: (A) 1.2 cm./hr. For nullipara the normal cervical dilatation should be 1.2 cm/hr. If it is less than that, it is considered a protracted active phase of the first stage. For multipara, the normal cervical dilatation is 1.5 cm/hr.
45. Answer: (B) Station "0". Station is defined as the relationship of the fetal head and the level of the ischial spine. At the level of the ischial spine, the station is "0". Above the ischial spine it is considered (-) station and below the ischial spine it is (+) station.
46. Answer: (A) LOA. The landmark used in determine fetal position is the posterior fontanel because this is the nearest to the occiput. So if the nurse palpated the occiput (O) at the left (L) side of the mother and at the upper/anterior (A) quadrant then the fetal position is LOA.
47. Answer: (D) Incomplete. Breech presentation means the buttocks of the fetus is the presenting part. If it is only the foot/feet, it is considered footling. If only the buttocks, it is frank breech. If both the feet and the buttocks are presenting it is called complete breech.
48. Answer: (C) Floating. The term floating means the fetal presenting part has not entered/descended into the pelvic inlet. If the fetal head has entered the pelvic inlet, it is said to be engaged.

49. Answer: (B) 30 minutes. The placenta is delivered within 30 minutes from the delivery of the baby. If it takes longer, probably the placenta is abnormally adherent and there is a need to refer already to the obstetrician.
50. Answer: (A) Under breast to mid-thigh including the pubic area. Shaving is done to prevent infection and the area usually shaved should sufficiently cover the area for surgery, cesarean section. The pubic hair is definitely to be included in the shaving

#### MIDWIFERY 5

1. Which of the following conditions will lead to a small-for-gestational age fetus due to less blood supply to the fetus?
- A. Diabetes in the mother
  - B. Maternal cardiac condition
  - C. Premature labor
  - D. Abruptio placenta

2. The lower limit of viability for infants in terms of age of gestation is:
- A. 21-24 weeks
  - B. 25-27 weeks
  - C. 28-30 weeks
  - D. 38-40 weeks
3. Which provision of our 1987 constitution guarantees the right of the unborn child to life from conception is
- A. Article II section 12
  - B. Article II section 15
  - C. Article XIII section 11
  - D. Article XIII section 15
4. In the Philippines, if a nurse performs abortion on the mother who wants it done and she gets paid for doing it, she will be held liable because
- A. Abortion is immoral and is prohibited by the church
  - B. Abortion is both immoral and illegal in our country
  - C. Abortion is considered illegal because you got paid for doing it
  - D. Abortion is illegal because majority in our country are catholics and it is prohibited by the church
5. The preferred manner of delivering the baby in a gravido-cardiac is vaginal delivery assisted by forceps under epidural anesthesia. The main rationale for this is:
- A. To allow atraumatic delivery of the baby
  - B. To allow a gradual shifting of the blood into the maternal circulation
  - C. To make the delivery effort free and the mother does not need to push with contractions
  - D. To prevent perineal laceration with the expulsion of the fetal head
6. When giving narcotic analgesics to mother in labor, the special consideration to follow is:
- A. The progress of labor is well established reaching the transitional stage
  - B. Uterine contraction is progressing well and delivery of the baby is imminent
  - C. Cervical dilatation has already reached at least 8 cm. and the station is at least (+)2

- D. Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.
7. 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:
- A. Labor is progressing as expected
  - B. The latent phase of Stage 1 is prolonged
  - C. The active phase of Stage 1 is protracted
  - D. The duration of labor is normal
8. Which of the following techniques during labor and delivery can lead to uterine inversion?
- A. Fundal pressure applied to assist the mother in bearing down during delivery of the fetal head
  - B. Strongly tugging on the umbilical cord to deliver the placenta and hasten placental separation
  - C. Massaging the fundus to encourage the uterus to contract
  - D. Applying light traction when delivering the placenta that has already detached from the uterine wall
9. The fetal heart rate is checked following rupture of the bag of waters in order to:
- A. Check if the fetus is suffering from head compression
  - B. Determine if cord compression followed the rupture
  - C. Determine if there is utero-placental insufficiency
  - D. Check if fetal presenting part has adequately descended following the rupture
10. Upon assessment, the nurse got the following findings: 2 perineal pads highly saturated with blood within 2 hours post partum, PR= 80 bpm, fundus soft and boundaries not well defined. The appropriate nursing diagnosis is:
- A. Normal blood loss
  - B. Blood volume deficiency
  - C. Inadequate tissue perfusion related to hemorrhage
  - D. Hemorrhage secondary to uterine atony
11. The following are signs and symptoms of fetal distress EXCEPT:

- A. Fetal heart rate (FHR) decreased during a contraction and persists even after the uterine contraction ends
  - B. The FHR is less than 120 bpm or over 160 bpm
  - C. The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm and FHR after uterine contraction is 126 bpm
  - D. FHR is 160 bpm, weak and irregular
12. If the labor period lasts only for 3 hours, the nurse should suspect that the following conditions may occur:
- 1. Laceration of cervix
  - 2. Laceration of perineum
  - 3. Cranial hematoma in the fetus
  - 4. Fetal anoxia
- A. 1 & 2
  - B. 2 & 4
  - C. 2,3,4
  - D. 1,2,3,4
13. The primary power involved in labor and delivery is
- A. Bearing down ability of mother
  - B. Cervical effacement and dilatation
  - C. Uterine contraction
  - D. Valsalva technique
14. The proper technique to monitor the intensity of a uterine contraction is
- A. Place the palm of the hands on the abdomen and time the contraction
  - B. Place the finger tips lightly on the suprapubic area and time the contraction
  - C. Put the tip of the fingers lightly on the fundal area and try to indent the abdominal wall at the height of the contraction
  - D. Put the palm of the hands on the fundal area and feel the contraction at the fundal area
15. To monitor the frequency of the uterine contraction during labor, the right technique is to time the contraction
- A. From the beginning of one contraction to the end of the same contraction
  - B. From the beginning of one contraction to the beginning of the next contraction
  - C. From the end of one contraction to the beginning of the next contraction

D. From the deceleration of one contraction to the acme of the next contraction

16. The peak point of a uterine contraction is called the

- A. Acceleration
- B. Acme
- C. Deceleration
- D. Axiom

17. When determining the duration of a uterine contraction the right technique is to time it from

- A. The beginning of one contraction to the end of the same contraction
- B. The end of one contraction to the beginning of another contraction
- C. The acme point of one contraction to the acme point of another contraction
- D. The beginning of one contraction to the end of another contraction

18. When the bag of waters ruptures, the nurse should check the characteristic of the amniotic fluid. The normal color of amniotic fluid is

- A. Clear as water
- B. Bluish
- C. Greenish
- D. Yellowish

19. When the bag of waters ruptures spontaneously, the nurse should inspect the vaginal introitus for possible cord prolapse. If there is part of the cord that has prolapsed into the vaginal opening the correct nursing intervention is:

- A. Push back the prolapse cord into the vaginal canal
- B. Place the mother on semifowler's position to improve circulation
- C. Cover the prolapse cord with sterile gauze wet with sterile NSS and place the woman on trendellenberg position
- D. Push back the cord into the vagina and place the woman on sims position

20. 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

- A. The heart rate will decelerate during a contraction and then go back to its pre-contraction rate after the contraction

- B. The heart rate will accelerate during a contraction and remain slightly above the pre-contraction rate at the end of the contraction
  - C. The rate should not be affected by the uterine contraction.
  - D. The heart rate will decelerate at the middle of a contraction and remain so for about a minute after the contraction
21. The mechanisms involved in fetal delivery is
- A. Descent, extension, flexion, external rotation
  - B. Descent, flexion, internal rotation, extension, external rotation
  - C. Flexion, internal rotation, external rotation, extension
  - D. Internal rotation, extension, external rotation, flexion
22. The first thing that a nurse must ensure when the baby's head comes out is
- A. The cord is intact
  - B. No part of the cord is encircling the baby's neck
  - C. The cord is still attached to the placenta
  - D. The cord is still pulsating
23. To ensure that the baby will breath as soon as the head is delivered, the nurse's priority action is to
- A. Suction the nose and mouth to remove mucous secretions
  - B. Slap the baby's buttocks to make the baby cry
  - C. Clamp the cord about 6 inches from the base
  - D. Check the baby's color to make sure it is not cyanotic
24. When doing perineal care in preparation for delivery, the nurse should observe the following EXCEPT
- A. Use up-down technique with one stroke
  - B. Clean from the mons veneris to the anus
  - C. Use mild soap and warm water
  - D. Paint the inner thighs going towards the perineal area
25. What are the important considerations that the nurse must remember after the placenta is delivered?
- 1. Check if the placenta is complete including the membranes
  - 2. Check if the cord is long enough for the baby

3. Check if the umbilical cord has 3 blood vessels
  4. Check if the cord has a meaty portion and a shiny portion
  - A. 1 and 3
  - B. 2 and 4
  - C. 1, 3, and 4
  - D. 2 and 3
26. The following are correct statements about false labor EXCEPT
- A. The pain is irregular in intensity and frequency.
  - B. The duration of contraction progressively lengthens over time
  - C. There is no vaginal bloody discharge
  - D. The cervix is still closed.
27. The passageway in labor and deliver of the fetus include the following EXCEPT
- A. Distensibility of lower uterine segment
  - B. Cervical dilatation and effacement
  - C. Distensibility of vaginal canal and introitus
  - D. Flexibility of the pelvis
28. The normal umbilical cord is composed of:
- A. 2 arteries and 1 vein
  - B. 2 veins and 1 artery
  - C. 2 arteries and 2 veins
  - D. none of the above
29. At what stage of labor and delivery does a primigravida differ mainly from a multigravida?
- A. Stage 1
  - B. Stage 2
  - C. Stage 3
  - D. Stage 4
30. The second stage of labor begins with \_\_\_\_ and ends with \_\_?
- A. Begins with full dilatation of cervix and ends with delivery of placenta
  - B. Begins with true labor pains and ends with delivery of baby

- C. Begins with complete dilatation and effacement of cervix and ends with delivery of baby
- D. Begins with passage of show and ends with full dilatation and effacement of cervix

31. The following are signs that the placenta has detached EXCEPT:

- A. Lengthening of the cord
- B. Uterus becomes more globular
- C. Sudden gush of blood
- D. Mother feels like bearing down

32. When the shiny portion of the placenta comes out first, this is called the \_\_\_\_ mechanism.

- A. Schultze
- B. Ritgens
- C. Duncan
- D. Marmets

33. When the baby's head is out, the immediate action of the nurse is

- A. Cut the umbilical cord
- B. Wipe the baby's face and suction mouth first
- C. Check if there is cord coiled around the neck
- D. Deliver the anterior shoulder

34. When delivering the baby's head the nurse supports the mother's perineum to prevent tear. This technique is called

- A. Marmet's technique
- B. Ritgen's technique
- C. Duncan maneuver
- D. Schultze maneuver

35. The basic delivery set for normal vaginal delivery includes the following instruments/articles EXCEPT:

- A. 2 clamps
- B. Pair of scissors
- C. Kidney basin

**D. Retractor**

**36. 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**

**37. 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:**

- A. Oxytocin will prevent bleeding**
- B. Oxytocin can make the cervix close and thus trap the placenta inside**
- C. Oxytocin will facilitate placental delivery**
- D. Giving oxytocin will ensure complete delivery of the placenta**

**38. In a gravido-cardiac mother, the first 2 hours postpartum (4th stage of labor and delivery) particularly in a cesarean section is a critical period because at this stage**

- A. There is a fluid shift from the placental circulation to the maternal circulation which can overload the compromised heart.**
- B. The maternal heart is already weak and the mother can die**
- C. The delivery process is strenuous to the mother**
- D. The mother is tired and weak which can distress the heart**

**39. The drug usually given parentally to enhance uterine contraction is:**

- A. Terbutalline**
- B. Pitocin**
- C. Magnesium sulfate**
- D. Lidocaine**

**40. The partograph is a tool used to monitor labor. The maternal parameters measured/monitored are the following EXCEPT:**

- A. Vital signs**
- B. Fluid intake and output**

- C. Uterine contraction
- D. Cervical dilatation

41. The following are natural childbirth procedures EXCEPT:

- A. Lamaze method
- B. Dick-Read method
- C. Ritgen's maneuver
- D. Psychoprophylactic method

42. The following are common causes of dysfunctional labor. Which of these can a nurse, on her own manage?

- A. Pelvic bone contraction
- B. Full bladder
- C. Extension rather than flexion of the head
- D. Cervical rigidity

43. At what stage of labor is the mother is advised to bear down?

- A. When the mother feels the pressure at the rectal area
- B. During a uterine contraction
- C. In between uterine contraction to prevent uterine rupture
- D. Anytime the mother feels like bearing down

44. The normal dilatation of the cervix during the first stage of labor in a nullipara is

- A. 1.2 cm./hr
- B. 1.5 cm./hr.
- C. 1.8 cm./hr
- D. 2.0 cm./hr

45. When the fetal head is at the level of the ischial spine, it is said that the station of the head is

- A. Station -1
- B. Station "0"
- C. Station +1
- D. Station +2

46. During an internal examination, the nurse palpated the posterior fontanel to be at the left side of the mother at the upper quadrant. The interpretation is that the position of the fetus is:

- A. LOA
- B. ROP
- C. LOP
- D. ROA

47. The following are types of breech presentation EXCEPT:

- A. Footling
- B. Frank
- C. Complete
- D. Incomplete

48. When the nurse palpates the suprapubic area of the mother and found that the presenting part is still movable, the right term for this observation that the fetus is

- A. Engaged
- B. Descended
- C. Floating
- D. Internal Rotation

49. The placenta should be delivered normally within \_\_\_ minutes after the delivery of the baby.

- A. 5 minutes
- B. 30 minutes
- C. 45 minutes
- D. 60 minutes

50. When shaving a woman in preparation for cesarean section, the area to be shaved should be from \_\_\_ to \_\_\_

- A. Under breast to mid-thigh including the pubic area
- B. The umbilicus to the mid-thigh
- C. Xyphoid process to the pubic area
- D. Above the umbilicus to the pubic area

Answers and Rationales

1. Answer: (B) Maternal cardiac condition. In general, when the heart is compromised such as in maternal cardiac condition, the condition can lead to less blood supply to the uterus consequently to the placenta which provides the fetus with the essential nutrients and oxygen. Thus if the blood supply is less, the baby will suffer from chronic hypoxia leading to a small-for-gestational age condition.
2. Answer: (A) 21-24 weeks. Viability means the capability of the fetus to live/survive outside of the uterine environment. With the present technological and medical advances, 21 weeks AOG is considered as the minimum fetal age for viability.
3. Answer: (A) Article II section 12. The Philippine Constitution of 1987 guarantees the right of the unborn child from conception equal to the mother as stated in Article II State Policies, Section 12.
4. Answer: (B) Abortion is both immoral and illegal in our country. Induced Abortion is illegal in the country as stated in our Penal Code and any person who performs the act for a fee commits a grave offense punishable by 10-12 years of imprisonment.
5. Answer: (C) To make the delivery effort free and the mother does not need to push with contractions. Forceps delivery under epidural anesthesia will make the delivery process less painful and require less effort to push for the mother. Pushing requires more effort which a compromised heart may not be able to endure.
6. Answer: (D) Uterine contractions are strong and the baby will not be delivered yet within the next 3 hours.. Narcotic analgesics must be given when uterine contractions are already well established so that it will not cause stoppage of the contraction thus protracting labor. Also, it should be given when delivery of fetus is imminent or too close because the fetus may suffer respiratory depression as an effect of the drug that can pass through placental barrier.
7. Answer: (C) The active phase of Stage 1 is protracted. The active phase of Stage I starts from 4cm cervical dilatation and is expected that the uterus will dilate by 1cm every hour. Since the time lapsed is already 2 hours, the dilatation is expected to be already 8 cm. Hence, the active phase is protracted.
8. Answer: (B) Strongly tugging on the umbilical cord to deliver the placenta and hasten placental separation. When the placenta is still attached to the uterine wall, tugging on the cord while the uterus is relaxed can lead to inversion of the uterus. Light tugging on the cord when placenta has detached is alright in order to help deliver the placenta that is already detached.
9. Answer: (B) Determine if cord compression followed the rupture. After the rupture of the bag of waters, the cord may also go with the water because of the pressure of the rupture and flow. If the cord goes out of the cervical opening, before the head is delivered (cephalic presentation), the head can compress on the cord causing fetal distress. Fetal distress can be detected

through the fetal heart tone. Thus, it is essential do check the FHB right after rupture of bag to ensure that the cord is not being compressed by the fetal head.

10. Answer: (D) Hemorrhage secondary to uterine atony. All the signs in the stem of the question are signs of hemorrhage. If the fundus is soft and boundaries not well defined, the cause of the hemorrhage could be uterine atony.
11. Answer: (C) The pre-contraction FHR is 130 bpm, FHR during contraction is 118 bpm and FHR after uterine contraction is 126 bpm. The normal range of FHR is 120-160 bpm, strong and regular. During a contraction, the FHR usually goes down but must return to its pre-contraction rate after the contraction ends.
12. Answer: (D) 1,2,3,4. all the above conditions can occur following a precipitate labor and delivery of the fetus because there was little time for the baby to adapt to the passageway. If the presentation is cephalic, the fetal head serves as the main part of the fetus that pushes through the birth canal which can lead to cranial hematoma, and possible compression of cord may occur which can lead to less blood and oxygen to the fetus (hypoxia). Likewise the maternal passageway (cervix, vaginal canal and perineum) did not have enough time to stretch which can lead to laceration.
13. Answer: (C) Uterine contraction. Uterine contraction is the primary force that will expel the fetus out through the birth canal Maternal bearing down is considered the secondary power/force that will help push the fetus out.
14. Answer: (C) Put the tip of the fingers lightly on the fundal area and try to indent the abdominal wall at the height of the contraction. In monitoring the intensity of the contraction the best place is to place the fingertips at the fundal area. The fundus is the contractile part of the uterus and the fingertips are more sensitive than the palm of the hand.
15. Answer: (B) From the beginning of one contraction to the beginning of the next contraction. Frequency of the uterine contraction is defined as from the beginning of one contraction to the beginning of another contraction.
16. Answer: (B) Acme. Acme is the technical term for the highest point of intensity of a uterine contraction.
17. Answer: (A) The beginning of one contraction to the end of the same contraction. Duration of a uterine contraction refers to one contraction. Thus it is correctly measure from the beginning of one contraction to the end of the same contraction and not of another contraction.
18. Answer: (A) Clear as water. The normal color of amniotic fluid is clear like water. If it is yellowish, there is probably Rh incompatibility. If the color is greenish, it is probably meconium stained.
19. Answer: (C) Cover the prolapse cord with sterile gauze wet with sterile NSS and place the woman on trendellenberg position. The correct action of the nurse is to cover the cord with sterile gauze wet with sterile NSS. Observe strict asepsis in the care of the cord to prevent infection. The cord has to be kept moist to prevent it from drying. Don't attempt to put back the cord into

the vagina but relieve pressure on the cord by positioning the mother either on trendellenberg or sims position

20. Answer: (A) The heart rate will decelerate during a contraction and then go back to its pre-contraction rate after the contraction. The normal fetal heart rate will decelerate (go down) slightly during a contraction because of the compression on the fetal head. However, the heart rate should go back to the pre-contraction rate as soon as the contraction is over since the compression on the head has also ended.
21. Answer: (B) Descent, flexion, internal rotation, extension, external rotation. The mechanism of fetal delivery begins with descent into the pelvic inlet which may occur several days before true labor sets in the primigravida. Flexion, internal rotation and extension are mechanisms that the fetus must perform as it accommodates through the passageway/birth canal. External rotation is done after the head is delivered so that the shoulders will be easily delivered through the vaginal introitus.
22. Answer: (B) No part of the cord is encircling the baby's neck. The nurse should check right away for possible cord coil around the neck because if it is present, the baby can be strangulated by it and the fetal head will have difficulty being delivered.
23. Answer: (A) Suction the nose and mouth to remove mucous secretions. Suctioning the nose and mouth of the fetus as soon as the head is delivered will remove any obstruction that maybe present allowing for better breathing. Also, if mucus is in the nose and mouth, aspiration of the mucus is possible which can lead to aspiration pneumonia. (Remember that only the baby's head has come out as given in the situation.)
24. Answer: (D) Paint the inner thighs going towards the perineal area. Painting of the perineal area in preparation for delivery of the baby must always be done but the stroke should be from the perineum going outwards to the thighs. The perineal area is the one being prepared for the delivery and must be kept clean
25. Answer: (A) 1 and 3. The nurse after delivering the placenta must ensure that all the cotyledons and the membranes of the placenta are complete. Also, the nurse must check if the umbilical cord is normal which means it contains the 3 blood vessels, 2 veins and 1 artery.
26. Answer: (B) The duration of contraction progressively lengthens over time. In false labor, the contractions remain to be irregular in intensity and duration while in true labor, the contractions become stronger, longer and more frequent.
27. Answer: (D) Flexibility of the pelvis. The pelvis is a bony structure that is part of the passageway but is not flexible. The lower uterine segment including the cervix as well as the vaginal canal and introitus are all part of the passageway in the delivery of the fetus.
28. Answer: (A) 2 arteries and 1 vein. The umbilical cord is composed of 2 arteries and 1 vein.

29. Answer: (A) Stage 1. In stage 1 during a normal vaginal delivery of a vertex presentation, the multigravida may have about 8 hours labor while the primigravida may have up to 12 hours labor.
30. Answer: (C) Begins with complete dilatation and effacement of cervix and ends with delivery of baby. Stage 2 of labor and delivery process begins with full dilatation of the cervix and ends with the delivery of baby. Stage 1 begins with true labor pains and ends with full dilatation and effacement of the cervix.
31. Answer: (D) Mother feels like bearing down. Placental detachment does not require the mother to bear down. A normal placenta will detach by itself without any effort from the mother.
32. Answer: (A) Schultze. There are 2 mechanisms possible during the delivery of the placenta. If the shiny portion comes out first, it is called the Schultze mechanism; while if the meaty portion comes out first, it is called the Duncan mechanism.
33. Answer: (C) Check if there is cord coiled around the neck. The nurse should check if there is a cord coil because the baby will not be delivered safely if the cord is coiled around its neck. Wiping of the face should be done seconds after you have ensured that there is no cord coil but suctioning of the nose should be done after the mouth because the baby is a "nasal obligate" breather. If the nose is suctioned first before the mouth, the mucus plugging the mouth can be aspirated by the baby.
34. Answer: (B) Ritgen's technique. Ritgen's technique is done to prevent perineal tear. This is done by the nurse by support the perineum with a sterile towel and pushing the perineum downward with one hand while the other hand is supporting the baby's head as it goes out of the vaginal opening.
35. Answer: (D) Retractor. For normal vaginal delivery, the nurse needs only the instruments for cutting the umbilical cord such as: 2 clamps (straight or curve) and a pair of scissors as well as the kidney basin to receive the placenta. The retractor is not part of the basic set. In the hospital setting, needle holder and tissue forceps are added especially if the woman delivering the baby is a primigravida wherein episiotomy is generally done.
36. Answer: (A) Inspect the placenta for completeness including the membranes. The placenta must be inspected for completeness to include the membranes because an incomplete placenta could mean that there is retention of placental fragments which can lead to uterine atony. If the uterus does not contract adequately, hemorrhage can occur.
37. Answer: (B) Oxytocin can make the cervix close and thus trap the placenta inside. The action of oxytocin is to make the uterus contract as well make the cervix close. If it is given prior to placental delivery, the placenta will be trapped inside because the action of the drug is almost immediate if given parentally.
38. Answer: (A) There is a fluid shift from the placental circulation to the maternal circulation which can overload the compromised heart.. During the

pregnancy, there is an increase in maternal blood volume to accommodate the need of the fetus. When the baby and placenta have been delivered, there is a fluid shift back to the maternal circulation as part of physiologic adaptation during the postpartum period. In cesarean section, the fluid shift occurs faster because the placenta is taken out right after the baby is delivered giving it less time for the fluid shift to gradually occur.

39. Answer: (B) Pitocin. The common oxytocin given to enhance uterine contraction is pitocin. This is also the drug given to induce labor.
40. Answer: (B) Fluid intake and output. Partograph is a monitoring tool designed by the World Health Organization for use by health workers when attending to mothers in labor especially the high risk ones. For maternal parameters all of the above is placed in the partograph except the fluid intake since this is placed in a separate monitoring sheet.
41. Answer: (C) Ritgen's maneuver. Ritgen's method is used to prevent perineal tear/laceration during the delivery of the fetal head. Lamaze method is also known as psychoprophylactic method and Dick-Read method are commonly known natural childbirth procedures which advocate the use of non-pharmacologic measures to relieve labor pain.
42. Answer: (B) Full bladder. Full bladder can impede the descent of the fetal head. The nurse can readily manage this problem by doing a simple catheterization of the mother.
43. Answer: (B) During a uterine contraction. The primary power of labor and delivery is the uterine contraction. This should be augmented by the mother's bearing down during a contraction.
44. Answer: (A) 1.2 cm./hr. For nullipara the normal cervical dilatation should be 1.2 cm/hr. If it is less than that, it is considered a protracted active phase of the first stage. For multipara, the normal cervical dilatation is 1.5 cm/hr.
45. Answer: (B) Station "0". Station is defined as the relationship of the fetal head and the level of the ischial spine. At the level of the ischial spine, the station is "0". Above the ischial spine it is considered (-) station and below the ischial spine it is (+) station.
46. Answer: (A) LOA. The landmark used in determine fetal position is the posterior fontanel because this is the nearest to the occiput. So if the nurse palpated the occiput (O) at the left (L) side of the mother and at the upper/anterior (A) quadrant then the fetal position is LOA.
47. Answer: (D) Incomplete. Breech presentation means the buttocks of the fetus is the presenting part. If it is only the foot/feet, it is considered footling. If only the buttocks, it is frank breech. If both the feet and the buttocks are presenting it is called complete breech.
48. Answer: (C) Floating. The term floating means the fetal presenting part has not entered/descended into the pelvic inlet. If the fetal head has entered the pelvic inlet, it is said to be engaged.

49. Answer: (B) 30 minutes. The placenta is delivered within 30 minutes from the delivery of the baby. If it takes longer, probably the placenta is abnormally adherent and there is a need to refer already to the obstetrician.
50. Answer: (A) Under breast to mid-thigh including the pubic area. Shaving is done to prevent infection and the area usually shaved should sufficiently cover the area for surgery, cesarean section. The pubic hair is definitely to be included in the shaving

#### MIDWIFERY 6

1. Postpartum Period: The fundus of the uterus is expected to go down normally postpartally about \_\_\_ cm per day.

- A. cm
- B. 2.0 cm
- C. 2.5 cm
- D. 3.0 cm

2. 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

3. Lochia normally disappears after how many days postpartum?

- A. 5 days
- B. 7-10 days
- C. 18-21 days
- D. 28-30 days

4. After an Rh(-) mother has delivered her Rh (+) baby, the mother is given RhoGam. This is done in order to:

- A. Prevent the recurrence of Rh(+) baby in future pregnancies
- B. Prevent the mother from producing antibodies against the Rh(+) antigen that she may have gotten when she delivered to her Rh(+) baby
- C. Ensure that future pregnancies will not lead to maternal illness
- D. To prevent the newborn from having problems of incompatibility when it breastfeeds

5. To enhance milk production, a lactating mother must do the following interventions EXCEPT:

- A. Increase fluid intake including milk
- B. Eat foods that increases lactation which are called galactagues
- C. Exercise adequately like aerobics
- D. Have adequate nutrition and rest

6. The nursing intervention to relieve pain in breast engorgement while the mother continues to breastfeed is

- A. Apply cold compress on the engorged breast
- B. Apply warm compress on the engorged breast
- C. Massage the breast
- D. Apply analgesic ointment

7. A woman who delivered normally per vagina is expected to void within \_\_\_ hours after delivery.

- A. 3 hrs
- B. 4 hrs.
- C. 6-8 hrs
- D. 12-24 hours

8. 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

9. An appropriate nursing intervention when caring for a postpartum mother with thrombophlebitis is:

- A. Encourage the mother to ambulate to relieve the pain in the leg
- B. Instruct the mother to apply elastic bondage from the foot going towards the knee to improve venous return flow
- C. Apply warm compress on the affected leg to relieve the pain
- D. Elevate the affected leg and keep the patient on bedrest

10. The nurse should anticipate that hemorrhage related to uterine atony may occur postpartally if this condition was present during the delivery:

- A. Excessive analgesia was given to the mother
- B. Placental delivery occurred within thirty minutes after the baby was born
- C. An episiotomy had to be done to facilitate delivery of the head
- D. The labor and delivery lasted for 12 hours

11. According to Rubin's theory of maternal role adaptation, the mother will go through 3 stages during the post partum period. These stages are:

- A. Going through, adjustment period, adaptation period
- B. Taking-in, taking-hold and letting-go
- C. Attachment phase, adjustment phase, adaptation phase
- D. Taking-hold, letting-go, attachment phase

12. The neonate of a mother with diabetes mellitus is prone to developing hypoglycemia because:

- A. The pancreas is immature and unable to secrete the needed insulin

- B. There is rapid diminution of glucose level in the baby's circulating blood and his pancreas is normally secreting insulin
  - C. The baby is reacting to the insulin given to the mother
  - D. His kidneys are immature leading to a high tolerance for glucose
13. Which of the following is an abnormal vital sign in postpartum?
- A. Pulse rate between 50-60/min
  - B. BP diastolic increase from 80 to 95mm Hg
  - C. BP systolic between 100-120mm Hg
  - D. Respiratory rate of 16-20/min
14. The uterine fundus right after delivery of placenta is palpable at
- A. Level of Xyphoid process
  - B. Level of umbilicus
  - C. Level of symphysis pubis
  - D. Midway between umbilicus and symphysis pubis
15. 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
16. In a woman who is not breastfeeding, menstruation usually occurs after how many weeks?
- A. 2-4 weeks
  - B. 6-8 weeks
  - C. 6 months
  - D. 12 months
17. The following are nursing measures to stimulate lactation EXCEPT
- A. Frequent regular breast feeding
  - B. Breast pumping
  - C. Breast massage
  - D. Application of cold compress on the breast

18. When the uterus is firm and contracted after delivery but there is vaginal bleeding, the nurse should suspect

- A. Laceration of soft tissues of the cervix and vagina
- B. Uterine atony
- C. Uterine inversion
- D. Uterine hypercontractility

19. The following are interventions to make the fundus contract postpartally EXCEPT

- A. Make the baby suck the breast regularly
- B. Apply ice cap on fundus
- C. Massage the fundus vigorously for 15 minutes until contracted
- D. Give oxytocin as ordered

20. The following are nursing interventions to relieve episiotomy wound pain EXCEPT

- A. Giving analgesic as ordered
- B. Sitz bath
- C. Perineal heat
- D. Perineal care

21. Postpartum blues is said to be normal provided that the following characteristics are present. These are

- 1. Within 3-10 days only;
- 2. Woman exhibits the following symptoms- episodic tearfulness, fatigue, oversensitivity, poor appetite;
- 3. Maybe more severe symptoms in primipara
  - A. All of the above
  - B. 1 and 2
  - C. 2 only
  - D. 2 and 3

22. The neonatal circulation differs from the fetal circulation because

- A. The fetal lungs are non-functioning as an organ and most of the blood in the fetal circulation is mixed blood.
- B. The blood at the left atrium of the fetal heart is shunted to the right atrium to facilitate its passage to the lungs

- C. The blood in left side of the fetal heart contains oxygenated blood while the blood in the right side contains unoxygenated blood.
  - D. None of the above
23. The normal respiration of a newborn immediately after birth is characterized as:
- A. Shallow and irregular with short periods of apnea lasting not longer than 15 seconds, 30-60 breaths per minute
  - B. 20-40 breaths per minute, abdominal breathing with active use of intercostals muscles
  - C. 30-60 breaths per minute with apnea lasting more than 15 seconds, abdominal breathing
  - D. 30-50 breaths per minute, active use of abdominal and intercostal muscles
24. The anterior fontanelle is characterized as:
- A. 3-4 cm antero-posterior diameter and 2-3 cm transverse diameter, diamond shape
  - B. 2-3 cm antero-posterior diameter and 3-4 cm transverse diameter and diamond shape
  - C. 2-3 cm in both antero-posterior and transverse diameter and diamond shape
  - D. none of the above
25. The ideal site for vitamin K injection in the newborn is:
- A. Right upper arm
  - B. Left upper arm
  - C. Either right or left buttocks
  - D. Middle third of the thigh
26. At what APGAR score at 5 minutes after birth should resuscitation be initiated?
- A. 1-3
  - B. 7-8
  - C. 9-10
  - D. 6-7
27. Right after birth, when the skin of the baby's trunk is pinkish but the soles of the feet and palm of the hands are bluish this is called:
- A. Syndactyly

- B. Acrocyanosis
- C. Peripheral cyanosis
- D. Cephalo-caudal cyanosis

28. The minimum birth weight for full term babies to be considered normal is:

- A. 2,000gms
- B. 1,500gms
- C. 2,500gms
- D. 3,000gms

29. The procedure done to prevent ophthalmia neonatorum is:

- A. Marmet's technique
- B. Crede's method
- C. Ritgen's method
- D. Ophthalmic wash

30. Which of the following characteristics will distinguish a postmature neonate at birth?

- A. Plenty of lanugo and vernix caseosa
- B. Lanugo mainly on the shoulders and vernix in the skin folds
- C. Pinkish skin with good turgor
- D. Almost leather-like, dry, cracked skin, negligible vernix caseosa

31. According to the Philippine Nursing Law, a registered nurse is allowed to handle mothers in labor and delivery with the following considerations:

1. The pregnancy is normal.;
  2. The labor and delivery is uncomplicated;
  3. Suturing of perineal laceration is allowed provided the nurse had special training;
  4. As a delivery room nurse she is not allowed to insert intravenous fluid unless she had special training for it.
- A. 1 and 2
  - B. 1, 2, and 3
  - C. 3 and 4
  - D. 1, 2, and 4

32. Birth Control Methods and Infertility: In basal body temperature (BBT) technique, the sign that ovulation has occurred is an elevation of body temperature by

- A. 1.0-1.4 degrees centigrade
- B. 0.2-0.4 degrees centigrade
- C. 2.0-4.0 degrees centigrade
- D. 1.0-4.0 degrees centigrade

33. Lactation Amenorrhea Method(LAM) can be an effective method of natural birth control if

- A. The mother breast feeds mainly at night time when ovulation could possibly occur
- B. The mother breastfeeds exclusively and regularly during the first 6 months without giving supplemental feedings
- C. The mother uses mixed feeding faithfully
- D. The mother breastfeeds regularly until 1 year with no supplemental feedings

34. Intra-uterine device prevents pregnancy by the ff. mechanism EXCEPT

- A. Endometrium inflames
- B. Fundus contracts to expel uterine contents
- C. Copper embedded in the IUD can kill the sperms
- D. Sperms will be barred from entering the fallopian tubes

35. Oral contraceptive pills are of different types. Which type is most appropriate for mothers who are breastfeeding?

- A. Estrogen only
- B. Progesterone only
- C. Mixed type- estrogen and progesterone
- D. 21-day pills mixed type

36. The natural family planning method called Standard Days (SDM), is the latest type and easy to use method. However, it is a method applicable only to women with regular menstrual cycles between \_\_\_ to \_\_\_ days.

- A. 21-26 days
- B. 26-32 days
- C. 28-30 days
- D. 24- 36 days

37. Which of the following are signs of ovulation?

1. Mittelschmerz;
  2. Spinnbarkeit;
  3. Thin watery cervical mucus;
  4. Elevated body temperature of 4.0 degrees centigrade
- A. 1 & 2
  - B. 1, 2, & 3
  - C. 3 & 4
  - D. 1, 2, 3, 4

38. The following methods of artificial birth control works as a barrier device EXCEPT:

- A. Condom
- B. Cervical cap
- C. Cervical Diaphragm
- D. Intrauterine device (IUD)

39. Which of the following is a TRUE statement about normal ovulation?

- A. It occurs on the 14th day of every cycle
- B. It may occur between 14-16 days before next menstruation
- C. Every menstrual period is always preceded by ovulation
- D. The most fertile period of a woman is 2 days after ovulation

40. If a couple would like to enhance their fertility, the following means can be done:

1. Monitor the basal body temperature of the woman everyday to determine peak period of fertility;
  2. Have adequate rest and nutrition;
  3. Have sexual contact only during the dry period of the woman;
  4. Undergo a complete medical check-up to rule out any debilitating disease
- A. 1 only
  - B. 1 & 4
  - C. 1,2,4
  - D. 1,2,3,4

41. In sympto-thermal method, the parameters being monitored to determine if the woman is fertile or infertile are:

- A. Temperature, cervical mucus, cervical consistency
- B. Release of ovum, temperature and vagina

- C. Temperature and wetness
- D. Temperature, endometrial secretion, mucus

42. The following are important considerations to teach the woman who is on low dose (mini-pill) oral contraceptive EXCEPT:

- A. The pill must be taken everyday at the same time
- B. If the woman fails to take a pill in one day, she must take 2 pills for added protection
- C. If the woman fails to take a pill in one day, she needs to take another temporary method until she has consumed the whole pack
- D. If she is breast feeding, she should discontinue using mini-pill and use the progestin-only type

43. To determine if the cause of infertility is a blockage of the fallopian tubes, the test to be done is

- A. Huhner's test
- B. Rubin's test
- C. Postcoital test
- D. None of the above

44. Infertility can be attributed to male causes such as the following EXCEPT:

- A. Cryptorchidism
- B. Orchitis
- C. Sperm count of about 20 million per milliliter
- D. Premature ejaculation

45. Spinnbarkeit is an indicator of ovulation which is characterized as:

- A. Thin watery mucus which can be stretched into a long strand about 10 cm
- B. Thick mucus that is detached from the cervix during ovulation
- C. Thin mucus that is yellowish in color with fishy odor
- D. Thick mucus vaginal discharge influence by high level of estrogen

46. Vasectomy is a procedure done on a male for sterilization. The organ involved in this procedure is

- A. Prostate gland
- B. Seminal vesicle

- C. Testes
- D. Vas deferens

47. Breast self examination is best done by the woman on herself every month during

- A. The middle of her cycle to ensure that she is ovulating
- B. During the menstrual period
- C. Right after the menstrual period so that the breast is not being affected by the increase in hormones particularly estrogen
- D. Just before the menstrual period to determine if ovulation has occurred

48. A woman is considered to be menopause if she has experienced cessation of her menses for a period of

- A. 6 months
- B. 12 months
- C. 18 months
- D. 24 months

49. Which of the following is the correct practice of self breast examination in a menopausal woman?

- A. She should do it at the usual time that she experiences her menstrual period in the past to ensure that her hormones are not at its peak
- B. Any day of the month as long it is regularly observed on the same day every month
- C. Anytime she feels like doing it ideally every day
- D. Menopausal women do not need regular self breast exam as long as they do it at least once every 6 months

50. In assisted reproductive technology (ART), there is a need to stimulate the ovaries to produce more than one mature ova. The drug commonly used for this purpose is:

- A. Bromocriptine
- B. Clomiphene
- C. Provera
- D. Estrogen

Answers and Rationales

1. Answer: (A) 1.0 cm. The uterus will begin involution right after delivery. It is expected to regress/go down by 1 cm. per day and becomes no longer palpable about 1 week after delivery.
2. Answer: (C) Reddish with some mucus. Right after delivery, the vaginal discharge called lochia will be reddish because there is some blood, endometrial tissue and mucus. Since it is not pure blood it is non-clotting.
3. Answer: (B) 7-10 days. Normally, lochia disappears after 10 days postpartum. What's important to remember is that the color of lochia gets to be lighter (from reddish to whitish) and scantier everyday.
4. Answer: (B) Prevent the mother from producing antibodies against the Rh(+) antigen that she may have gotten when she delivered to her Rh(+) baby. In Rh incompatibility, an Rh(-) mother will produce antibodies against the fetal Rh (+) antigen which she may have gotten because of the mixing of maternal and fetal blood during labor and delivery. Giving her RhoGam right after birth will prevent her immune system from being permanently sensitized to Rh antigen.
5. Answer: (C) Exercise adequately like aerobics. All the above nursing measures are needed to ensure that the mother is in a healthy state. However, aerobics does not necessarily enhance lactation.
6. Answer: (B) Apply warm compress on the engorged breast. Warm compress is applied if the purpose is to relieve pain but ensure lactation to continue. If the purpose is to relieve pain as well as suppress lactation, the compress applied is cold.
7. Answer: (C) 6-8 hrs. A woman who has had normal delivery is expected to void within 6-8 hrs. If she is unable to do so after 8 hours, the nurse should stimulate the woman to void. If nursing interventions to stimulate spontaneous voiding don't work, the nurse may decide to catheterize the woman.
8. Answer: (A) Breast feed the baby on self-demand day and night. Feeding on self-demand means the mother feeds the baby according to baby's need. Therefore, this means there will be regular emptying of the breasts, which is essential to maintain adequate lactation.
9. Answer: (D) Elevate the affected leg and keep the patient on bedrest. If the mother already has thrombophlebitis, the nursing intervention is bedrest to prevent the possible dislodging of the thrombus and keeping the affected leg elevated to help reduce the inflammation.
10. Answer: (A) Excessive analgesia was given to the mother. Excessive analgesia can lead to uterine relaxation thus lead to hemorrhage postpartally. Both B and D are normal and C is at the vaginal introitus thus will not affect the uterus.
11. Answer: (B) Taking-in, taking-hold and letting-go. Rubin's theory states that the 3 stages that a mother goes through for maternal adaptation are: taking-in, taking-hold and letting-go. In the taking-in stage, the mother is more passive and dependent on others for care. In taking-hold, the mother begins

to assume a more active role in the care of the child and in letting-go, the mother has become adapted to her maternal role.

12. Answer: (B) There is rapid diminution of glucose level in the baby's circulating blood and his pancreas is normally secreting insulin. If the mother is diabetic, the fetus while in utero has a high supply of glucose. When the baby is born and is now separate from the mother, it no longer receives a high dose of glucose from the mother. In the first few hours after delivery, the neonate usually does not feed yet thus this can lead to hypoglycemia.
13. Answer: (B) BP diastolic increase from 80 to 95mm Hg. All the vital signs given in the choices are within normal range except an increase of 15mm Hg in the diastolic which is a possible sign of hypertension in pregnancy.
14. Answer: (B) Level of umbilicus. Immediately after the delivery of the placenta, the fundus of the uterus is expected to be at the level of the umbilicus because the contents of the pregnancy have already been expelled. The fundus is expected to recede by 1 fingerbreadths (1cm) everyday until it becomes no longer palpable above the symphysis pubis.
15. Answer: (C) 6 weeks. According to the DOH protocol postpartum check-up is done 6-8 weeks after delivery to make sure complete involution of the reproductive organs has been achieved.
16. Answer: (B) 6-8 weeks. When the mother does not breastfeed, the normal menstruation resumes about 6-8 weeks after delivery. This is due to the fact that after delivery, the hormones estrogen and progesterone gradually decrease thus triggering negative feedback to the anterior pituitary to release the Folicle-Stimulating Hormone (FSH) which in turn stimulates the ovary to again mature a graafian follicle and the menstrual cycle post pregnancy resumes.
17. Answer: (D) Application of cold compress on the breast. To stimulate lactation, warm compress is applied on the breast. Cold application will cause vasoconstriction thus reducing the blood supply consequently the production of milk.
18. Answer: (A) Laceration of soft tissues of the cervix and vagina. When uterus is firm and contracted it means that the bleeding is not in the uterus but other parts of the passageway such as the cervix or the vagina.
19. Answer: (C) Massage the fundus vigorously for 15 minutes until contracted. Massaging the fundus of the uterus should not be vigorous and should only be done until the uterus feel firm and contracted. If massaging is vigorous and prolonged, the uterus will relax due to over stimulation.
20. Answer: (D) Perineal care. Perineal care is primarily done for personal hygiene regardless of whether there is pain or not; episiotomy wound or not.
21. Answer: (A) All of the above. All the symptoms 1-3 are characteristic of postpartal blues. It will resolve by itself because it is transient and is due to a number of reasons like changes in hormonal levels and adjustment to motherhood. If symptoms lasts more than 2 weeks, this could be a sign of abnormality like postpartum depression and needs treatment.

22. Answer: (A) The fetal lungs are non-functioning as an organ and most of the blood in the fetal circulation is mixed blood.. The fetal lungs is fluid-filled while in utero and is still not functioning. It only begins to function in extra uterine life. Except for the blood as it enters the fetus immediately from the placenta, most of the fetal blood is mixed blood.
23. Answer: (A) Shallow and irregular with short periods of apnea lasting not longer than 15 seconds, 30-60 breaths per minute. A newly born baby still is adjusting to xtra uterine life and the lungs are just beginning to function as a respiratory organ. The respiration of the baby at this time is characterized as usually shallow and irregular with short periods of apnea, 30-60 breaths per minute. The apneic periods should be brief lasting not more than 15 seconds otherwise it will be considered abnormal.
24. Answer: (A) 3-4 cm antero-posterior diameter and 2-3 cm transverse diameter, diamond shape. The anterior fontanelle is diamond shape with the antero-posterior diameter being longer than the transverse diameter. The posterior fontanelle is triangular shape.
25. Answer: (D) Middle third of the thigh. Neonates do not have well developed muscles of the arm. Since Vitamin K is given intramuscular, the site must have sufficient muscles like the middle third of the thigh.
26. Answer: (A) 1-3. An APGAR of 1-3 is a sign of fetal distress which requires resuscitation. The baby is alright if the score is 8-10.
27. Answer: (B) Acrocyanosis. Acrocyanosis is the term used to describe the baby's skin color at birth when the soles and palms are bluish but the trunk is pinkish.
28. Answer: (C) 2,500gms. According to the WHO standard, the minimum normal birth weight of a full term baby is 2,500 gms or 2.5 Kg.
29. Answer: (B) Crede's method. Crede's method/prophylaxis is the procedure done to prevent ophthalmia neonatorum which the baby can acquire as it passes through the birth canal of the mother. Usually, an ophthalmic ointment is used.
30. Answer: (D) Almost leather-like, dry, cracked skin, negligible vernix caseosa. A post mature fetus has the appearance of an old person with dry wrinkled skin and the vernix caseosa has already diminished.
31. Answer: (B) 1, 2, and 3. To be allowed to handle deliveries, the pregnancy must be normal and uncomplicated. And in RA9172, the nurse is now allowed to suture perineal lacerations provided s/he has had the special training. Also, in this law, there is no longer an explicit provision stating that the nurse still needs special training for IV insertion.
32. Answer: (B) 0.2-0.4 degrees centigrade. The release of the hormone progesterone in the body following ovulation causes a slight elevation of basal body temperature of about 0.2 – 0.4 degrees centigrade
33. Answer: (B) The mother breastfeeds exclusively and regularly during the first 6 months without giving supplemental feedings. A mother who breastfeeds exclusively and regularly during the first 6 months benefits from lactation

amenorrhea. There is evidence to support the observation that the benefits of lactation amenorrhea lasts for 6 months provided the woman has not had her first menstruation since delivery of the baby.

34. Answer: (D) Sperms will be barred from entering the fallopian tubes. An intrauterine device is a foreign body so that if it is inserted into the uterine cavity the initial reaction is to produce inflammatory process and the uterus will contract in order to try to expel the foreign body. Usually IUDs are coated with copper to serve as spermicide killing the sperms deposited into the female reproductive tract. But the IUD does not completely fill up the uterine cavity thus sperms which are microscopic is size can still pass through.
35. Answer: (B) Progesterone only. If mother is breastfeeding, the progesterone only type is the best because estrogen can affect lactation.
36. Answer: (B) 26-32 days. Standard Days Method (SDM) requires that the menstrual cycles are regular between 26-32 days. There is no need to monitor temperature or mucus secretion. This natural method of family planning is very simple since all that the woman pays attention to is her cycle. With the aid of CycleBeads, the woman can easily monitor her cycles.
37. Answer: (B) 1, 2, & 3. Mittelschmerz, spinnbarkeit and thin watery cervical mucus are signs of ovulation. When ovulation occurs, the hormone progesterone is released which can cause a slight elevation of temperature between 0.2-0.4 degrees centigrade and not 4 degrees centigrade.
38. Answer: (D) Intrauterine device (IUD). Intrauterine device prevents pregnancy by not allowing the fertilized ovum from implanting on the endometrium. Some IUDs have copper added to it which is spermicidal. It is not a barrier since the sperms can readily pass through and fertilize an ovum at the fallopian tube.
39. Answer: (B) It may occur between 14-16 days before next menstruation. Not all menstrual cycles are ovulatory. Normal ovulation in a woman occurs between the 14th to the 16th day before the NEXT menstruation. A common misconception is that ovulation occurs on the 14th day of the cycle. This is a misconception because ovulation is determined NOT from the first day of the cycle but rather 14-16 days BEFORE the next menstruation.
40. Answer: (C) 1,2,4. All of the above are essential for enhanced fertility except no. 3 because during the dry period the woman is in her infertile period thus even when sexual contact is done, there will be no ovulation, thus fertilization is not possible.
41. Answer: (A) Temperature, cervical mucus, cervical consistency. The 3 parameters measured/monitored which will indicate that the woman has ovulated are- temperature increase of about 0.2-0.4 degrees centigrade, softness of the cervix and cervical mucus that looks like the white of an egg which makes the woman feel "wet".
42. Answer: (B) If the woman fails to take a pill in one day, she must take 2 pills for added protection. If the woman fails to take her usual pill for the day, taking a double dose does not give additional protection. What she needs to

do is to continue taking the pills until the pack is consumed and use at the time another temporary method to ensure that no pregnancy will occur. When a new pack is started, she can already discontinue using the second temporary method she employed.

43. Answer: (B) Rubin's test. Rubin's test is a test to determine patency of fallopian tubes. Huhner's test is also known as post-coital test to determine compatibility of the cervical mucus with sperms of the sexual partner.
44. Answer: (C) Sperm count of about 20 million per milliliter. Sperm count must be within normal in order for a male to successfully sire a child. The normal sperm count is 20 million per milliliter of seminal fluid or 50 million per ejaculate.
45. Answer: (A) Thin watery mucus which can be stretched into a long strand about 10 cm . At the midpoint of the cycle when the estrogen level is high, the cervical mucus becomes thin and watery to allow the sperm to easily penetrate and get to the fallopian tubes to fertilize an ovum. This is called spinnbarkeit. And the woman feels "wet". When progesterone is secreted by the ovary, the mucus becomes thick and the woman will feel "dry".
46. Answer: (D) Vas deferens. Vasectomy is a procedure wherein the vas deferens of the male is ligated and cut to prevent the passage of the sperms from the testes to the penis during ejaculation.
47. Answer: (C) Right after the menstrual period so that the breast is not being affected by the increase in hormones particularly estrogen. The best time to do self breast examination is right after the menstrual period is over so that the hormonal level is low thus the breasts are not tender.
48. Answer: (B) 12 months. If a woman has not had her menstrual period for 12 consecutive months, she is considered to be in her menopausal stage.
49. Answer: (B) Any day of the month as long it is regularly observed on the same day every month. Menopausal women still need to do self examination of the breast regularly. Any day of the month is alright provided that she practices it monthly on the same day that she has chosen. The hormones estrogen and progesterone are already diminished during menopause so there is no need to consider the time to do it in relation to the menstrual cycle.
50. Answer: (B) Clomiphene. Clomiphene or Clomid acts as an ovarian stimulant to promote ovulation. The mature ova are retrieved and fertilized outside the fallopian tube (in-vitro fertilization) and after 48 hours the fertilized ovum is inserted into the uterus for implantation.

**MIDWIFERY 7**

**1. Samantha, a seasoned pediatric nurse, is preparing for the discharge of a term neonate who is just two days old. While conducting her meticulous final physical examination, she scrutinizes the baby's hands and palms. In Samantha's observation, which specific characteristic on the neonate's palms would necessitate additional evaluation?**

- A. Presence of a single, distinct crease running across the palm.**
- B. Numerous intersecting creases scattered over the palm.**
- C. Two dominant creases transversing the breadth of the palm.**
- D. No visible creases found on the surface of the palm.**

**2. A new mother is preparing to take her baby home. During their conversation, she curiously asks Nurse Rachel about the timeline for the closure of her baby's "soft spots". Rachel explains to the mother that the anterior fontanel, one of the infant's 'soft spots,' usually seals by what age range?**

- A. Between 2 to 3 months of age.**
- B. Approximately at 6 to 8 months of age.**
- C. Around the age of 12 to 18 months.**

**D. Typically between 20 to 24 months of age.**

**3. Nurse Alex is performing a physical assessment of a term neonate, while the baby's mother watches with interest. Alex then proceeds to examine the baby's feet, sharing some key details about the typical appearance of sole creases in a newborn. Alex tells the mother that in a term neonate, the creases on the soles of the feet are...?**

**A. Dispersed uniformly over the entirety of the foot.**

**B. Exclusively visible beneath the heels.**

**C. Detected solely near the transverse arch of the foot.**

**D. Not present near the heel area.**

**4. While examining a newborn's eyes, Nurse Jake observes several characteristics: no tear production, different sized corneas, pupils constricting in response to bright light, and red circles visible on the pupils during an ophthalmic examination. Which one of these observations made by Nurse Jake would call for additional investigation?**

**A. Pupil constriction in response to bright light.**

**B. The presence of red circles on the pupils.**

**C. The disparity in the sizes of the corneas.**

**D. Lack of tear production.**

**5. Nurse Lisa has been discussing the neonate's positive Babinski reflex with the mother. She gauges the mother's understanding of this reflex based on the mother's response. Lisa concludes that the mother correctly understands the implications of a positive Babinski reflex when she says it signifies?**

**A. A potential defect in the lower spinal cord.**

**B. Immature coordination of muscles.**

**C. Potential damage to the nerves that supply the feet.**

**D. An immature central nervous system.**

6. Nurse Mark is set to conduct a physical assessment of a 24-hour-old male neonate, who was born through vaginal delivery. He needs to carefully plan the timing of this assessment. When should Mark ideally plan to assess the physical condition of the neonate?

- A. Right after the baby has been fed.
- B. Just before feeding the baby.
- C. After ensuring the baby has been NPO (nothing by mouth) for three hours.
- D. In between the baby's feeding times.

7. Nurse Jacob is performing an assessment of a 24-hour-old male neonate, who was delivered vaginally. He notices a particular swelling on the neonate's scalp that is soft, puffy, and does not cross the suture lines. He knows that this swelling is likely to resolve on its own over time. How should Nurse Jacob correctly document this type of swelling observed on the neonate's scalp that does not cross the suture lines?

- A. As perinatal caput.
- B. As caput succedaneum.
- C. As cephalic hematoma.
- D. As hemorrhage edema.

8. As part of a routine assessment, Nurse Amelia measures the head and chest circumference of the neonate. Afterwards, she explains to the baby's mother about the typical comparison between these two measurements in neonates. Amelia communicates to the mother that, when compared, the neonate's head is generally?

- A. Approximately 4 centimeters larger in circumference than the chest.
- B. Roughly 2 centimeters smaller in circumference than the chest.
- C. Around 2 centimeters larger in circumference than the chest.
- D. Essentially the same size in circumference as the chest.

9. After a conversation with a new mother about cranial molding in neonates, Nurse Anna must evaluate the mother's understanding. She listens carefully to the mother's statements to determine if further explanation is necessary. Which of the following statements from the mother indicates to Nurse Anna that further instructions regarding cranial molding are required?

- A. "The molding occurs due to the cranial bones overlapping each other."
- B. "The molding will fade away within a few days."
- C. "The fontanelles could be damaged if the molding doesn't resolve quickly."
- D. "The extent of the molding is proportional to the amount of pressure exerted on the head."

10. Nurse Ethan is discussing the importance of sensory and visual stimulation with a new mother. During the conversation, he plans to share information about which sense is most developed in a neonate. Ethan informs the mother that the most highly developed sense in a neonate is?

- A. Smell
- B. Hearing
- C. Touch
- D. Taste

11. Nurse Zoe is consulting with a mother who has brought her 4-month-old baby to the clinic. The mother is curious about the right time to transition her baby from breastfeeding to using a cup. Nurse Zoe plans to guide her based on signs of the infant's readiness to be weaned. Zoe advises the mother that the infant will exhibit readiness to be weaned from breastfeeding when the infant starts?

- A. Adhering to a regular eating schedule.
- B. Spending less time nursing.
- C. Sleeping throughout the night without interruptions.
- D. Accepting solid foods without difficulties.

**12. Nurse Laura is advising a mother whose infant, after breastfeeding, refuses to eat the foods recommended by the physician. Laura needs to provide an effective suggestion for modifying the feeding plan. What suggestion should Nurse Laura offer the mother to successfully alter the infant's feeding routine?**

- A. Continue providing breast milk as long as the infant refuses to eat solid food.**
- B. Combine minced food with cow's milk and feed it to the infant using a nipple with a large hole.**
- C. First offer a dessert, followed by vegetables and meat.**
- D. Let the infant breastfeed for a few minutes, then introduce solid food.**

**13. Nurse Liam is conducting a routine developmental assessment of a 4-month-old infant. He is evaluating the baby's progress in mastering certain physical and emotional skills at this stage of development. Which of the following abilities would Nurse Liam anticipate a 4-month-old infant to possess?**

- A. Able to sit up without support.**
- B. Rolls from belly to back.**
- C. Walks while holding onto furniture.**
- D. Speaks in two-word sentences.**

**14. Nurse Emily is preparing to administer the Denver Developmental Screening Test (DDST) to a five-month-old infant. She aims to clarify the purpose of this test to the baby's mother. What should Nurse Emily communicate to the mother about what the DDST assesses in an infant?**

- A. Emotional developmental progress.**
- B. Susceptibility to genetic and allergic conditions.**
- C. Intelligence quotient.**
- D. Progress in social and physical activities.**

**15. Nurse Emma is having a conversation with the mother of a seven-month-old infant about the baby's motor skills development. She explains what the infant**

should typically be able to do at this stage. Emma clarifies that by the age of seven months, an infant is likely able to...?

- A. Sit unassisted, using hands for balance.
- B. Walk with assistance.
- C. Stand while grasping onto furniture.
- D. Feed themselves using a spoon.

16. Nurse Alex is assessing a one-month-old infant who has been brought to the clinic for a check-up. He's evaluating the baby's progress against standard developmental milestones expected at this age. Which of the following developmental accomplishments should Nurse Alex be evaluating for in a one-month-old infant?

- A. The ability to turn the head from side to side.
- B. The capability to roll from the back to the side.
- C. The responses of smiling and laughing out loud.
- D. The skill to briefly hold a rattle.

17. Nurse Jacob is preparing to administer the first DPT immunization to a two-month-old infant who has been brought to the clinic. He needs to choose the appropriate route for this vaccination. Through which route should Nurse Jacob administer the DPT vaccine to the two-month-old infant?

- A. Via the superficial intradermal pathway.
- B. Through the deeper intramuscular route.
- C. By utilizing the oral method.
- D. By opting for the subcutaneous administration route.

18. Nurse Laura is educating a mother about the normal reactions her infant might experience 12 to 24 hours post the DPT immunization. Laura wants to make sure the mother is aware of potential side effects. Laura is discussing with the mother that after the DPT immunization, the infant might experience which of the following normal reactions?

- A. The unfortunate experience of diarrhea.
- B. The uncomfortable condition of nasal congestion.
- C. A noticeable state of lethargy, or unusual sleepiness.
- D. A mild fever, slightly elevated above the normal body temperature.

19. Nurse Max is observing an infant who is proficient in certain developmental skills: the infant stares at objects, can put her hands in her mouth and remove them, coos and gargles while interacting, and supports part of her own weight when held upright. Max is assessing the infant's age based on these skills. Based on these developmental competencies, what age would Nurse Max accurately assess the infant to be?

- A. A relatively young age of two months.
- B. A somewhat more developed age of four months.
- C. A more advanced stage of six months.
- D. A notably older age of eight months.

20. Nurse Lilibeth is talking to a mother who's concerned about the size of the soft spot (anterior fontanel) on her baby's head. The mother is wondering when it will close. Lilibeth is prepared to give the mother an accurate response. What would be Nurse Lilibeth's accurate response to the mother's question about when the soft spot (anterior fontanel) on her baby's head will typically close?

- A. Between 2 to 4 months.
- B. Between 5 to 8 months.
- C. Between 9 to 12 months.
- D. Between 13 to 18 months.

21. Nurse Emma is conversing with a mother who expresses concerns about her 9-month old baby's development, thinking it might be slow. Emma is evaluating the infant's development against normal expectations for a 9-month old. What activity would Nurse Emma not typically expect a normally developing 9-month old infant to be able to do?

- A. Start using imitative verbal expressions.
- B. Creep and crawl.
- C. Insert an arm through a sleeve while being dressed.
- D. Hold a bottle with good hand-mouth coordination.

22. Nurse Michael is talking to a mother who is having difficulties introducing new foods to her 9-month old baby's diet. The baby spits out everything new. Michael is planning to give the mother some advice on this issue. What advice should Nurse Michael give to the mother having trouble adding new foods to her 9-month old baby's diet?

- A. Introduce new foods one at a time.
- B. Serve new foods after offering formula.
- C. Combine new foods with more familiar ones.
- D. Mix new foods with formula.

23. Nurse Kim is evaluating the developmental milestones of an 18-month-old baby, by observing the tasks the baby can typically perform. Which of the following tasks would be typical for an 18-month-old baby?

- A. Playing toys with other children.
- B. Copying a circle.
- C. Pulling toys along while walking.
- D. Building a tower of eight blocks.

24. Nurse Maya is conducting a check-up for a typically developing 3-year-old child brought in by her mother, Riza. Maya is evaluating the child's motor skills against what would be expected for a child of this age. What motor skill would Nurse Maya expect a typically developing 3-year-old child to have at least mastered?

- A. Riding a bicycle.

- B. Tying shoelaces.**
- C. Stringing large beads.**
- D. Using blunt scissors.**

**25. Nurse Ava is providing advice to a mother struggling with toilet training her 2-year-old. She emphasizes the primary reason why toilet training can sometimes fail in toddlers. According to Nurse Ava, what is the primary reason why toilet training often fails in toddlers?**

- A. The child is not developmentally ready to be trained.**
- B. The training equipment used is not suitable.**
- C. The rewards given are too minimal.**
- D. Parents tend to dismiss “accidents” that occur during training.**

**26. Nurse Alex is at the clinic, where a father brings in his 2.5-year-old child who has been expressing fear of the dark and often says “no” when asked to do something. Nurse Alex is tasked with explaining the child’s behavior. Nurse Alex explains to the father that the toddler’s negativism is often an expression of what?**

- A. Separation anxiety.**
- B. Hyperactivity.**
- C. Sibling rivalry.**
- D. The child’s pursuit of autonomy.**

**27. Nurse Rebecca is discussing with a father about his child’s fear of darkness. She refers to Piaget’s cognitive development stages to clarify the reason behind the child’s fear. Nurse Rebecca explains to the father that which Piaget’s concept of cognitive development is underlying the child’s fear of darkness?**

- A. The principle of conservation of matter.**
- B. The understanding of reversibility.**
- C. The concept known as animism.**

**D. The cognitive realization of object permanence.**

**28. Nurse Patricia is having a conversation with a mother who is seeking advice on discipline methods for her child. The nurse, keeping the child's best interest in mind, shares her recommendation. Nurse Patricia suggests that the mother should primarily resort to which of the following disciplinary methods?**

**A. The old-fashioned method of spanking.**

**B. The method of structured interaction, designed to guide behavior.**

**C. The typical approach of scolding or reprimanding.**

**D. The compassionate approach of reasoning and discussion.**

**29. Nurse Marianne is assessing a toddler for potential signs of discomfort or pain. Understanding that toddlers may not express pain verbally, she needs to rely on specific methods. Nurse Marianne knows that which of the following techniques is least effective when assessing pain in toddlers?**

**A. Observing for signs of restlessness.**

**B. Listening for pain cues in their cries.**

**C. Asking them directly about the pain.**

**D. Watching their faces for signs of grimness.**

**30. Nurse Andrew observes that a mother appears frustrated when she talks about her child's tantrums every night at bedtime. She seeks advice on how to make the bedtime routine more pleasant for both of them. What advice should Nurse Andrew give to the mother to help make her child's bedtime more pleasant and less stressful?**

**A. Establish a consistent bedtime and stick to a routine.**

**B. Allow the child to play with toys immediately before bedtime.**

**C. Offer the child a cookie if the bedtime routine is carried out without tantrums.**

**D. Permit the child to stay up later than usual one or two nights a week.**

**31. Nurse Riley is approached by a worried mother in a community health clinic. The mother diligently assists her young daughter with daily toothbrushing and is curious about additional dental care steps. In this situation, how should Nurse Riley best advise the mother about her child's dental health?**

- A. "Even if there aren't any apparent dental issues, it would still be beneficial to have a routine dental check-up."**
- B. "Although dental visits should ideally start earlier, there's no such thing as too late for a first appointment."**
- C. "There's no rush in visiting a dentist until your child starts her schooling."**
- D. "Given that you're ensuring good brushing habits, a dental visit isn't essential at this time."**

**32. Nurse Roselyn is at a community pediatric clinic when a mother, eager to foster her child's autonomy, inquires about the appropriate age to let her child brush her teeth unassisted. What age should Nurse Roselyn advise the mother that her child can start brushing her teeth independently?**

- A. As soon as the first tooth appears.**
- B. At the age of 1.**
- C. At the age of 6.**
- D. At the age of 10.**

**33. Nurse Martin meets a mother at the children's clinic. This mother is concerned about her 4-year-old son's peculiar eating habits, such as leaving meals unfinished and consuming the same meals for several consecutive days. She's eager to create a strategy to manage this situation. When creating this plan, what factor should Nurse Martin and the mother take into consideration?**

- A. Prohibiting him from engaging in playtime with friends until he consumes all the served food.**
- B. Enforcing a rule that he must eat the meals served during mealtimes.**
- C. Establishing a suitable reward system for meal completion.**
- D. Giving him the autonomy to make some choices about his meal contents.**

**34. At a pediatric health workshop, Nurse Bryan is tasked with teaching a four-year-old about safety. He's well aware of the strategies that work best with this age group. What is the most effective strategy for Nurse Bryan to impart safety knowledge to a four-year-old?**

- A. Reprimand him for unsafe behavior by labelling his actions as 'bad'.**
- B. Point out and discuss potential dangers he should steer clear of.**
- C. Exhibit positive safety behaviors for him to follow.**
- D. Show him images of children who have been in accidents as a warning.**

**35. Nurse Anderson is performing an annual physical checkup on a healthy 9-year-old girl at a pediatric clinic. During the assessment, Nurse Anderson inquires about the girl's best friend. By asking about the girl's best friend, what aspect of the child's development is Nurse Anderson assessing?**

- A. The progression of her motor skills.**
- B. Her neurological development status.**
- C. The stages of her social development.**
- D. The evolution of her language capabilities.**

**36. At a community health center, Nurse George is speaking with a child who proudly declares that the task of brushing and flossing her teeth falls squarely on her own shoulders. How should Nurse George interpret this child's claim to dental hygiene responsibility?**

- A. The child is likely not ready to handle such responsibility.**
- B. The child may be overstating her level of responsibility.**
- C. The child is likely fully capable of handling this responsibility.**
- D. The child should have taken on this responsibility even earlier.**

**37. During a home visit, Nurse Liam hears a mother's concern about her child's relentless joking and riddle-telling, which has been testing the patience of the family.**

What should Nurse Liam explain as the likely reason for the child's constant humor and riddles?

- A. Influence from peers that may not be suitable.
- B. Acquired proficiency in navigating the nuances of language.
- C. A sign of lacking parental attention.
- D. An outcome of watching too much television.

38. In a counseling session, Nurse Owen hears from a mother that her child is starting to associate behaviors pleasing to others as "good behavior". Which level of Kohlberg's moral development does the child's behavior align with?

- A. The initial level of preconventional morality.
- B. The higher level of postconventional morality.
- C. The middle-ground known as conventional morality.
- D. The individualistic stage of autonomous morality.

39. During a wellness visit, Nurse Adele chats with a mother concerned about her child's constant need for snacks, particularly post-school. They work together on a nutrition plan for the child. What essential understanding should guide the development of the child's nutritional plan?

- A. The child doesn't require food intake between main meals.
- B. The child will naturally opt for nutritious snack choices.
- C. The child should consume snacks prepared by the mother.
- D. The child should take part in the preparation of their own snacks.

40. Nurse Mason has a consultation with a worried mother whose child has developed a strong inclination towards collecting various items. She seeks to understand the cognitive significance of this behavior. How should Nurse Mason explain this behavior in terms of the child's cognitive development?

- A. The child is demonstrating the ability to coordinate actions.
- B. The child is in the stage of formal operations.
- C. The child is exhibiting tertiary circular reactions.
- D. The child is engaged in concrete operational thought processes.

41. In a parent guidance session, Nurse Isabelle explains to a mother how play, as per Erikson's theory of psychosocial development, can assist a school-age child's development. According to Erikson's framework, through play, what psychosocial attribute is a school-age child likely to develop?

- A. A sense of industry.
- B. A sense of intimacy.
- C. A sense of identity.
- D. A sense of initiative.

42. Nurse Harper is organizing a series of safety and accident prevention lessons for a group of third graders. Recognizing the leading causes of accidental injury and death for this age group, she is determining the key preventive measures to highlight in her initial class. Given the primary causes of unintentional injuries and fatalities among children of this age, what preventive measures should Nurse Harper emphasize in her inaugural lesson?

- A. The importance of wearing protective eyewear.
- B. The necessity of using life preservers.
- C. The role of flame-retardant clothing.
- D. The crucial need for utilizing auto seat belts.

43. Nurse Katrina is in a consultation with a mother who is worried about her 10-year-old son's overweight status. They're collaborating to devise a plan of care. In creating this care plan, what strategy should Nurse Katrina encourage the mother to implement?

- A. Forbid the child from outdoor play if he consumes snacks.

- B. Restrict the child's daily caloric intake to 1,200kCal.**
- C. Limit the child's snacking between meals.**
- D. Involve the child in planning and preparing meals.**

**44. During a regular check-up, Nurse Gabriel observes a prominent abdomen in an 18-month-old child. He considers the possible reasons for this physical characteristic. What could explain the rationale for this finding in the toddler's physical appearance?**

- A. The underdevelopment of the child's abdominal muscles.**
- B. The child's bow-legged posture.**
- C. The nature of the child's linear growth curve.**
- D. An increased food intake typical of the child's age.**

**45. Nurse Maya is counseling parents of a toddler. They tend to assist their child in tasks where he is capable of applying his own skills, which might impact his psychosocial development. If parents continue to treat their toddler as dependent in areas where he can utilize his own abilities, which feeling might the toddler develop?**

- A. A sense of inferiority.**
- B. A sense of guilt.**
- C. A sense of shame.**
- D. A sense of mistrust.**

**46. Nurse Olivia is guiding new parents about common fears associated with different stages of childhood. She wants to discuss fears that are often seen in toddlers. Which fear is typically associated with toddlerhood?**

- A. Fear of ghosts.**
- B. Fear of going to sleep.**
- C. Fear of mutilation.**
- D. Fear of the dark.**

47. In a hospital setting, Nurse Alex encounters a 2-year-old who starts to cry inconsolably after her mother leaves to attend to her other children. The nurse contemplates how best to soothe the toddler. What could best help comfort this inconsolable 2-year-old in her mother's absence?

- A. Her favorite blanket.
- B. A large, cuddly stuffed dog.
- C. Encouraging her to take a nap.
- D. Introducing her to a peer play group.

48. Nurse Emma is advising a parent on suitable play items for her 18-month-old child. The parent wants to ensure the toy selected is age-appropriate and promotes the child's development. Which of the following options would be a suitable toy for an 18-month-old child?

- A. Miniature cars.
- B. Finger paints.
- C. A puzzle with multiple pieces.
- D. A comic book.

49. Nurse Liam is providing guidance to parents about normal eating patterns observed in toddlers. He's selecting key aspects to highlight in his advice. What characteristic should be included when discussing typical toddler eating patterns?

- A. An increased appetite.
- B. A preference for solitary eating.
- C. The ability to consistently demonstrate table manners.
- D. Food "jags"

50. Nurse Amelia is advising the parents of a 5-month-old baby on choosing safe and stimulating toys for their infant. Which of the following play items should Nurse Amelia recommend for a 5-month-old infant?

- A. A large red balloon.
- B. A wooden push-pull truck.
- C. A colorful activity cube, often called a “busy box.”
- D. A teddy bear with button eyes.

#### Answers & Rationales

##### 1. Correct answer:

A. Presence of a single, distinct crease running across the palm. The presence of a single, distinct crease running across the palm, also known as a “simian crease” or “palmar crease,” is not typically seen in most individuals. In the general population, the palm usually has multiple creases. A single palmar crease can be a normal variant in some people; however, it is more commonly associated with certain genetic conditions, such as Down syndrome. Therefore, if Samantha observes a single crease on the neonate’s palm, it would necessitate additional evaluation to rule out any potential underlying conditions.

Think of the palm creases like the lines on a road map. Normally, there are many lines intersecting and going in different directions, representing different paths or routes. A single crease is like having just one main road on the map, which can indicate that something is different or unusual.

##### Incorrect answer options:

B. Numerous intersecting creases scattered over the palm. Numerous intersecting creases scattered over the palm are normal findings. They do not indicate any underlying genetic or health condition. These creases form due to the flexing and movement of the hand and fingers.

C. Two dominant creases transversing the breadth of the palm. Having two dominant creases transversing the breadth of the palm is also a normal finding. It does not necessitate any additional evaluation.

**D. No visible creases found on the surface of the palm. While it's unusual to have no visible creases on the palm, it's not typically associated with any specific genetic or health condition. However, it could indicate skin or connective tissue issues, but these are usually accompanied by other signs and symptoms.**

**2. Correct answer:**

**C. Around the age of 12 to 18 months. The anterior fontanel, also known as the "soft spot," is a gap at the junction of the frontal and parietal bones in an infant's skull. This gap is covered by a tough membrane that protects the underlying soft tissues and brain. The primary purpose of these fontanels is to facilitate the passage of the baby's head through the birth canal during delivery and to allow for rapid brain growth during the first year of life.**

**The anterior fontanel typically closes between 12 to 18 months of age. This is a gradual process where the bones of the skull slowly grow towards each other until they meet and fuse. This fusion process is also known as ossification.**

**Think of the fontanels like the seams on a basketball. When the ball is deflated (like the baby's head during birth), the seams provide flexibility for the ball to change shape and pass through a small opening. As the ball is inflated (like the baby's brain growing), the seams gradually come together until they're tightly sealed.**

**Incorrect answer options:**

**A. Between 2 to 3 months of age. This is too early for the anterior fontanel to close. At this age, the baby's brain is still rapidly growing, and the fontanel needs to remain open to accommodate this growth. Closing at this age could potentially restrict brain development and lead to complications.**

**B. Approximately at 6 to 8 months of age. While some variation in the timing of fontanel closure is normal, closure at 6 to 8 months is still considered early. Most babies' anterior fontanels do not close until after their first birthday. Early closure could potentially indicate a condition called craniosynostosis, where the bones in a baby's skull join together too early.**

**D. Typically between 20 to 24 months of age.** This is later than the typical range for the closure of the anterior fontanel. While there is some variation in the timing of fontanel closure, most babies' anterior fontanels close by 18 months. If the fontanel remains open beyond 24 months, it could potentially indicate an underlying health issue, such as hydrocephalus or a growth disorder, and should be evaluated by a healthcare provider.

**3. Correct answer:**

**A. Dispersed uniformly over the entirety of the foot.** In a term neonate, the creases on the soles of the feet are typically dispersed uniformly over the entirety of the foot. This is because the baby has reached full term and has had ample time for these creases to develop due to movement and growth in the womb. The creases are formed due to the flexing and movement of the foot, similar to how creases form in a well-used piece of leather.

Think of the creases on the soles of the feet like the lines on a well-used piece of paper. When the paper is new and flat (like the foot of a preterm baby), there are no creases. But as the paper is used and folded (like the foot of a term neonate), creases form all over it, not just in one specific area.

**Incorrect answer options:**

**B. Exclusively visible beneath the heels.** This is incorrect. In a term neonate, the creases are not exclusively visible beneath the heels. They are typically dispersed uniformly over the entirety of the foot.

**C. Detected solely near the transverse arch of the foot.** This is not accurate. While it's true that creases can be found near the transverse arch of the foot, they are not exclusive to this area. In a term neonate, the creases are typically dispersed uniformly over the entirety of the foot.

**D. Not present near the heel area.** This is also incorrect. In a term neonate, the creases are typically present near the heel area as they are dispersed uniformly over the entirety of the foot.

**4. Correct answer:**

**C. The disparity in the sizes of the corneas. The corneas, the clear front surface of the eyes, should be of equal size in a healthy newborn. A disparity in the sizes of the corneas, a condition known as anisocoria, could potentially indicate an underlying issue such as congenital glaucoma, a neurological disorder, or other eye abnormalities. Therefore, this observation would necessitate further investigation.**

**Think of the corneas like the front windows of a car. They should be the same size to provide a clear and equal view of the road ahead. If one window was suddenly smaller or larger than the other, it could indicate a problem with the car that needs to be addressed.**

**Incorrect answer options:**

**A. Pupil constriction in response to bright light. Pupil constriction in response to bright light is a normal reflex known as the pupillary light reflex. This reflex helps protect the retina, the light-sensitive tissue at the back of the eye, from excessive light that could potentially cause damage. Therefore, this observation does not necessitate further investigation.**

**B. The presence of red circles on the pupils. The presence of red circles on the pupils during an ophthalmic examination, also known as the “red reflex,” is a normal finding. The red reflex is caused by light reflecting off the retina. Absence of the red reflex could indicate an issue such as cataracts or retinoblastoma, a rare form of eye cancer.**

**D. Lack of tear production. Lack of tear production is normal in newborns. Newborns do not produce tears until they are about one to three months old. They can still feel discomfort and cry, but you won’t see any tears. Therefore, this observation does not necessitate further investigation.**

**5. Correct answer:**

**D. An immature central nervous system. The Babinski reflex is a normal reflex in infants and children up to 2 years of age. When the sole of the foot is stroked, the**

big toe bends back towards the top of the foot and the other toes fan out. This is a positive Babinski reflex and it indicates an immature central nervous system. As the child grows and the nervous system matures, this reflex will disappear and stroking the sole of the foot will cause the toes to curl (plantar reflex).

Think of the Babinski reflex like a construction site. When a building (the central nervous system) is still under construction, there are signs and signals (the Babinski reflex) that indicate work is still being done. Once the building is complete, those signs and signals are no longer necessary and are removed.

**Incorrect answer options:**

**A. A potential defect in the lower spinal cord. This is incorrect. A positive Babinski reflex in a neonate does not indicate a potential defect in the lower spinal cord. It is a normal finding in infants and young children. However, a positive Babinski reflex in older children and adults could indicate a problem with the nerves or the brain.**

**B. Immature coordination of muscles. While it's true that a neonate's muscle coordination is not fully developed, a positive Babinski reflex does not specifically indicate this. The reflex is a sign of an immature central nervous system, not muscle coordination.**

**C. Potential damage to the nerves that supply the feet. This is incorrect. A positive Babinski reflex in a neonate does not indicate potential damage to the nerves that supply the feet. It is a normal finding in infants and young children. However, a positive Babinski reflex in older children and adults could indicate a problem with the nerves or the brain.**

**6. Correct answer:**

**D. In between the baby's feeding times. The best time to conduct a physical assessment of a neonate is typically in between feeding times. This is because newborns often sleep after feeding, and disturbing them for an assessment could cause unnecessary stress and agitation. Additionally, conducting an assessment immediately after feeding could potentially lead to regurgitation or vomiting due to the handling of the baby.**

Think of the baby's feeding and sleep cycle like the cycle of a car engine. After the car has been refueled (the baby has been fed), it's best to let it run smoothly for a while (let the baby sleep) before doing any maintenance work (conducting the physical assessment). Doing maintenance work right after refueling could disrupt the smooth running of the engine (disturb the baby's sleep and digestion).

**Incorrect answer options:**

**A. Right after the baby has been fed. This is not the ideal time for a physical assessment. As mentioned above, newborns often sleep after feeding, and disturbing them could cause unnecessary stress. Additionally, handling the baby for an assessment immediately after feeding could potentially lead to regurgitation or vomiting.**

**B. Just before feeding the baby. While this might seem like a reasonable time, it's not ideal. Newborns can become quite agitated when they are hungry, which could make the physical assessment more difficult. It's generally best to conduct the assessment when the baby is calm and alert, which is typically in between feeding times.**

**C. After ensuring the baby has been NPO (nothing by mouth) for three hours. This is not necessary for a physical assessment. Newborns typically feed every 2 to 3 hours, so waiting for the baby to be NPO for three hours could mean the baby is hungry and agitated, making the assessment more difficult. The ideal time for an assessment is in between feeding times when the baby is calm and alert.**

**7. Correct answer:**

**B. As caput succedaneum. Caput succedaneum is a type of swelling or edema that occurs in a newborn's scalp, typically as a result of pressure from the birth canal during a vaginal delivery. This swelling is soft and puffy, and it can extend across the suture lines of the skull. However, it does not typically cause any harm to the baby and usually resolves on its own within a few days after birth.**

Think of caput succedaneum like a water balloon being squeezed. When you apply pressure to one part of the balloon (like the baby's head passing through the birth

canal), the water (or in this case, fluid) moves to another part of the balloon, causing it to swell. Once the pressure is released, the water redistributes and the balloon returns to its original shape.

**Incorrect answer options:**

**A. As perinatal caput. There is no such term as “perinatal caput” in the context of neonatal assessments. The term “perinatal” refers to the period just before and after birth, and “caput” is part of the term “caput succedaneum,” which refers to a specific type of swelling on a newborn’s scalp.**

**C. As cephalic hematoma. A cephalic hematoma is a different type of swelling that can occur on a newborn’s scalp. Unlike caput succedaneum, a cephalic hematoma is a collection of blood that results from bleeding between the skull and its covering membranes. This type of swelling does not cross the suture lines and is usually firmer to the touch. It also takes longer to resolve, often several weeks to a month.**

**D. As hemorrhage edema. “Hemorrhage edema” is not a term typically used in neonatal assessments. Edema refers to swelling caused by excess fluid, and hemorrhage refers to bleeding. While both of these conditions can occur in newborns, they are different from the swelling known as caput succedaneum.**

**8. Correct answer:**

**C. Around 2 centimeters larger in circumference than the chest. In a neonate, the head circumference is typically larger than the chest circumference. This is due to the fact that significant brain development occurs during the fetal period, particularly in the third trimester, which results in a larger head size at birth. The difference is usually around 2 centimeters, although this can vary slightly between individual babies.**

**The head size of a neonate is an important indicator of brain growth and development. A larger head size at birth is generally a positive sign, as it indicates that the brain has had sufficient space to grow and develop during the prenatal period. As the baby grows and develops after birth, the chest circumference will gradually increase and by around 1 to 2 years of age, it will typically surpass the head circumference.**

Consider the baby's head and chest like a plant and its pot. At the time of planting (birth), the plant (the brain) is larger than the pot (the chest). This is because the plant has been growing rapidly and needs a larger pot to accommodate its size. However, as time goes on, the pot (the chest) grows larger to accommodate the growing plant (the brain and other organs).

**Incorrect answer options:**

**A. Approximately 4 centimeters larger in circumference than the chest. While the head circumference is indeed larger than the chest circumference in a neonate, a difference of 4 centimeters is typically larger than the average difference. A larger difference could potentially indicate an unusually large head size, which may be a sign of a condition such as hydrocephalus.**

**B. Roughly 2 centimeters smaller in circumference than the chest. This is incorrect. In a neonate, the head circumference is typically larger, not smaller, than the chest circumference. If the head circumference were smaller than the chest, it could potentially indicate a problem with brain development or growth.**

**D. Essentially the same size in circumference as the chest. This is also incorrect. In a neonate, the head circumference is typically larger than the chest circumference. If the head and chest were the same size, it could potentially indicate a problem with brain development or growth.**

**9. Correct answer:**

**C. "The fontanelles could be damaged if the molding doesn't resolve quickly." This statement indicates a misunderstanding about cranial molding and fontanelles. Cranial molding is a normal process that occurs when the flexible plates in a baby's skull shift and overlap to allow the head to pass through the birth canal. This can cause the baby's head to appear elongated or misshapen at birth. However, this is temporary and the head will gradually return to a more rounded shape over the first few weeks of life.**

The fontanel, or “soft spots” on a baby’s head, are gaps between the skull plates that allow for the rapid brain growth that occurs during the first year of life. They are covered by a tough membrane that protects the underlying brain tissue. Cranial molding does not damage the fontanel. In fact, the presence of the fontanel allows for the cranial molding to occur without causing harm to the brain.

Think of the baby’s skull like a jigsaw puzzle with pieces that haven’t been fully locked into place. During birth, these pieces can shift and overlap (cranial molding) to allow the puzzle (the baby’s head) to fit through a narrow space (the birth canal). The fontanel is like a gap in the puzzle where a piece is missing, but these gaps are covered by a protective layer (the membrane covering the fontanel). The shifting and overlapping of the puzzle pieces doesn’t damage these gaps.

**Incorrect answer options:**

A. “The molding occurs due to the cranial bones overlapping each other.” This statement is correct. Cranial molding does occur due to the cranial bones overlapping each other as the baby passes through the birth canal. This is a normal process and does not indicate a need for further instruction.

B. “The molding will fade away within a few days.” This statement is also correct. The effects of cranial molding typically start to fade within a few days after birth as the skull plates gradually move back to their normal positions.

D. “The extent of the molding is proportional to the amount of pressure exerted on the head.” This statement is correct as well. The extent of the cranial molding is indeed proportional to the amount of pressure exerted on the head during birth. A longer labor or a narrower birth canal can result in more pronounced cranial molding.

**10. Correct answer:**

B. Hearing. Among the five senses, hearing is the most developed at birth. In fact, the auditory system starts to develop early in utero, around the 20th week of gestation, and continues to mature throughout the pregnancy. By the time of birth, a baby can recognize their mother’s voice and even respond to familiar sounds that they heard frequently in the womb.

The sense of hearing plays a crucial role in the early stages of language development and social interaction. Babies use their hearing to pick up on the sounds of their environment, including the voices of their parents and caregivers, which helps them start to understand language and communication.

Think of the baby's sense of hearing like a radio that's been turned on before the other appliances in a house. Even though the lights (vision), the heater (touch), the food processor (taste), and the air freshener (smell) are important, the radio (hearing) is the first to be turned on and start receiving signals (sounds).

**Incorrect answer options:**

**A. Smell.** While the sense of smell is present at birth, it is not as developed as the sense of hearing. Newborns can recognize the smell of their mother's breast milk, and this helps them find the breast for feeding. However, their ability to distinguish other smells continues to develop over the first few months of life.

**C. Touch.** The sense of touch is also present at birth, and skin-to-skin contact is important for bonding and comfort. However, like smell, the sense of touch continues to develop after birth. Newborns initially respond most strongly to touch around the mouth, the soles of their feet, and the palms of their hands.

**D. Taste.** Newborns can distinguish between different tastes, including sweet, sour, bitter, and salty. They show a preference for sweet tastes, which is thought to help them accept breast milk and formula. However, the sense of taste is not as developed at birth as the sense of hearing.

**11. Correct answer:**

**D. Accepting solid foods without difficulties.** The transition from breastfeeding to using a cup is a significant milestone in an infant's life and is often linked to the introduction of solid foods. This typically occurs around 6 months of age, but it can vary depending on the individual child. When an infant starts accepting solid foods without difficulties, it's a sign that they may be ready to start learning to drink from a cup.

The introduction of solid foods is a complex process that involves the development of new skills, such as chewing and swallowing, as well as the maturation of the digestive system. When an infant can handle solid foods, it indicates that they are developmentally ready to handle other new forms of nutrition and feeding methods, such as drinking from a cup.

The transition to cup feeding is not just about nutrition, but also about developing motor skills and independence. Learning to hold and drink from a cup is a complex task that requires coordination of the hands, mouth, and swallowing muscles. When an infant is able to handle solid foods, it suggests that they may also have the motor skills needed to handle a cup.

Think of the transition from breastfeeding to cup feeding like learning to ride a bike. Just as a child needs to master certain skills (like balance and pedaling) before they can ride a bike on their own, an infant needs to master certain skills (like chewing and swallowing solid foods) before they can drink from a cup.

Incorrect answer options:

A. Adhering to a regular eating schedule. While adhering to a regular eating schedule is a positive sign of development, it does not necessarily indicate readiness to be weaned from breastfeeding. Many breastfed infants establish a regular feeding schedule long before they are ready to be weaned. Furthermore, the transition to cup feeding involves the development of new motor skills, which is not directly related to the establishment of a regular eating schedule.

B. Spending less time nursing. Spending less time nursing can be a sign of many things, not necessarily readiness to be weaned. It could be that the baby is becoming more efficient at nursing, or it could be a sign of a growth spurt or a change in sleep patterns. While it's true that as babies start to consume more solid foods, they may spend less time nursing, this on its own is not a reliable indicator of readiness to be weaned.

C. Sleeping throughout the night without interruptions. Sleeping through the night without interruptions is a milestone that many parents look forward to, but it does not necessarily indicate readiness to be weaned from breastfeeding. Some breastfed

babies continue to wake for night feedings even after they have started solid foods and are learning to drink from a cup. The ability to sleep through the night is more related to the development of the baby's sleep patterns and less to their readiness to be weaned.

**12. Correct answer:**

**D. Let the infant breastfeed for a few minutes, then introduce solid food. This approach can be effective because it allows the infant to get some of the hunger satisfaction from breastfeeding, which is a familiar and comforting experience, and then introduces the new food when the infant is more relaxed and receptive. This gradual transition can help the infant adjust to the new texture and taste of solid foods.**

Breastfeeding before offering solid food can also help to reduce the infant's resistance to trying new foods. The act of breastfeeding releases hormones that promote bonding and relaxation in both the mother and the infant. By breastfeeding first, the mother can take advantage of these hormones to create a positive and relaxed atmosphere for introducing new foods.

Furthermore, this approach respects the infant's ongoing need for breast milk. Breast milk provides important nutrients and antibodies that support the infant's growth and immune system. By continuing to offer breast milk, the mother ensures that the infant's nutritional needs are met while they are learning to accept solid foods.

Think of this approach like warming up before a workout. Just as you wouldn't jump straight into a high-intensity workout without warming up first, it's not ideal to introduce new foods to an infant without first providing the comfort and familiarity of breastfeeding.

**Incorrect answer options:**

**A. Continue providing breast milk as long as the infant refuses to eat solid food. While it's important to continue breastfeeding while introducing solid foods, simply continuing to offer only breast milk if the infant refuses solid food is not an effective**

strategy for transitioning to solid foods. This approach does not encourage the infant to try new foods and can delay the development of important feeding skills.

**B. Combine minced food with cow's milk and feed it to the infant using a nipple with a large hole. This approach is not recommended for several reasons. First, cow's milk is not recommended for infants under 12 months of age because it can be hard for them to digest and it does not provide all the necessary nutrients. Second, feeding solid foods through a bottle can increase the risk of choking and does not help the infant learn to eat from a spoon.**

**C. First offer a dessert, followed by vegetables and meat. While it might be tempting to offer sweet foods first to entice the infant to eat, this approach can lead to a preference for sweet foods and make it more difficult to introduce other flavors. It's better to introduce a variety of flavors from the start, including vegetables, fruits, and meats, to help the infant develop a broad palate.**

**13. Correct answer:**

**B. Rolls from belly to back. At around 4 months of age, an infant typically starts to develop the ability to roll from belly to back. This is a significant motor development milestone that involves the coordination of several muscle groups. It's one of the first major movements that infants learn and it sets the stage for other movements like sitting, crawling, and eventually walking.**

**Rolling over requires strength and coordination in the neck, arm, and trunk muscles. By 4 months, most infants have developed enough strength in these muscles to start experimenting with rolling movements. They also start to use their eyes and hands in a more coordinated way, which helps them understand and control their movements in space.**

**Think of the infant's development like building a house. Rolling over is like laying the foundation. It's one of the first steps, and it provides the base for all the other skills (like sitting, crawling, and walking) that will be built on top of it.**

**Incorrect answer options:**

**A. Able to sit up without support.** This is typically a skill that infants develop a bit later, usually around 6 months of age. At 4 months, most infants are still working on head control and core strength, which are necessary for sitting up independently.

**C. Walks while holding onto furniture.** This is a skill known as “cruising” and it usually develops much later, typically around 9-12 months of age. Before an infant can start cruising, they need to master other skills like sitting, crawling, and pulling up to stand.

**D. Speaks in two-word sentences.** This is a language development milestone that typically occurs much later, usually around 18-24 months of age. At 4 months, infants are usually still in the cooing stage, making vowel sounds like “ah” and “oh”. They start babbling (making consonant-vowel combinations like “ba” and “da”) around 6 months, and usually say their first words around their first birthday.

**14. Correct answer:**

**D. Progress in social and physical activities.** The Denver Developmental Screening Test (DDST) is a widely used assessment tool designed to identify children who may be experiencing developmental delays. It evaluates a child’s progress in four areas: gross motor skills, fine motor skills, language development, and personal-social development.

Gross motor skills involve the large muscles of the body and include activities like rolling over, sitting, crawling, and walking. Fine motor skills involve the smaller muscles of the hands and fingers and include activities like grasping objects, transferring objects from one hand to the other, and using a pincer grasp.

Language development includes both receptive language (understanding what others say) and expressive language (using sounds, gestures, and eventually words to communicate). Personal-social development involves the child’s interactions with others and their growing independence, such as smiling socially, feeding themselves, and showing an understanding of “no.”

The DDST is not a measure of a child’s intelligence or potential, but rather a tool to identify children who may need further evaluation or early intervention services. It’s important to note that the DDST is a screening tool, not a diagnostic tool. If a child’s

scores on the DDST suggest a possible delay, further evaluation with more comprehensive tests would be needed to confirm the diagnosis.

Think of the DDST like a regular check-up for your car. Just as you take your car in for regular check-ups to make sure everything is running smoothly and catch any potential problems early, the DDST is a regular check-up for your child's development.

**Incorrect answer options:**

**A. Emotional developmental progress.** While the DDST does assess some aspects of a child's emotional development through the personal-social domain, it is not a comprehensive assessment of emotional development. Emotional development involves a wide range of skills and abilities, including the ability to identify and understand one's own feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and their expression in a constructive manner, to regulate one's own behavior, to develop empathy for others, and to establish and sustain relationships.

**B. Susceptibility to genetic and allergic conditions.** The DDST is not designed to assess a child's susceptibility to genetic or allergic conditions. These types of conditions would be evaluated through medical examinations and tests, not a developmental screening tool.

**C. Intelligence quotient.** The DDST does not measure a child's intelligence quotient (IQ). IQ tests are designed to measure a person's intellectual potential, not their developmental progress. While some of the skills assessed on the DDST, such as language and problem-solving skills, are related to intelligence, the DDST is not an IQ test.

**15. Correct answer:**

**A. Sit unassisted, using hands for balance.** By the age of seven months, most infants have developed the ability to sit unassisted, using their hands for balance. This is a significant motor development milestone that involves the strengthening and coordination of several muscle groups, including the neck, back, and abdominal muscles.

**Sitting up allows the infant to explore their environment from a new perspective and frees their hands to explore objects, which supports cognitive and fine motor development. It's also a precursor to crawling, standing, and walking, as it develops the core strength and balance necessary for these skills.**

**The ability to sit unassisted also has social implications. When an infant can sit up, they can more easily engage with people and objects in their environment. They can play with toys, interact with caregivers, and start to participate in social activities like mealtime.**

**Think of the infant's development like building a tower. Just as you need a solid base to build a tower, an infant needs to develop core strength and balance (through skills like sitting) before they can move on to more advanced skills like crawling and walking.**

**Incorrect answer options:**

**B. Walk with assistance. While some infants may start to take their first steps with assistance around this age, it's more common for this skill to emerge a bit later, usually around 9-12 months. Walking requires a combination of strength, balance, and coordination that most seven-month-olds are still developing.**

**C. Stand while grasping onto furniture. This is a skill known as "cruising" and it usually develops later, typically around 9-12 months of age. Before an infant can start cruising, they need to master other skills like sitting, crawling, and pulling up to stand.**

**D. Feed themselves using a spoon. While some seven-month-olds may start to experiment with self-feeding, the coordination to use a spoon typically comes later. At this age, infants are still developing the fine motor skills they need to grasp objects, bring them to their mouth, and release them again.**

**16. Correct answer:**

**A. The ability to turn the head from side to side. At one month of age, an infant typically has the ability to turn their head from side to side. This is a significant motor development milestone that reflects the strengthening of the infant's neck muscles. It's one of the first movements that infants learn and it sets the stage for other movements like rolling over, sitting up, and eventually crawling and walking.**

The ability to turn the head from side to side is not just about physical strength, but also about sensory integration and coordination. Infants use this movement to explore their environment and respond to stimuli. For example, they may turn their head toward a sound or a familiar voice, or away from a bright light or uncomfortable sensation.

This skill also has important implications for feeding and social interaction. Infants who can turn their head can more easily latch onto the breast or bottle during feeding, and they can engage in eye contact and social interaction with their caregivers.

Think of the infant's development like a journey. Just as a journey begins with a single step, an infant's motor development begins with simple movements like turning the head from side to side.

**Incorrect answer options:**

**B. The capability to roll from the back to the side. While some infants may start to show signs of rolling from the back to the side around this age, it's more common for this skill to emerge a bit later, usually around 3-4 months. Rolling over requires a combination of strength, balance, and coordination that most one-month-olds are still developing.**

**C. The responses of smiling and laughing out loud. Smiling and laughing out loud are typically skills that develop a bit later, usually around 2-3 months of age. At one month, infants are still developing the social and emotional skills they need to engage in these types of interactions.**

**D. The skill to briefly hold a rattle. While some one-month-olds may start to grasp objects that are placed in their hand, the coordination to hold a rattle and shake it**

typically comes later. At this age, infants are still developing the fine motor skills they need to grasp objects, bring them to their mouth, and release them again.

**17. Correct answer:**

**B. Through the deeper intramuscular route. The DPT vaccine, which stands for Diphtheria, Pertussis, and Tetanus, is typically administered via the intramuscular route. This is because the intramuscular route allows for the vaccine to be delivered directly into the muscle, where it can be absorbed into the bloodstream more quickly and efficiently. This is important for vaccines like the DPT vaccine, which need to stimulate a strong immune response to protect against these serious diseases.**

The intramuscular route also has the advantage of being able to accommodate larger volumes of medication, which can be important for some vaccines. Additionally, because the muscle tissue has a greater blood supply than the subcutaneous tissue, the immune response to the vaccine can be faster and more robust.

When administering an intramuscular injection to an infant, the nurse should choose the vastus lateralis muscle in the thigh as the injection site. This muscle is large enough to accommodate the injection, and it's far away from major nerves and blood vessels, reducing the risk of injury.

Think of the intramuscular route like a fast lane on a highway. Just as the fast lane allows cars to reach their destination more quickly, the intramuscular route allows the vaccine to reach the bloodstream more quickly, leading to a faster and more efficient immune response.

**Incorrect answer options:**

**A. Via the superficial intradermal pathway. The intradermal route is used for certain types of vaccinations, such as the tuberculosis skin test (PPD), but it is not typically used for the DPT vaccine. Intradermal injections are given into the dermis, the layer of skin just below the epidermis, and they can only accommodate small volumes of medication.**

**C. By utilizing the oral method. While some vaccines are given orally, such as the rotavirus vaccine, the DPT vaccine is not one of them. Oral vaccines work best for diseases that affect or originate in the digestive tract, which is not the case for diphtheria, pertussis, or tetanus.**

**D. By opting for the subcutaneous administration route. The subcutaneous route, which involves injecting into the fatty tissue just below the skin, is used for some vaccines, but not for the DPT vaccine. Subcutaneous injections are absorbed more slowly than intramuscular injections, and they can only accommodate small volumes of medication.**

**18. Correct answer:**

**D. A mild fever, slightly elevated above the normal body temperature. As a nurse, it's important to understand that a mild fever is a common reaction in infants following the DPT (Diphtheria, Pertussis, and Tetanus) vaccine. This is a normal response and is indicative of the body's immune system reacting to the vaccine and building protection against the diseases it targets. The fever is usually low-grade and temporary, typically resolving within 24 to 48 hours.**

**The fever occurs because the immune system perceives the vaccine as a foreign substance and reacts accordingly. This reaction is part of the body's natural defense mechanism. When the immune system detects something foreign, like a bacteria or virus, it raises the body's temperature to create an environment that's less hospitable to these invaders. In the case of a vaccine, the immune system is reacting to a harmless version of the bacteria or virus, but it responds in the same way.**

**As a nurse, you should monitor the infant's temperature after vaccination and take steps to keep them comfortable. If the fever is causing discomfort, you may administer a non-aspirin pain reliever as ordered by the physician. If the fever is high or lasts for more than a couple of days, you should report this to the healthcare provider.**

**To provide a practical analogy, think of the fever like a security system. Just as a security system sounds an alarm when it detects an intruder, the immune system raises the body's temperature when it detects a foreign substance.**

**Incorrect answer options:**

**A. The unfortunate experience of diarrhea. While some vaccines can cause mild gastrointestinal symptoms, diarrhea is not a common side effect of the DPT vaccine. If an infant experiences diarrhea after vaccination, it's important to assess for other potential causes and report this to the healthcare provider.**

**B. The uncomfortable condition of nasal congestion. Nasal congestion is not a typical side effect of the DPT vaccine. It's more commonly associated with respiratory illnesses or allergies. If an infant experiences nasal congestion after vaccination, it's important to assess for other potential causes and report this to the healthcare provider.**

**C. A noticeable state of lethargy, or unusual sleepiness. While some infants may be a bit fussier or sleepier than usual after receiving a vaccine, extreme lethargy or unusual sleepiness is not a typical reaction to the DPT vaccine. If an infant is excessively sleepy or difficult to wake up after vaccination, this should be reported to the healthcare provider immediately.**

**19. Correct answer:**

**B. A somewhat more developed age of four months. Based on the developmental competencies described, Nurse Max would accurately assess the infant to be around four months of age. At this stage, infants typically begin to show interest in their surroundings and can focus on and follow moving objects with their eyes, which aligns with the infant's ability to stare at objects.**

**The ability to bring hands to mouth and remove them is a sign of developing motor skills and hand-eye coordination, which are typically seen around this age. This skill is important for self-soothing and later for self-feeding.**

**The cooing and gargling sounds are part of the early language development that typically begins around this age. These sounds are the infant's way of experimenting with different sounds and beginning to communicate with their caregivers.**

Supporting part of their own weight when held upright is another developmental milestone typically achieved around this age. This indicates strengthening of the neck and trunk muscles, which is a precursor to sitting up independently.

Think of the infant's development as a building under construction. At two months of age, the building's foundation has been laid. The infant is starting to interact with the world, much like the basic structure of a building is taking shape.

By four months of age, the building's framework is up. The infant is becoming more interactive, starting to "coo" and "gargle," and gaining control over their movements, similar to how a building's framework allows us to see its basic shape and size.

At six months, the building's walls and roof are on, and it's starting to look more like a finished building. Similarly, the infant is becoming more mobile (rolling over, sitting without support), and their communication is becoming more complex (babbling with consonants).

By eight months, the building is near completion, with only the interior work left. Similarly, the infant is nearing the end of their first year, and their skills are becoming more refined. They're starting to move around more independently (crawling, pulling to stand), and their communication is becoming more sophisticated (using simple gestures, babbling with more complex sounds).

**Incorrect answer options:**

**A. A relatively young age of two months. At two months, while some infants may begin to make cooing sounds and bring their hands to their mouth, they typically do not yet have the strength to support part of their own weight when held upright.**

**C. A more advanced stage of six months. By six months, infants typically have more advanced motor skills, such as rolling over in both directions and sitting without support. They may also begin to babble, combining vowels and consonants, which is a more advanced language skill than the cooing and gargling described.**

**D. A notably older age of eight months. By eight months, infants typically have even more advanced motor skills, such as crawling or scooting, pulling to a standing**

position, and possibly even beginning to “cruise” along furniture. They may also begin to use consonant sounds when babbling and may start to use simple gestures, such as shaking their head “no” or waving “bye-bye”.

20. Correct answer:

D. The anterior fontanel, or the “soft spot” on a baby’s head, typically closes between 13 to 18 months of age. The anterior fontanel is a diamond-shaped membrane-covered gap between the bones of a baby’s skull. It allows for the rapid growth of the brain during the first year of life. The fontanel is firm and slightly concave to the touch, and it pulsates with the heartbeat, providing a visible sign of the baby’s circulatory system at work.

The timing of fontanel closure can vary somewhat, but it generally begins to close or “fuse” around the age of 7 months and is fully closed by 18 months. This process happens as the bones of the skull grow and meet along the suture lines of the skull, eventually hardening and closing the fontanel.

A study by Boran et al. (2018) found that the mean fontanel closure time was  $9.7 \pm 5.0$  months, with no significant difference between boys and girls. However, it’s important to note that this is an average, and the timing can vary among individual infants. The same study also emphasized that children with fontanels measuring above the 95th percentile should be monitored closely and investigated further for potentially associated diseases.

Another study by Tiansyah et al. (2012) found a positive correlation between gestational age and birth weight to head circumference size, but not to anterior fontanel size. This suggests that while the size of the fontanel can vary, it doesn’t necessarily correlate with the baby’s overall size or gestational age.

Think of the baby’s skull as a house under construction. The anterior fontanel is like an opening in the roof, allowing room for the house (the brain) to grow and expand. Over time, as the house nears completion, the roof (the skull) gradually fills in the opening, much like the fontanel closes. This process isn’t instant; it’s a gradual “construction” that completes typically between 13 to 18 months, providing a fully formed “roof” for the brain.

**Incorrect Answers:**

**A. Between 2 to 4 months:** This is too early for the anterior fontanel to close. The fontanel is still quite large at this age to allow for rapid brain growth.

**B. Between 5 to 8 months:** While the process of fontanel closure may begin during this period, it is typically not fully closed until later.

**C. Between 9 to 12 months:** Some babies may have their fontanel close during this period, but it's not the norm. Most babies will have their fontanel close between 13 to 18 months.

In conclusion, the closure of the anterior fontanel is a normal part of an infant's development and is typically completed by the age of 18 months. However, if parents have concerns about the size or closure of their baby's fontanel, they should consult with a healthcare provider.

**21. Correct answer:**

**C. Insert an arm through a sleeve while being dressed.** At 9 months old, infants are typically developing fine and gross motor skills, but the ability to insert an arm through a sleeve while being dressed is a more complex task that requires a higher level of coordination and understanding. This skill is usually developed later, around the age of 2 years, when toddlers begin to show interest in dressing themselves and have developed the necessary motor skills to do so. At this stage, they start to understand the concept of "in" and "out" and can coordinate their movements to insert an arm or leg into clothing with assistance.

The development of self-dressing skills is a gradual process that begins with simpler tasks. Initially, children learn to cooperate with dressing by holding out a hand or foot, and later they learn to remove loose clothing. By around 18 months, they may be able to remove some clothing items, such as shoes and socks, and by 2 years, they may be able to put on simple items with assistance. The ability to dress oneself independently typically develops between 3 and 5 years of age.

In the context of a 9-month old infant, expecting them to insert an arm through a sleeve while being dressed is not developmentally appropriate. Instead, at this age, infants are usually able to hold out their arms and legs while being dressed and may begin to show interest in the dressing process. However, the fine motor skills and cognitive understanding necessary to insert an arm into a sleeve independently are not typically developed until later.

Think of a 9-month old infant's development as a construction project. At this stage, the infant is like a builder who has just started to gather the basic tools and materials. They have a hammer and nails (basic motor skills), a blueprint (cognitive understanding), and some building blocks (simple tasks). They're starting to put together small structures, like stacking blocks (imitative verbal expressions), moving blocks from one place to another (crawling), and even using a simple tool like a paintbrush (holding a bottle). However, asking them to insert an arm through a sleeve is like asking this builder to construct a complex structure like a multi-story building. It's a task that requires more advanced tools and skills (fine motor skills and cognitive understanding) that they haven't acquired yet. Just as the builder needs more time and experience to take on more complex projects, the infant also needs more time to develop the necessary skills for more complex tasks like self-dressing.

**Incorrect answer options:**

**A. Start using imitative verbal expressions.** At around 9 months of age, infants often begin to use imitative verbal expressions. This is a normal part of language development and is a precursor to the development of actual speech. Infants at this age are typically able to mimic sounds and gestures, and they often enjoy games that involve imitation. They may start to understand simple words like "no" and "bye-bye," and they may use their voices to express joy and displeasure.

Imitative verbal expressions at this age can include babbling and the use of "mama" and "dada" nonspecifically, meaning they don't yet associate these sounds with their parents. This stage of language development is crucial as it sets the foundation for more complex language skills. Therefore, it is developmentally appropriate for a 9-month old infant to start using imitative verbal expressions.

**B. Creep and crawl.** Creeping and crawling are typical motor milestones for a 9-month old infant. These activities are part of the infant's increasing mobility and exploration of their environment. Creeping, or moving on the stomach using the

arms and legs to pull forward, usually comes before crawling. Crawling, which is moving on hands and knees, typically develops between 6 and 10 months of age.

Crawling is an important developmental milestone as it strengthens the muscles, improves coordination, and provides the infant with a new way to explore their environment. It also sets the stage for the next big motor milestone: walking. Therefore, it is developmentally appropriate and expected for a 9-month old infant to be able to creep and crawl.

D. Hold a bottle with good hand-mouth coordination. By 9 months of age, most infants have developed enough hand-eye coordination to hold a bottle and guide it to their mouth. This is a part of their developing fine motor skills, which involve smaller, more precise movements, usually involving the hands and fingers.

The ability to hold a bottle is often seen as a sign of independence in feeding. It allows the infant to control the pace of their feeding, which can be beneficial for their digestion and sense of autonomy. Therefore, it is developmentally appropriate and expected for a 9-month old infant to be able to hold a bottle with good hand-mouth coordination.

22. Correct answer:

A. Introduce new foods one at a time. Introducing new foods one at a time is a recommended approach when starting to diversify a baby's diet. This method allows parents to monitor for any potential allergic reactions or sensitivities to specific foods. If multiple new foods are introduced at once and the baby has a reaction, it can be difficult to determine which food caused it.

Moreover, introducing new foods one at a time can help the baby adjust to different tastes and textures gradually. It's important to remember that the experience of eating solid foods is entirely new for babies. They are used to the uniform texture and taste of breast milk or formula, so encountering new flavors and textures can be a surprise. By introducing one new food at a time, parents can help their baby gradually become accustomed to the variety and complexity of solid foods.

It's also worth noting that babies may initially reject new foods. This is a normal part of the weaning process and doesn't necessarily mean the baby dislikes the food. It

can take multiple exposures to a new food before a baby accepts it, so parents should be encouraged to be patient and persistent.

Think of introducing new foods to a baby as introducing a person to swimming. If you were teaching someone to swim, you wouldn't take them to the deep end of the pool on their first day. Instead, you'd start in the shallow end, where they can touch the bottom and feel safe. You'd introduce one skill at a time, starting with basic skills like floating and kicking. Once they've mastered these skills, you'd move on to more complex ones like different swimming strokes. Similarly, when introducing new foods to a baby, it's best to start with one food at a time. This allows the baby to get used to the taste and texture of each new food, and it allows you to monitor for any reactions. Just as you wouldn't rush someone learning to swim, it's important not to rush a baby's introduction to new foods.

**Incorrect answer options:**

**B. Serve new foods after offering formula.** Serving new foods after offering formula is not the best advice. Babies often drink formula or breast milk until they feel full, so if new foods are offered after this, they may not be hungry and therefore more likely to reject the new food. Instead, it's usually recommended to offer new foods at the start of the meal when the baby is hungry.

**C. Combine new foods with more familiar ones.** While this strategy can be effective for older infants and toddlers, it's not the best approach for a 9-month old baby who is just starting to eat solid foods. Combining new and familiar foods can make it difficult to determine if the baby has a reaction to the new food. It's generally better to introduce new foods one at a time until the baby is used to eating a variety of foods.

**D. Mix new foods with formula.** Mixing new foods with formula is not typically recommended. This can alter the taste and texture of the formula, which might lead to the baby rejecting the formula altogether. Additionally, like combining new foods with familiar ones, this approach can make it difficult to determine if the baby has a reaction to the new food.

**23. Correct answer:**

**C. Pulling toys along while walking.** At 18 months, a typical developmental milestone is the ability to pull toys along while walking. This task demonstrates the child's growing motor skills, including balance, coordination, and strength. At this age, children are usually confident walkers and are beginning to explore their environment more actively. Pulling a toy along while walking not only shows physical development but also cognitive development as the child begins to understand cause and effect (pulling the toy causes it to move).

To visualize this, consider a young bird learning to fly. Initially, the bird might only flutter its wings while remaining stationary. As it grows stronger and more confident, it starts to lift off the ground, but still stays close to its nest. Pulling a toy while walking is like this stage in the bird's flight training. The child is moving around their environment with increasing confidence, but still has a lot to learn about navigating their world.

**Incorrect answer options:**

**A. Playing toys with other children.** While some 18-month-old children may start to show interest in other children, their play is typically parallel, meaning they play alongside other children, not with them. Cooperative play, where children actively engage with each other in their play, typically develops later, around the age of 3 or 4 years.

**B. Copying a circle.** Copying a circle is a task that requires fine motor skills and visual-motor integration that is typically beyond the abilities of an 18-month-old. This skill is usually not expected until around the age of 3 years.

**D. Building a tower of eight blocks.** While an 18-month-old child is likely to enjoy playing with blocks, building a tower of eight blocks is a task that typically isn't mastered until around 2 years of age. At 18 months, a child might be expected to stack two to four blocks.

**24. Correct answer:**

**C. Stringing large beads.** At the age of 3, a child is typically expected to have developed the fine motor skills necessary to string large beads. This activity requires a certain level of hand-eye coordination and dexterity, which are usually well-

developed by this age. The child has to be able to grasp the bead, hold it steady, and guide the string through the hole, all of which are indicative of the fine motor control that is developing at this stage.

Stringing beads is not just a motor task, but also a cognitive one. It involves concentration, problem-solving, and sometimes even planning and sequencing, especially if the child is trying to create a specific pattern with the beads. Therefore, the ability to string beads is a good indicator of a child's overall development, encompassing both motor and cognitive skills.

Furthermore, activities like bead stringing are often used to prepare children for more complex tasks that they will encounter when they start school, such as writing. The pincer grip used to pick up and manipulate the beads is the same grip used to hold a pencil. Therefore, bead stringing is not only a milestone in itself, but also a stepping stone towards future developmental tasks.

Think of a 3-year-old child's development as learning to play a piano. Stringing large beads is like playing a simple melody with one hand. It requires coordination and control, but it's within the child's capabilities at this stage. On the other hand, tasks like riding a bicycle, tying shoelaces, or using scissors are like trying to play a complex piece of music with both hands. These tasks require a higher level of skill and coordination that the child is still developing. Just as a piano student starts with simple melodies before moving on to more complex pieces, a child develops basic motor skills like stringing beads before moving on to more complex tasks.

**Incorrect answer options:**

**A. Riding a bicycle.** Riding a bicycle is a complex task that requires a high level of balance, coordination, and strength. While some 3-year-olds may be able to ride a tricycle or a bicycle with training wheels, it is not typically expected for a child of this age to be able to ride a bicycle independently. This skill is usually mastered later, often around the age of 5 or 6 years.

**B. Tying shoelaces.** Tying shoelaces is a complex fine motor task that is typically beyond the abilities of a 3-year-old. This skill requires a high level of dexterity and coordination, as well as the cognitive ability to understand and follow the steps involved in tying a bow. Most children do not master this skill until around the age of 5 or 6 years.

**D. Using blunt scissors.** While some 3-year-olds may start to show an interest in using scissors, the ability to use them effectively and safely is usually not developed until later. Using scissors requires a combination of fine motor skills, including hand-eye coordination, finger strength, and the ability to manipulate objects with precision, which are typically not fully developed in a 3-year-old. This skill is usually expected to be mastered around the age of 4 or 5 years.

**25. Correct answer:**

**A. The child is not developmentally ready to be trained.** Toilet training is a significant milestone in a child's development, and it's crucial to remember that each child develops at their own pace. The primary reason why toilet training often fails in toddlers is that the child is not developmentally ready to be trained. This readiness includes both physical and psychological readiness. Physically, the child needs to be able to control their bladder and bowel movements, which usually happens around the age of 18 months to 3 years. Psychologically, the child needs to be able to recognize the sensation of needing to go to the bathroom, be able to communicate this, and have the desire to use the toilet.

To understand this better, let's use a practical analogy. Imagine trying to teach someone to drive a car before they've learned how to ride a bike. They might understand the concept of driving, but without the foundational skills of balance and coordination developed from bike riding, they're likely to struggle and become frustrated. Similarly, if a child is not developmentally ready for toilet training, they may become frustrated and resistant, leading to a negative association with the process.

Furthermore, forcing toilet training before a child is ready can lead to negative outcomes such as increased resistance to training, increased incidence of accidents, and even potential emotional distress. It's like trying to force a square peg into a round hole – it just won't fit, no matter how much force you apply. It's better to wait until the child is ready, turning the process into more of a collaboration between the child and the parent, rather than a battle of wills.

**Incorrect answer options:**

**B. The training equipment used is not suitable. While it's true that unsuitable equipment can make toilet training more challenging, it's not the primary reason for failure. The equipment, such as a potty chair or toilet seat adapter, should be safe, comfortable, and appropriately sized for the child. However, even with the best equipment, if the child is not developmentally ready, toilet training will likely be unsuccessful. It's like having the best quality paint and brushes, but if the canvas isn't prepared, the painting won't turn out as expected.**

**C. The rewards given are too minimal. Rewards can be a useful tool in toilet training, providing positive reinforcement for successful attempts. However, the absence or insufficiency of rewards is not the primary reason why toilet training fails. If a child is developmentally ready and understands the process, they will make progress even without rewards. It's like learning to ride a bike – the reward of being able to ride is often enough motivation, even without additional incentives.**

**D. Parents tend to dismiss “accidents” that occur during training. While it's important for parents to respond appropriately to accidents – with understanding and reassurance rather than punishment – this is not the primary reason for toilet training failure. Accidents are a normal part of the learning process. If a child is developmentally ready and supported in their training, they will eventually learn, even if accidents occur along the way. It's like learning to walk – falling down is part of the process, but with encouragement and support, the child will eventually learn to walk.**

**26. Correct answer:**

**D. The child's pursuit of autonomy. The toddler years are a time of rapid development and change. One of the key developmental milestones during this period is the pursuit of autonomy. This is when children start to realize that they are separate individuals from their parents and begin to assert their independence. This pursuit of autonomy often manifests as negativism, where the child frequently says “no” when asked to do something. This is not because they are being difficult or contrary, but because they are testing their boundaries and asserting their independence.**

**To understand this better, let's use a practical analogy. Imagine you're learning to drive. At first, you need someone else in the car with you, guiding you and telling you what to do. But as you become more confident and skilled, you start to want to make decisions for yourself. You might even start to resist when the other person**

tries to tell you what to do, not because you're being difficult, but because you want to assert your independence and show that you can make decisions on your own. This is similar to what toddlers are experiencing. They're learning to navigate the world and want to make decisions for themselves.

It's important for parents to understand this and to provide opportunities for their child to make choices and exert control in appropriate ways. This can help to reduce the frequency of negativism and make this developmental stage a bit easier to navigate. For example, instead of telling the child what to wear, the parent could offer two options and let the child choose. This satisfies the child's desire for autonomy while still providing the parent with some control over the situation.

**Incorrect answer options:**

**A. Separation anxiety.** While separation anxiety is a common issue in toddlers, it's not typically the cause of negativism. Separation anxiety occurs when children become distressed in the absence of their primary caregivers. It's more likely to manifest as clinginess or distress when the caregiver leaves, rather than as a tendency to say "no" to requests or instructions.

**B. Hyperactivity.** Hyperactivity refers to a state of being unusually or abnormally active. While hyperactive children may sometimes resist instructions or refuse to comply with requests, this behavior is typically driven by their inability to sit still or focus, rather than a pursuit of autonomy. Hyperactivity is more commonly associated with conditions like Attention-Deficit/Hyperactivity Disorder (ADHD).

**C. Sibling rivalry.** Sibling rivalry typically involves competition or conflict between siblings. While it can sometimes lead to negativism, particularly if the child is acting out to gain attention, it's not the primary reason why a toddler would frequently say "no". This behavior is more likely to be a normal part of their developmental stage, as they seek to assert their independence and control over their environment.

**27. Correct answer:**

**C. The concept known as animism.** Animism is a concept from Piaget's theory of cognitive development, specifically from the preoperational stage, which typically includes children aged 2 to 7 years. Animism is the belief that inanimate objects have

feelings, thoughts, and have the qualities of living things. This can lead to fears such as fear of the dark, as the child may believe that the darkness itself is a living entity that can harm them.

To understand this better, let's use a practical analogy. Imagine you're watching a movie and you start to believe that the characters on the screen are real people with their own thoughts and feelings. You might even start to worry about them when they're in danger or feel happy for them when they succeed. This is similar to how a child in the preoperational stage might view the world. They might believe that the darkness in their room at night is a living, thinking entity that could potentially harm them.

It's important for parents to understand this stage of cognitive development and to be patient and supportive. They can reassure their child that the dark is not dangerous and can even use night lights or leave the bedroom door slightly open to help alleviate their child's fear. Over time, as the child's cognitive development progresses, they will outgrow this belief.

**Incorrect answer options:**

**A. The principle of conservation of matter.** The principle of conservation of matter is a concept from the concrete operational stage of Piaget's theory, which typically includes children aged 7 to 11 years. This principle refers to the understanding that the quantity of a substance remains the same even when its shape or appearance changes. This concept is not typically related to a fear of the dark.

**B. The understanding of reversibility.** Reversibility is another concept from the concrete operational stage of Piaget's theory. It refers to the understanding that actions can be reversed, and an object can return to its original state. This understanding is not typically related to a fear of the dark.

**D. The cognitive realization of object permanence.** Object permanence is a concept from the sensorimotor stage of Piaget's theory, which typically includes children aged 0 to 2 years. This concept refers to the understanding that objects continue to exist even when they cannot be seen, heard, or touched. While this is a crucial milestone in cognitive development, it's not typically related to a fear of the dark.

**28. Correct answer:**

**D. The compassionate approach of reasoning and discussion. The compassionate approach of reasoning and discussion is often the most effective method of discipline for children. This method involves explaining to the child why their behavior was inappropriate and discussing better alternatives. It helps children understand the consequences of their actions and encourages them to think about how their behavior affects others.**

To understand this better, let's use a practical analogy. Imagine you're learning to cook. If you make a mistake, like burning the food, it's much more helpful if someone explains what you did wrong and how to avoid it in the future, rather than just telling you off or punishing you. This way, you learn from your mistake and are less likely to repeat it in the future. Similarly, when children understand why their behavior is inappropriate, they're more likely to change it.

This approach also respects the child's feelings and dignity, which can help to build a stronger, more trusting relationship between the parent and child. It's like treating the child as a junior partner in a dance – you're leading, but you're also listening and responding to their movements.

**Incorrect answer options:**

**A. The old-fashioned method of spanking. Spanking is a form of corporal punishment that involves hitting a child in response to misbehavior. While it was once a common method of discipline, research has shown that it can have negative effects on children's mental and emotional health, and it is not recommended by most child development experts. It's like using a sledgehammer to fix a watch – it's not only inappropriate, but it can also cause more harm than good.**

**B. The method of structured interaction, designed to guide behavior. Structured interaction can be a useful tool in managing a child's behavior, but it should not be the primary method of discipline. This method involves setting up specific rules and routines to guide the child's behavior. However, without the understanding and empathy provided by reasoning and discussion, it can feel restrictive and arbitrary to the child. It's like following a dance routine without understanding the rhythm or the meaning of the movements.**

**C. The typical approach of scolding or reprimanding. Scolding or reprimanding is a common approach to discipline, but it's not always the most effective. This method involves criticizing or chastising the child for their behavior. While it might stop the behavior in the short term, it doesn't help the child understand why their behavior was wrong or what they should do differently in the future. It's like yelling at someone for stepping on your toes during a dance, without showing them the correct steps.**

**29. Correct answer:**

**C. Asking them directly about the pain. While it's always important to communicate with a child about their feelings and experiences, asking a toddler directly about their pain is often the least effective method for assessing pain. Toddlers, especially younger ones, may not have the language skills to accurately describe their pain or may not understand the concept of pain well enough to identify it. They may also be hesitant to talk about their pain due to fear or discomfort.**

**Imagine you're trying to find out if a non-English speaker is hungry, but they don't understand the word "hungry". You could ask them directly if they're hungry, but they might not understand the question. However, if you observe their behavior – like if they're reaching for food or their stomach is growling – you can get a better idea of whether they're hungry or not. Similarly, observing a toddler's behavior and physical cues can often provide more accurate information about their pain than asking them directly.**

**Incorrect answer options:**

**A. Observing for signs of restlessness. Observing for signs of restlessness can be an effective way to assess pain in toddlers. Restlessness, irritability, or changes in activity level can all be signs of discomfort or pain in young children. This is because toddlers often express their discomfort through their behavior, rather than through verbal communication.**

**B. Listening for pain cues in their cries. Listening for pain cues in a toddler's cries can also be an effective method for assessing pain. Changes in the tone, volume, or**

frequency of a child's cries can indicate discomfort or pain. For example, a high-pitched, continuous cry is often associated with acute pain.

**D. Watching their faces for signs of grimness.** Facial expressions can be a useful indicator of pain in toddlers. Grimacing, frowning, or other changes in facial expression can indicate that a child is in pain. This is why pain scales for young children often include pictures of faces showing different levels of discomfort or pain.

**30. Correct answer:**

**A. Establish a consistent bedtime and stick to a routine.** Establishing a consistent bedtime and sticking to a routine is one of the most effective ways to make bedtime more pleasant and less stressful for both the child and the parent. Children thrive on routine and predictability. Knowing what to expect can help reduce anxiety and resistance, making the transition to sleep smoother and more pleasant.

To understand this better, imagine you're training for a marathon. If you have a consistent training schedule, you know what to expect each day, and your body gets used to the routine. This makes the training process smoother and more effective. Similarly, a consistent bedtime routine helps signal to the child's body that it's time to wind down and prepare for sleep.

A bedtime routine might include activities like brushing teeth, reading a story, and saying goodnight to everyone. These activities should be calming and enjoyable, helping the child relax and look forward to bedtime. It's also important to make sure the child's sleep environment is comfortable and conducive to sleep, with a comfortable bed, a quiet room, and a suitable temperature.

**Incorrect answer options:**

**B. Allow the child to play with toys immediately before bedtime.** Allowing the child to play with toys immediately before bedtime can actually make it harder for them to wind down and get ready for sleep. Play is stimulating and can increase the child's alertness, making it harder for them to fall asleep. It's like drinking a cup of coffee right before trying to go to sleep – it's likely to keep you awake rather than help you sleep.

**C. Offer the child a cookie if the bedtime routine is carried out without tantrums. While rewards can sometimes be effective in encouraging desired behavior, offering a cookie as a reward for a tantrum-free bedtime routine is not the best approach. This could lead to an unhealthy association between behavior and food rewards, and it could also disrupt the child's sleep if they eat a sugary snack right before bed. It's like rewarding yourself with a piece of cake every time you finish a workout – it might motivate you in the short term, but it's not a healthy or sustainable strategy.**

**D. Permit the child to stay up later than usual one or two nights a week. Permitting the child to stay up later than usual one or two nights a week can disrupt their sleep routine and make it harder for them to fall asleep at the usual time on other nights. Consistency is key when it comes to bedtime routines. It's like trying to wake up early a few days a week and then sleeping in on other days – it can throw off your body's internal clock and make it harder to establish a consistent sleep-wake cycle.**

**31. Correct answer:**

**A. "Even if there aren't any apparent dental issues, it would still be beneficial to have a routine dental check-up." Even if there aren't any apparent dental issues, it's still beneficial to have routine dental check-ups. Regular dental visits can help catch potential problems early, before they become more serious and harder to treat. Dentists can also provide advice on proper oral hygiene techniques, diet, and other factors that can affect dental health.**

**To understand this better, imagine you're maintaining a car. Even if the car seems to be running smoothly, it's still important to have regular maintenance checks. These checks can catch potential problems early, like worn-out brake pads or low fluid levels, before they lead to more serious issues like brake failure or engine damage. Similarly, regular dental check-ups can catch early signs of tooth decay or gum disease before they lead to more serious problems like cavities or tooth loss.**

**Furthermore, regular dental visits can help children become more comfortable with the dentist and reduce dental anxiety. It's like getting used to going to the doctor or the hairdresser – the more familiar the experience, the less scary it becomes.**

**Incorrect answer options:**

**B. “Although dental visits should ideally start earlier, there’s no such thing as too late for a first appointment.” While it’s true that it’s never too late to start regular dental visits, this statement could potentially discourage parents from starting dental visits at the recommended age. The American Academy of Pediatrics and the American Dental Association recommend that children have their first dental visit by their first birthday or within six months after their first tooth erupts.**

**C. “There’s no rush in visiting a dentist until your child starts her schooling.” Waiting until a child starts school to begin dental visits is not recommended. Dental problems can start early, and the earlier they’re caught, the easier they are to treat. Regular dental visits should start by the child’s first birthday or within six months after the first tooth erupts.**

**D. “Given that you’re ensuring good brushing habits, a dental visit isn’t essential at this time.” While good brushing habits are crucial for dental health, they’re not a substitute for regular dental visits. Dentists can catch potential problems that might not be visible to the untrained eye and can provide professional cleanings that are more thorough than brushing alone.**

**32. Correct answer:**

**C. At the age of 6. Typically, children can start brushing their teeth independently around the age of 6. By this age, they have developed the necessary motor skills to effectively brush their teeth, and they also have a better understanding of the importance of oral hygiene. However, even though they can brush their teeth independently, it’s still important for parents to supervise and assist as needed to ensure that all areas of the mouth are being cleaned properly.**

**To understand this better, imagine teaching a child to tie their shoes. At first, you would do it for them, then you would guide them through the process, and finally, once they’ve developed the necessary motor skills and understanding, they would be able to do it on their own. However, you would still supervise them for a while to make sure they’re doing it correctly. Similarly, with brushing teeth, the child starts to do it independently around the age of 6, but the parent should still supervise and assist as needed.**

It's also important to note that the transition to independent brushing should be gradual and based on the individual child's abilities and understanding. Some children might be ready to start brushing independently a bit earlier, while others might need a bit more time. It's like learning to dance – some people pick up the steps quickly, while others need a bit more practice.

**Incorrect answer options:**

**A. As soon as the first tooth appears. While it's important to start cleaning a child's teeth as soon as the first tooth appears, children are not capable of brushing their teeth independently at this age. Parents should clean their child's teeth for them until the child is old enough to brush independently.**

**B. At the age of 1. One-year-olds are generally not ready to brush their teeth independently. They might not have the necessary motor skills to effectively clean all areas of their mouth, and they might not fully understand the importance of oral hygiene.**

**D. At the age of 10. Waiting until the age of 10 to start independent brushing is generally too late. Most children are capable of brushing their teeth independently around the age of 6, and delaying independent brushing until the age of 10 could hinder the development of good oral hygiene habits.**

**33. Correct answer:**

**D. Giving him the autonomy to make some choices about his meal contents. Giving a child the autonomy to make some choices about their meal contents can be an effective strategy for managing picky eating habits. This approach can help the child feel more engaged and invested in their meals, which can increase their willingness to eat. It also respects the child's developing autonomy and can help them learn about different foods and their nutritional value.**

To understand this better, imagine you're at a buffet. If you're allowed to choose your own food, you're more likely to enjoy your meal and eat a good amount. But if someone else chooses your food for you, you might not like what they choose, and you might not eat as much. Similarly, giving a child some choice in their meals can make the meals more appealing and enjoyable for them.

However, it's important to ensure that the choices offered are all healthy and balanced. For example, you might let the child choose between two different types of vegetables or decide whether they want their chicken grilled or baked. It's also important to continue offering a variety of foods, even if the child initially rejects them, as it can take multiple exposures to a new food before a child is willing to try it.

**Incorrect answer options:**

**A. Prohibiting him from engaging in playtime with friends until he consumes all the served food. Using playtime with friends as a reward for eating can create a negative association with mealtime and can lead to power struggles. It can also put too much pressure on the child to eat, which can actually decrease their appetite and enjoyment of food.**

**B. Enforcing a rule that he must eat the meals served during mealtimes. While it's important to encourage children to eat at mealtimes, enforcing a strict rule that they must eat everything served can create pressure and anxiety around mealtime. This can actually decrease their appetite and enjoyment of food, and it can lead to power struggles.**

**C. Establishing a suitable reward system for meal completion. While rewards can sometimes be effective in encouraging desired behavior, using rewards for meal completion can create an unhealthy relationship with food. It can lead to the child eating just to get the reward, rather than because they're hungry or because they enjoy the food. It can also put too much pressure on the child to eat, which can decrease their appetite and enjoyment of food.**

**34. Correct answer:**

**C. Exhibit positive safety behaviors for him to follow. Exhibiting positive safety behaviors for a four-year-old to follow is the most effective strategy for imparting safety knowledge. At this age, children learn a lot through observation and imitation. They are keen observers of the actions of adults around them and often model their behavior after what they see. By demonstrating safe behaviors, Nurse Bryan can provide a clear, tangible example for the child to follow.**

To understand this better, imagine you're learning a new dance. You could read about the steps or listen to someone describe them, but it's much easier to learn if you can watch someone else do the dance. You can see exactly how the steps are supposed to look and then try to replicate them. Similarly, by watching Nurse Bryan demonstrate safe behaviors, the child can see exactly what he's supposed to do and then try to replicate those behaviors.

Moreover, this approach can also help to foster a positive attitude towards safety. Instead of viewing safety rules as restrictions or punishments, the child can see them as normal, everyday behaviors. This can make the child more willing to follow the rules and can help to establish a lifelong habit of safety.

Finally, it's important for Nurse Bryan to reinforce the child's positive behaviors with praise and encouragement. This can help to motivate the child to continue practicing safe behaviors and can help to build their confidence in their ability to stay safe.

**Incorrect answer options:**

**A. Reprimand him for unsafe behavior by labelling his actions as 'bad'. While it's important to correct unsafe behavior, reprimanding a child and labeling their actions as 'bad' can be counterproductive. It can make the child feel ashamed or defensive, which can hinder their learning. It's more effective to explain why the behavior is unsafe and to demonstrate the correct behavior.**

**B. Point out and discuss potential dangers he should steer clear of. While it's important to make children aware of potential dangers, simply pointing out these dangers might not be enough for a four-year-old. At this age, children learn best through active engagement and hands-on experiences. Demonstrating safe behaviors provides a more concrete and engaging learning experience.**

**D. Show him images of children who have been in accidents as a warning. Showing a four-year-old images of children who have been in accidents is not an appropriate or effective strategy for teaching safety. It can be frightening and traumatic for the child, and it doesn't provide them with the practical skills they need to stay safe.**

**35. Correct answer:**

**C. The stages of her social development. By asking about the girl's best friend, Nurse Anderson is assessing the stages of her social development. Friendships play a crucial role in a child's social development, providing opportunities for the child to practice and develop social skills such as communication, cooperation, and conflict resolution. Friendships also contribute to a child's sense of belonging and self-esteem.**

To understand this better, imagine you're learning to play a team sport, like basketball. You can learn the rules and practice shooting hoops on your own, but to really develop your skills, you need to play with a team. You need to learn how to pass the ball, how to coordinate with your teammates, and how to handle the ups and downs of a game. Similarly, friendships provide a "practice ground" for children to develop their social skills.

Moreover, the nature of a child's friendships can provide insight into their social development. For example, a child who has a best friend may have developed the ability to form close, reciprocal relationships. On the other hand, a child who frequently changes friends or has difficulty maintaining friendships may be struggling with social skills.

Finally, asking about a child's best friend can also provide an opportunity to assess the child's social environment and to identify any potential issues, such as bullying or peer pressure.

**Incorrect answer options:**

**A. The progression of her motor skills. Asking about a child's best friend is not a direct assessment of her motor skills. Motor skills refer to the child's ability to move and control her body and would typically be assessed through physical tasks such as running, jumping, or writing.**

**B. Her neurological development status. While social development is linked to neurological development, asking about a child's best friend is not a direct assessment of her neurological status. Neurological development would typically be**

assessed through tasks that require cognitive processing, sensory integration, or motor coordination.

D. The evolution of her language capabilities. While friendships can contribute to language development by providing opportunities for communication, asking about a child's best friend is not a direct assessment of her language capabilities. Language development would typically be assessed by evaluating the child's ability to understand and use language, such as following instructions, answering questions, or telling a story.

36. Correct answer:

C. The child is likely fully capable of handling this responsibility. If a child is proudly declaring that she is responsible for brushing and flossing her teeth, it's likely that she is fully capable of handling this responsibility. Typically, children develop the necessary motor skills to effectively brush and floss their teeth around the age of 6 to 8. They also have a better understanding of the importance of oral hygiene at this age. However, even though they can brush and floss independently, it's still important for parents to supervise and assist as needed to ensure that all areas of the mouth are being cleaned properly.

To understand this better, imagine you're learning to ride a bike. At first, you would need someone to hold the bike steady for you and guide you. But as you practice and develop your balance and coordination, you would eventually be able to ride on your own. Similarly, with brushing and flossing teeth, the child starts to do it independently around the age of 6 to 8, but the parent should still supervise and assist as needed.

Moreover, the child's pride in her dental hygiene responsibility is a positive sign. It shows that she values oral hygiene and is motivated to take care of her teeth. This can contribute to the development of lifelong oral hygiene habits.

Incorrect answer options:

A. The child is likely not ready to handle such responsibility. While it's important to ensure that a child is ready to handle the responsibility of brushing and flossing their teeth, a child who is proudly declaring this responsibility is likely ready and capable.

This statement could potentially underestimate the child's abilities and undermine her confidence.

**B.** The child may be overstating her level of responsibility. While it's possible that a child could overstate her level of responsibility, it's also important to take her declaration seriously and to encourage her independence. This statement could potentially dismiss the child's efforts and discourage her from taking responsibility.

**D.** The child should have taken on this responsibility even earlier. While it's important to start oral hygiene habits early, children typically don't develop the necessary motor skills to effectively brush and floss their teeth until around the age of 6 to 8. This statement could potentially put undue pressure on the child and the parents.

**37. Correct answer:**

**B.** Acquired proficiency in navigating the nuances of language. A child's relentless joking and riddle-telling is often a sign of their acquired proficiency in navigating the nuances of language. As children grow and their language skills develop, they begin to understand and appreciate humor, wordplay, and the unexpected twists that make riddles and jokes fun. This is a normal part of language and cognitive development, and it can be a sign that the child is exploring and experimenting with language.

To understand this better, imagine you're learning to play a musical instrument. At first, you learn the basics, like how to hold the instrument and how to play simple notes. But as you become more proficient, you start to experiment with different techniques and styles. You might start to improvise, play around with different rhythms, or even compose your own music. Similarly, as children become more proficient with language, they start to experiment with different ways of using language, such as telling jokes and riddles.

Moreover, this stage of language development can also contribute to a child's social development. Jokes and riddles can be a way for children to connect with others, express their creativity, and entertain themselves and others. It can also help them learn about social norms and expectations, as they learn what types of jokes are appropriate in different situations.

Finally, it's important for parents to support and encourage their child's language development, even if the constant joking and riddle-telling can sometimes be testing. Parents can do this by laughing at their child's jokes, engaging with their riddles, and even sharing their own jokes and riddles. This can help to foster a positive attitude towards language and learning, and it can provide opportunities for fun and bonding.

**Incorrect answer options:**

**A. Influence from peers that may not be suitable.** While peers can certainly influence a child's behavior, a child's interest in jokes and riddles is typically a normal part of language development and is not necessarily a sign of unsuitable peer influence.

**C. A sign of lacking parental attention.** While children sometimes use certain behaviors to seek attention, a child's interest in jokes and riddles is typically a normal part of language development and is not necessarily a sign of lacking parental attention.

**D. An outcome of watching too much television.** While television can expose children to jokes and riddles, a child's interest in these forms of wordplay is typically a normal part of language development and is not necessarily an outcome of watching too much television.

**38. Correct answer:**

**C. The middle-ground known as conventional morality.** The child's behavior aligns with the conventional level of Kohlberg's stages of moral development. This level typically emerges in the school-age years and continues into adulthood. It is characterized by an understanding of morality based on societal rules and the expectations of others. Children at this stage start to internalize the moral standards of the valued adult role models in their life and judge the morality of actions by their direct consequences.

To understand this better, imagine you're playing a board game. At first, you might just be focused on trying to win, regardless of the rules (preconventional morality).

But as you play more, you start to understand that the game only works if everyone follows the rules. You start to play by the rules, not just because you'll get in trouble if you don't, but because you understand that the rules are what make the game fair and enjoyable for everyone (conventional morality).

Children at the conventional level of moral development often believe that conforming to societal rules and norms is important in itself, regardless of the potential punishments or rewards. They start to understand that these rules maintain social order and promote the general good. They also begin to judge their own and others' behavior based on these societal standards, which is why the child in the scenario is starting to associate behaviors pleasing to others as "good behavior".

Incorrect answer options:

A. The initial level of preconventional morality. In the preconventional level of Kohlberg's stages of moral development, children understand morality in terms of direct consequences to themselves. They view "good behavior" as behavior that allows them to avoid punishment or gain rewards. The child's behavior in the scenario shows a more advanced understanding of morality, aligning more with the conventional level.

B. The higher level of postconventional morality. The postconventional level of moral development, which often emerges in adulthood, involves understanding morality in terms of abstract principles and values that may sometimes conflict with societal rules. The child's behavior in the scenario shows an understanding of morality based on societal rules and the expectations of others, which aligns more with the conventional level.

D. The individualistic stage of autonomous morality. This is not one of Kohlberg's stages of moral development. The stages are preconventional, conventional, and postconventional.

39. Correct answer:

D. The child should take part in the preparation of their own snacks. Involving the child in the preparation of their own snacks is an essential understanding that should

guide the development of the child's nutritional plan. This approach can have several benefits. First, it can help the child develop a sense of autonomy and responsibility for their own health. Second, it can provide an opportunity for the child to learn about nutrition and the importance of healthy eating. Third, it can make the child more likely to eat the snacks they've helped prepare.

To understand this better, imagine you're building a model airplane. If someone else builds the airplane for you, you might appreciate the finished product, but you won't learn much about how it was built. But if you build the airplane yourself, you'll learn about each part and how they fit together. You'll also feel a sense of accomplishment when you finish, and you'll probably take better care of the airplane because you put effort into building it. Similarly, when children help prepare their own snacks, they learn about the ingredients and how they contribute to a healthy diet. They also feel a sense of accomplishment and are more likely to eat the snacks they've prepared.

Moreover, involving the child in snack preparation can also provide an opportunity for bonding and fun. The child and mother can enjoy the process of preparing the snacks together, and the child can take pride in sharing the snacks they've helped prepare with other family members.

**Incorrect answer options:**

**A. The child doesn't require food intake between main meals. While it's important to ensure that snacks don't replace main meals, children often need snacks between meals to meet their energy and nutrient needs. This statement could potentially lead to inadequate food intake and nutrient deficiencies.**

**B. The child will naturally opt for nutritious snack choices. While some children may naturally prefer nutritious foods, many children need guidance and education to make healthy food choices. This statement could potentially underestimate the importance of parental involvement and education in promoting healthy eating habits.**

**C. The child should consume snacks prepared by the mother. While it's important for parents to provide healthy food options, involving the child in the preparation of their own snacks can have additional benefits, as discussed above. This statement could potentially underestimate the importance of fostering the child's autonomy and involvement in their own health.**

**40. Correct answer:**

**D. The child is engaged in concrete operational thought processes. The child's inclination towards collecting various items is indicative of concrete operational thought processes, a stage in Piaget's theory of cognitive development that typically occurs between the ages of 7 and 11. During this stage, children start to think logically about concrete events and begin to understand the concept of conservation, that is, the understanding that quantity remains the same despite changes in shape or arrangement. They also start to classify items into different sets and subsets, which is likely what the child is doing by collecting various items.**

To understand this better, imagine you're sorting a deck of cards. At first, you might just group the cards randomly. But as you become more familiar with the cards, you start to sort them by suit or by number. You understand that a card can belong to the group of hearts and the group of number 5 cards at the same time. Similarly, when children are in the concrete operational stage, they start to classify items into different categories based on their characteristics.

Moreover, collecting items can also provide opportunities for children to practice other cognitive skills, such as comparing and contrasting (which item is bigger, which is heavier), sequencing (arranging items in order of size or age), and problem-solving (how to organize the collection, how to find a missing item).

**Incorrect answer options:**

**A. The child is demonstrating the ability to coordinate actions. While collecting items does involve coordinating actions, this behavior is more indicative of concrete operational thought processes, as it involves classifying items into different categories based on their characteristics.**

**B. The child is in the stage of formal operations. The stage of formal operations, which typically begins around age 12, involves abstract thinking and hypothetical reasoning. While collecting items can involve some level of abstract thinking (e.g., understanding the concept of a "collection"), this behavior is more indicative of concrete operational thought processes.**

**C. The child is exhibiting tertiary circular reactions. Tertiary circular reactions are a part of the sensorimotor stage in Piaget's theory, which typically occurs between birth and 2 years of age. This stage involves the exploration of new ways to produce the same outcome or different outcomes. The child's behavior of collecting items is more indicative of concrete operational thought processes.**

**41. Correct answer:**

**A. A sense of industry. According to Erikson's theory of psychosocial development, school-age children (typically between the ages of 6 and 11) are in the stage of "Industry vs. Inferiority". During this stage, children begin to develop a sense of industry, which is a feeling of competence and productivity. They start to take pride in their accomplishments and abilities, and they enjoy engaging in tasks and activities that allow them to demonstrate their skills and abilities.**

**Play can play a crucial role in this stage of development. Through play, children can explore different roles and tasks, practice their skills, and experience the satisfaction of completing a task or achieving a goal. For example, a child might enjoy building a complex structure with blocks, solving a challenging puzzle, or playing a game that requires strategy and skill. These play activities can help the child develop a sense of industry, as they provide opportunities for the child to demonstrate competence and productivity.**

**To understand this better, imagine you're learning to cook. At first, you might just follow simple recipes. But as you become more proficient, you start to experiment with different ingredients and techniques. You take pride in the meals you prepare, and you enjoy the process of cooking. Similarly, when children are in the stage of "Industry vs. Inferiority", they enjoy engaging in tasks and activities that allow them to demonstrate their skills and abilities, and they take pride in their accomplishments.**

**Incorrect answer options:**

**B. A sense of intimacy. A sense of intimacy is developed during the stage of "Intimacy vs. Isolation", which typically occurs in young adulthood. This stage involves forming intimate, loving relationships with other people.**

**C. A sense of identity.** A sense of identity is developed during the stage of “Identity vs. Role Confusion”, which typically occurs during adolescence. This stage involves developing a sense of self and personal identity.

**D. A sense of initiative.** A sense of initiative is developed during the stage of “Initiative vs. Guilt”, which typically occurs during the preschool years. This stage involves taking initiative in learning and other activities.

**42. Correct answer:**

**D. The crucial need for utilizing auto seat belts.** Motor vehicle accidents are one of the leading causes of accidental injury and death among school-age children. Therefore, emphasizing the crucial need for utilizing auto seat belts is an important preventive measure that Nurse Harper should highlight in her inaugural lesson. Seat belts, when used correctly, can significantly reduce the risk of serious injury and death in the event of a car accident.

To understand this better, imagine you’re on a roller coaster. The roller coaster has a safety bar that you’re required to lower before the ride starts. This safety bar keeps you securely in your seat as the roller coaster twists, turns, and goes upside down. Without the safety bar, you could easily be thrown from the roller coaster and seriously injured. Similarly, a seat belt in a car acts like the safety bar on a roller coaster. It keeps you securely in your seat and prevents you from being thrown from the car in the event of an accident.

Moreover, teaching children about the importance of seat belts can also provide an opportunity to discuss other aspects of car safety, such as the importance of sitting in the back seat, the proper use of booster seats, and the dangers of distracting the driver.

**Incorrect answer options:**

**A. The importance of wearing protective eyewear.** While wearing protective eyewear is important for certain activities, such as playing certain sports or doing science experiments, it’s not one of the primary preventive measures for reducing the risk of accidental injury and death among school-age children.

**B. The necessity of using life preservers. While using life preservers is crucial for water safety, it's not one of the primary preventive measures for reducing the risk of accidental injury and death among school-age children. However, it could be an important topic to cover if the lessons include water safety.**

**C. The role of flame-retardant clothing. While flame-retardant clothing can help prevent burn injuries, it's not one of the primary preventive measures for reducing the risk of accidental injury and death among school-age children.**

**43. Correct answer:**

**D. Involve the child in planning and preparing meals. Involving the child in planning and preparing meals is a key strategy that Nurse Katrina should encourage the mother to implement. This approach can have several benefits. First, it can help the child develop a sense of autonomy and responsibility for their own health. Second, it can provide an opportunity for the child to learn about nutrition and the importance of healthy eating. Third, it can make the child more likely to eat the meals they've helped prepare.**

**To understand this better, imagine you're building a model airplane. If someone else builds the airplane for you, you might appreciate the finished product, but you won't learn much about how it was built. But if you build the airplane yourself, you'll learn about each part and how they fit together. You'll also feel a sense of accomplishment when you finish, and you'll probably take better care of the airplane because you put effort into building it. Similarly, when children help prepare their own meals, they learn about the ingredients and how they contribute to a healthy diet. They also feel a sense of accomplishment and are more likely to eat the meals they've prepared.**

**Moreover, involving the child in meal preparation can also provide an opportunity for bonding and fun. The child and mother can enjoy the process of preparing the meals together, and the child can take pride in sharing the meals they've helped prepare with other family members.**

**Incorrect answer options:**

**A. Forbid the child from outdoor play if he consumes snacks. This strategy could potentially lead to negative associations with food and physical activity, which could be harmful in the long term. It's important to encourage both healthy eating and regular physical activity, without using one as a punishment or reward for the other.**

**B. Restrict the child's daily caloric intake to 1,200kCal. While it's important to ensure that the child's caloric intake is appropriate for their age, sex, and activity level, a daily caloric intake of 1,200kCal is likely too low for a 10-year-old boy. This could potentially lead to inadequate nutrient intake and growth problems.**

**C. Limit the child's snacking between meals. While it's important to ensure that snacks don't replace main meals, healthy snacks can play an important role in a child's diet by providing additional nutrients and helping to manage hunger between meals.**

**44. Correct answer:**

**A. The underdevelopment of the child's abdominal muscles. The prominent abdomen observed in an 18-month-old child can be attributed to the underdevelopment of the child's abdominal muscles. At this age, the abdominal muscles are not yet fully developed and strong enough to pull in the abdomen, which can give the abdomen a protruding appearance. This is a normal part of physical development in toddlers and is not usually a cause for concern.**

**To understand this better, imagine a balloon filled with water. Without any external support, the water causes the balloon to bulge out. Similarly, in toddlers, the abdominal organs push against the weak abdominal muscles, causing the abdomen to protrude. As the child grows and the abdominal muscles strengthen, the abdomen will become less prominent.**

**Moreover, the toddler's posture can also contribute to the appearance of a prominent abdomen. Toddlers often have a lordotic posture, which means they tend to arch their backs, which can make the abdomen stick out more.**

**Incorrect answer options:**

**B. The child's bow-legged posture. While bow-legged posture can be a normal part of physical development in toddlers, it does not typically cause a prominent abdomen. Bow-legged posture refers to a condition where the knees stay wide apart while standing with feet and ankles together, which primarily affects the alignment of the legs, not the abdomen.**

**C. The nature of the child's linear growth curve. While the child's growth curve can provide important information about their overall growth and development, it does not directly explain the appearance of a prominent abdomen. The growth curve typically reflects changes in height and weight over time, not specific physical characteristics like the shape of the abdomen.**

**D. An increased food intake typical of the child's age. While toddlers often have an increased appetite due to rapid growth and development, this does not typically cause a permanently prominent abdomen. While overeating can cause the abdomen to distend immediately after a large meal, it does not cause a consistently prominent abdomen unless it leads to overweight or obesity.**

**45. Correct answer:**

**C. A sense of shame. According to Erikson's theory of psychosocial development, toddlers (typically between the ages of 1 and 3) are in the stage of "Autonomy vs. Shame and Doubt". During this stage, children begin to develop a sense of autonomy, or independence, as they learn to perform tasks on their own, such as feeding themselves, dressing themselves, or using the toilet. If parents continue to treat their toddler as dependent in areas where he can utilize his own abilities, the toddler might develop a sense of shame and doubt about his own abilities.**

**To understand this better, imagine you're learning to ride a bike. At first, you might need someone to hold onto the bike while you learn to balance. But as you become more proficient, you want to try riding on your own. If the person holding the bike refuses to let go, you might start to doubt your ability to ride on your own. You might feel ashamed that you can't do something that you believe you're capable of doing. Similarly, when toddlers are ready to start performing tasks on their own, they need the opportunity to try. If their parents continue to do everything for them, they might start to doubt their own abilities and feel ashamed.**

Moreover, developing a sense of autonomy is important for a child's self-esteem and confidence. When children are allowed to do things on their own, they develop a sense of competence and belief in their abilities, which can contribute to a positive sense of self.

**Incorrect answer options:**

**A. A sense of inferiority.** A sense of inferiority is developed during the stage of "Industry vs. Inferiority", which typically occurs in middle childhood (ages 6 to 11). This stage involves developing a sense of competence and productivity.

**B. A sense of guilt.** A sense of guilt is developed during the stage of "Initiative vs. Guilt", which typically occurs during the preschool years (ages 3 to 5). This stage involves taking initiative in learning and other activities.

**D. A sense of mistrust.** A sense of mistrust is developed during the stage of "Trust vs. Mistrust", which typically occurs in infancy (birth to 1 year). This stage involves developing a sense of trust in others.

**46. Correct answer:**

**D. Fear of the dark.** Fear of the dark is a common fear that is typically associated with toddlerhood. This fear can be attributed to several factors. First, toddlers are beginning to develop their imaginations, which can lead to fears of imaginary creatures or situations, especially in the dark where they can't see clearly. Second, toddlers are also developing a sense of independence, but they still have a strong attachment to their caregivers. Being alone in the dark can make them feel separated from their caregivers, which can be scary.

To understand this better, imagine you're in a room filled with various objects. When the lights are on, you can see everything clearly and navigate the room without any problems. But when the lights are turned off, you can't see the objects anymore. You might start to imagine that the objects are something else, like a monster or a ghost. You might also feel anxious because you can't see where you're going. This is similar to how a toddler might feel in the dark.

Moreover, it's important to note that fears are a normal part of development and can be managed with understanding and reassurance. Parents can help their toddlers cope with fear of the dark by providing a nightlight, leaving the bedroom door open, or incorporating a comforting bedtime routine.

**Incorrect answer options:**

**A. Fear of ghosts.** While some toddlers might develop a fear of ghosts, this is more common in older children who have a more developed understanding of the concept of ghosts.

**B. Fear of going to sleep.** While some toddlers might resist going to bed or have difficulty sleeping through the night, this is not typically due to a fear of sleep itself. It's more likely related to separation anxiety or a desire to stay up and play.

**C. Fear of mutilation.** Fear of mutilation, or fear of bodily injury, is more common in the phallic stage of psychosexual development, according to Freud's theory. This stage typically occurs around the ages of 3 to 6 years, not in toddlerhood.

**47. Correct answer:**

**A. Her favorite blanket.** A favorite blanket, or any other familiar object, can provide a sense of security and comfort to a toddler, especially in the absence of a primary caregiver. This is because toddlers often form strong emotional attachments to certain objects, which are known as transitional objects. These objects serve as a bridge between the child and the caregiver, providing comfort and reducing anxiety when the caregiver is not present.

To understand this better, imagine you're in a foreign country where you don't speak the language and don't know anyone. You might feel anxious and out of place. But if you have something familiar with you, like a favorite book or a photo of your loved ones, it can make you feel more secure and comfortable. Similarly, for a toddler, a favorite blanket can provide a sense of familiarity and comfort in an unfamiliar environment or situation.

Moreover, it's important to note that the use of transitional objects is a normal part of development and can be encouraged. It's a healthy way for toddlers to cope with separation anxiety and to self-soothe.

**Incorrect answer options:**

**B. A large, cuddly stuffed dog. While a stuffed animal might provide some comfort, it's not likely to be as effective as a favorite blanket or other familiar object. This is because the comfort provided by transitional objects comes from their familiarity and the emotional attachment the child has formed with them.**

**C. Encouraging her to take a nap. While sleep might provide a temporary distraction from the separation, it's not likely to address the underlying issue of separation anxiety. Furthermore, if the child is feeling anxious, she might have difficulty falling asleep.**

**D. Introducing her to a peer play group. While social interaction can be beneficial for toddlers, introducing her to a group of unfamiliar peers is unlikely to comfort her in the immediate aftermath of her mother's departure. In fact, it might increase her anxiety due to the unfamiliar environment and people.**

**48. Correct answer:**

**B. Finger paints. Finger paints are an excellent choice for an 18-month-old child. At this age, children are developing their fine motor skills and sensory experiences, and finger painting can help promote these areas of development. Finger painting allows toddlers to explore different textures and colors, and it encourages creativity. It also helps strengthen their hand and finger muscles, which is important for later skills such as writing.**

To understand this better, imagine you're learning to cook. At first, you might follow recipes exactly, measuring out each ingredient precisely. But as you become more comfortable in the kitchen, you might start to experiment a bit, adding a pinch of this or a dash of that, and seeing how it changes the taste of the dish. This is similar to how a toddler might explore with finger paints, experimenting with mixing different colors and creating different shapes and patterns.

Moreover, it's important to note that finger painting can be a messy activity, so it's a good idea to have materials on hand for clean-up and to dress the child in clothes that can get dirty. Also, always ensure that the paints are non-toxic and safe for children.

**Incorrect answer options:**

**A. Miniature cars.** Miniature cars can pose a choking hazard for an 18-month-old child. At this age, children often explore objects by putting them in their mouth, so it's important to avoid toys with small parts.

**C. A puzzle with multiple pieces.** While puzzles can be a good learning tool, a puzzle with multiple pieces might be too complex for an 18-month-old child. At this age, children are still developing their problem-solving skills and hand-eye coordination, so a simpler puzzle with large pieces would be more appropriate.

**D. A comic book.** While books are a great tool for promoting language development, a comic book is likely too advanced for an 18-month-old child. At this age, children typically prefer books with large, colorful pictures and simple, repetitive text.

**49. Correct answer:**

**D. Food "jags"** Food "jags" are a common characteristic of toddler eating patterns. A food jag occurs when a toddler eats one food repeatedly, then suddenly refuses to eat that food. This can be frustrating for parents, but it's a normal part of toddler development. Toddlers are learning about their preferences and asserting their independence, and this can manifest in their eating habits.

To understand this better, imagine you've discovered a new song that you really like. You might listen to it on repeat for several days, enjoying it each time. But after a while, you might get tired of the song and stop listening to it, even though you liked it so much before. This is similar to how a toddler might experience a food jag, enjoying a certain food for a while and then suddenly losing interest in it.

Moreover, it's important to note that while food jags can be a source of stress for parents, they usually don't affect a toddler's overall nutrition as long as the diet is varied and balanced. Offering a variety of foods and encouraging, but not forcing, the toddler to try new foods can help manage food jags.

**Incorrect answer options:**

**A. An increased appetite.** While toddlers may have periods of increased appetite, especially during growth spurts, they generally have a decreased appetite compared to their infancy. This is because their growth rate slows down after the first year of life.

**B. A preference for solitary eating.** Toddlers typically enjoy social interaction, including during meal times. Eating together as a family can provide opportunities for social learning and can help establish healthy eating habits.

**C. The ability to consistently demonstrate table manners.** While toddlers can begin learning basic table manners, such as using utensils and not throwing food, they are still developing their motor skills and self-control. Therefore, they may not be able to consistently demonstrate table manners.

**50. Correct answer:**

**C. A colorful activity cube, often called a "busy box."** A colorful activity cube, or "busy box," is an excellent choice for a 5-month-old infant. At this age, babies are developing their fine motor skills, hand-eye coordination, and color and shape recognition. An activity cube can stimulate these areas of development. It often includes various activities on each side of the cube, such as spinning gears, sliding beads, or shape sorters, which can keep a baby engaged and promote exploration and learning.

To understand this better, imagine you're at a buffet with a variety of dishes to choose from. You might try a little bit of everything, enjoying the different flavors and textures. This is similar to how a baby might explore an activity cube, engaging with the different activities and learning from each one.

Moreover, it's important to note that when choosing toys for infants, safety should be the top priority. The toy should be large enough that it can't be swallowed, it should not have small parts that could pose a choking hazard, and it should be made of non-toxic materials.

**Incorrect answer options:**

**A. A large red balloon. While a balloon might seem like a fun toy, it can pose a choking hazard if it pops. Therefore, it's not a safe choice for a 5-month-old infant.**

**B. A wooden push-pull truck. A push-pull truck is more suitable for older infants or toddlers who are learning to walk. A 5-month-old infant is not yet developmentally ready for this type of toy.**

**D. A teddy bear with button eyes. While a teddy bear can be a comforting toy, a teddy bear with button eyes is not safe for a 5-month-old infant. The button eyes could come off and pose a choking hazard.**

### **MIDWIFERY 8 (Antepartum)**

**1. A nursing instructor is conducting lecture and is reviewing the functions of the female reproductive system. She asks Mark to describe the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH). Mark accurately responds by stating that:**

- A. FSH and LH are released from the anterior pituitary gland.**
- B. FSH and LH are secreted by the corpus luteum of the ovary**
- C. FSH and LH are secreted by the adrenal glands**
- D. FSH and LH stimulate the formation of milk during pregnancy.**

2. A nurse is describing the process of fetal circulation to a client during a prenatal visit. The nurse accurately tells the client that fetal circulation consists of:

- A. Two umbilical veins and one umbilical artery
- B. Two umbilical arteries and one umbilical vein
- C. Arteries carrying oxygenated blood to the fetus
- D. Veins carrying deoxygenated blood to the fetus

3. During a prenatal visit at 38 weeks, a nurse assesses the fetal heart rate. The nurse determines that the fetal heart rate is normal if which of the following is noted?

- A. 80 BPM
- B. 100 BPM
- C. 150 BPM
- D. 180 BPM

4. A client arrives at a prenatal clinic for the first prenatal assessment. The client tells a nurse that the first day of her last menstrual period was September 19th, 2013. Using Naegele's rule, the nurse determines the estimated date of confinement as:

- A. July 26, 2013
- B. June 12, 2014
- C. June 26, 2014
- D. July 12, 2014

5. A nurse is collecting data during an admission assessment of a client who is pregnant with twins. The client has a healthy 5-year old child that was delivered at 37 weeks and tells the nurse that she doesn't have any history of abortion or fetal demise. The nurse would document the GTPAL for this client as:

- A. G = 3, T = 2, P = 0, A = 0, L = 1
- B. G = 2, T = 0, P = 1, A = 0, L = 1
- C. G = 1, T = 1, P = 1, A = 0, L = 1
- D. G = 2, T = 0, P = 0, A = 0, L = 1

6. A nurse is performing an assessment of a primipara who is being evaluated in a clinic during her second trimester of pregnancy. Which of the following indicates an abnormal physical finding necessitating further testing?

- A. Consistent increase in fundal height
- B. Fetal heart rate of 180 BPM

- C. Braxton hicks contractions
- D. Quickening

7. A nurse is reviewing the record of a client who has just been told that a pregnancy test is positive. The physician has documented the presence of a Goodell's sign. The nurse determines this sign indicates:

- A. A softening of the cervix
- B. A soft blowing sound that corresponds to the maternal pulse during auscultation of the uterus.
- C. The presence of hCG in the urine
- D. The presence of fetal movement

8. A nursing instructor asks a nursing student who is preparing to assist with the assessment of a pregnant client to describe the process of quickening. Which of the following statements if made by the student indicates an understanding of this term?

- 1. "It is the irregular, painless contractions that occur throughout pregnancy."
- 2. "It is the soft blowing sound that can be heard when the uterus is auscultated."
- 3. "It is the fetal movement that is felt by the mother."
- 4. "It is the thinning of the lower uterine segment."

9. A nurse midwife is performing an assessment of a pregnant client and is assessing the client for the presence of ballottement. Which of the following would the nurse implement to test for the presence of ballottement?

- A. Auscultating for fetal heart sounds
- B. Palpating the abdomen for fetal movement
- C. Assessing the cervix for thinning
- D. Initiating a gentle upward tap on the cervix

10. A nurse is assisting in performing an assessment on a client who suspects that she is pregnant and is checking the client for probable signs of pregnancy. Select all probable signs of pregnancy.

- A. Uterine enlargement
- B. Fetal heart rate detected by nonelectric device
- C. Outline of the fetus via radiography or ultrasound
- D. Chadwick's sign
- E. Braxton Hicks contractions
- F. Ballottement

11. A pregnant client calls the clinic and tells a nurse that she is experiencing leg cramps and is awakened by the cramps at night. To provide relief from the leg cramps, the nurse tells the client to:

- A. Dorsiflex the foot while extending the knee when the cramps occur
- B. Dorsiflex the foot while flexing the knee when the cramps occur
- C. Plantar flex the foot while flexing the knee when the cramps occur
- D. Plantar flex the foot while extending the knee when the cramps occur.

12. A nurse is providing instructions to a client in the first trimester of pregnancy regarding measures to assist in reducing breast tenderness. The nurse tells the client to:

- A. Avoid wearing a bra
- B. Wash the nipples and areola area daily with soap, and massage the breasts with lotion.
- C. Wear tight-fitting blouses or dresses to provide support
- D. Wash the breasts with warm water and keep them dry

13. A pregnant client in the last trimester has been admitted to the hospital with a diagnosis of severe preeclampsia. A nurse monitors for complications associated with the diagnosis and assesses the client for:

- A. Any bleeding, such as in the gums, petechiae, and purpura.
- B. Enlargement of the breasts
- C. Periods of fetal movement followed by quiet periods
- D. Complaints of feeling hot when the room is cool

14. A client in the first trimester of pregnancy arrives at a health care clinic and reports that she has been experiencing vaginal bleeding. A threatened abortion is suspected, and the nurse instructs the client regarding management of care. Which statement, if made by the client, indicates a need for further education?

- A. "I will maintain strict bedrest throughout the remainder of pregnancy."
- B. "I will avoid sexual intercourse until the bleeding has stopped, and for 2 weeks following the last evidence of bleeding."
- C. "I will count the number of perineal pads used on a daily basis and note the amount and color of blood on the pad."
- D. "I will watch for the evidence of the passage of tissue."

15. A prenatal nurse is providing instructions to a group of pregnant client regarding measures to prevent toxoplasmosis. Which statement if made by one of the clients indicates a need for further instructions?

- A. "I need to cook meat thoroughly."
- B. "I need to avoid touching mucous membranes of the mouth or eyes while handling raw meat."
- C. "I need to drink unpasteurized milk only."
- D. "I need to avoid contact with materials that are possibly contaminated with cat feces."

16. A homecare nurse visits a pregnant client who has a diagnosis of mild Preeclampsia and who is being monitored for pregnancy induced hypertension (PIH). Which assessment finding indicates a worsening of the Preeclampsia and the need to notify the physician?

- A. Blood pressure reading is at the prenatal baseline
- B. Urinary output has increased
- C. The client complains of a headache and blurred vision
- D. Dependent edema has resolved

17. A nurse implements a teaching plan for a pregnant client who is newly diagnosed with gestational diabetes. Which statement if made by the client indicates a need for further education?

- A. "I need to stay on the diabetic diet."
- B. "I will perform glucose monitoring at home."
- C. "I need to avoid exercise because of the negative effects of insulin production."
- D. "I need to be aware of any infections and report signs of infection immediately to my health care provider."

18. A primigravida is receiving magnesium sulfate for the treatment of pregnancy induced hypertension (PIH). The nurse who is caring for the client is performing assessments every 30 minutes. Which assessment finding would be of most concern to the nurse?

- A. Urinary output of 20 ml since the previous assessment
- B. Deep tendon reflexes of 2+
- C. Respiratory rate of 10 BPM
- D. Fetal heart rate of 120 BPM

19. A nurse is caring for a pregnant client with Preeclampsia. The nurse prepares a plan of care for the client and documents in the plan that if the client progresses from Preeclampsia to eclampsia, the nurse's first action is to:

- A. Administer magnesium sulfate intravenously
- B. Assess the blood pressure and fetal heart rate
- C. Clean and maintain an open airway
- D. Administer oxygen by face mask

20. A nurse is monitoring a pregnant client with pregnancy induced hypertension who is at risk for Preeclampsia. The nurse checks the client for which specific signs of Preeclampsia (select all that apply)?

- A. Elevated blood pressure
- B. Negative urinary protein
- C. Facial edema
- D. Increased respirations

21. Rho (D) immune globulin (RhoGAM) is prescribed for a woman following delivery of a newborn infant and the nurse provides information to the woman about the purpose of the medication. The nurse determines that the woman understands the purpose of the medication if the woman states that it will protect her next baby from which of the following?

- A. Being affected by Rh incompatibility
- B. Having Rh positive blood
- C. Developing a rubella infection
- D. Developing physiological jaundice

22. A pregnant client is receiving magnesium sulfate for the management of preeclampsia. A nurse determines the client is experiencing toxicity from the medication if which of the following is noted on assessment?

- A. Presence of deep tendon reflexes
- B. Serum magnesium level of 6 mEq/L
- C. Proteinuria of +3
- D. Respirations of 10 per minute

23. A woman with preeclampsia is receiving magnesium sulfate. The nurse assigned to care for the client determines that the magnesium therapy is effective if:

- A. Ankle clonus is noted
- B. The blood pressure decreases
- C. Seizures do not occur
- D. Scotomas are present

24. A nurse is caring for a pregnant client with severe preeclampsia who is receiving IV magnesium sulfate. Select all nursing interventions that apply in the care for the client.

- A. Monitor maternal vital signs every 2 hours
- B. Notify the physician if respirations are less than 18 per minute.
- C. Monitor renal function and cardiac function closely
- D. Keep calcium gluconate on hand in case of a magnesium sulfate overdose
- E. Monitor deep tendon reflexes hourly
- F. Monitor I and O's hourly
- G. Notify the physician if urinary output is less than 30 ml per hour.

25. In the 12th week of gestation, a client completely expels the products of conception. Because the client is Rh negative, the nurse must:

- A. Administer RhoGAM within 72 hours
- B. Make certain she receives RhoGAM on her first clinic visit
- C. Not give RhoGAM, since it is not used with the birth of a stillborn
- D. Make certain the client does not receive RhoGAM, since the gestation only lasted 12 weeks.

26. In a lecture on sexual functioning, the nurse plans to include the fact that ovulation occurs when the:

- A. Oxytocin is too high
- B. Blood level of LH is too high
- C. Progesterone level is high
- D. Endometrial wall is sloughed off.

27. The chief function of progesterone is the:

- A. Development of the female reproductive system
- B. Stimulation of the follicles for ovulation to occur
- C. Preparation of the uterus to receive a fertilized egg
- D. Establishment of secondary male sex characteristics

28. The developing cells are called a fetus from the:

- A. Time the fetal heart is heard
- B. Eighth week to the time of birth
- C. Implantation of the fertilized ovum
- D. End of the second week to the onset of labor

29. After the first four months of pregnancy, the chief source of estrogen and progesterone is the:

- A. Placenta
- B. Adrenal cortex
- C. Corpus luteum
- D. Anterior hypophysis

30. The nurse recognizes that an expected change in the hematologic system that occurs during the 2nd trimester of pregnancy is:

- A. A decrease in WBC's
- B. An increase in hematocrit
- C. An increase in blood volume
- D. A decrease in sedimentation rate

31. The nurse is aware that an adaptation of pregnancy is an increased blood supply to the pelvic region that results in a purplish discoloration of the vaginal mucosa, which is known as:

- A. Ladin's sign
- B. Hegar's sign
- C. Goodell's sign
- D. Chadwick's sign

32. A pregnant client is making her first Antepartum visit. She has a two year old son born at 40 weeks, a 5 year old daughter born at 38 weeks, and 7 year old twin daughters born at 35 weeks. She had a spontaneous abortion 3 years ago at 10 weeks. Using the GTPAL format, the nurse should identify that the client is:

- A. G4 T3 P2 A1 L4
- B. G5 T2 P2 A1 L4
- C. G5 T2 P1 A1 L4
- D. G4 T3 P1 A1 L4

**33. An expected cardiopulmonary adaptation experienced by most pregnant women is:**

- A. Tachycardia**
- B. Dyspnea at rest**
- C. Progression of dependent edema**
- D. Shortness of breath on exertion**

**34. Nutritional planning for a newly pregnant woman of average height and weighing 145 pounds should include:**

- A. A decrease of 200 calories a day**
- B. An increase of 300 calories a day**
- C. An increase of 500 calories a day**
- D. A maintenance of her present caloric intake per day**

**35. During a prenatal examination, the nurse draws blood from a young Rh negative client and explain that an indirect Coombs test will be performed to predict whether the fetus is at risk for:**

- A. Acute hemolytic disease**
- B. Respiratory distress syndrome**
- C. Protein metabolic deficiency**
- D. Physiologic hyperbilirubinemia**

**36. When involved in prenatal teaching, the nurse should advise the clients that an increase in vaginal secretions during pregnancy is called leukorrhea and is caused by increased:**

- A. Metabolic rates**
- B. Production of estrogen**
- C. Functioning of the Bartholin glands**
- D. Supply of sodium chloride to the cells of the vagina**

**37. A 26-year old multigravida is 14 weeks' pregnant and is scheduled for an alpha-fetoprotein test. She asks the nurse, "What does the alpha-fetoprotein test indicate?" The nurse bases a response on the knowledge that this test can detect:**

- A. Kidney defects**
- B. Cardiac defects**
- C. Neural tube defects**

**D. Urinary tract defects**

**38. At a prenatal visit at 36 weeks' gestation, a client complains of discomfort with irregularly occurring contractions. The nurse instructs the client to:**

- A. Lie down until they stop**
- B. Walk around until they subside**
- C. Time contraction for 30 minutes**
- D. Take 10 grains of aspirin for the discomfort**

**39. The nurse teaches a pregnant woman to avoid lying on her back. The nurse has based this statement on the knowledge that the supine position can:**

- A. Unduly prolong labor**
- B. Cause decreased placental perfusion**
- C. Lead to transient episodes of hypotension**
- D. Interfere with free movement of the coccyx**

**40. The pituitary hormone that stimulates the secretion of milk from the mammary glands is:**

- A. Prolactin**
- B. Oxytocin**
- C. Estrogen**
- D. Progesterone**

**41. Which of the following symptoms occurs with a hydatidiform mole?**

- A. Heavy, bright red bleeding every 21 days**
- B. Fetal cardiac motion after 6 weeks gestation**
- C. Benign tumors found in the smooth muscle of the uterus**
- D. "Snowstorm" pattern on ultrasound with no fetus or gestational sac**

**42. Which of the following terms applies to the tiny, blanched, slightly raised end arterioles found on the face, neck, arms, and chest during pregnancy?**

- A. Epulis**
- B. Linea nigra**
- C. Striae gravidarum**
- D. Telangiectasias**

43. Which of the following conditions is common in pregnant women in the 2nd trimester of pregnancy?

- A. Mastitis
- B. Metabolic alkalosis
- C. Physiologic anemia
- D. Respiratory acidosis

44. A 21-year old client, 6 weeks' pregnant is diagnosed with hyperemesis gravidarum. This excessive vomiting during pregnancy will often result in which of the following conditions?

- A. Bowel perforation
- B. Electrolyte imbalance
- C. Miscarriage
- D. Pregnancy induced hypertension (PIH)

45. Clients with gestational diabetes are usually managed by which of the following therapies?

- A. Diet
- B. NPH insulin (long-acting)
- C. Oral hypoglycemic drugs
- D. Oral hypoglycemic drugs and insulin

46. The antagonist for magnesium sulfate should be readily available to any client receiving IV magnesium. Which of the following drugs is the antidote for magnesium toxicity?

- A. Calcium gluconate
- B. Hydralazine (Apresoline)
- C. Narcan
- D. RhoGAM

47. Which of the following answers best describes the stage of pregnancy in which maternal and fetal blood are exchanged?

- A. Conception
- B. 9 weeks' gestation, when the fetal heart is well developed
- C. 32-34 weeks gestation
- D. maternal and fetal blood are never exchanged

48. Gravida refers to which of the following descriptions?

- A. A serious pregnancy
- B. Number of times a female has been pregnant
- C. Number of children a female has delivered
- D. Number of term pregnancies a female has had.

49. A pregnant woman at 32 weeks' gestation complains of feeling dizzy and lightheaded while her fundal height is being measured. Her skin is pale and moist. The nurse's initial response would be to:

- A. Assess the woman's blood pressure and pulse
- B. Have the woman breathe into a paper bag
- C. Raise the woman's legs
- D. Turn the woman on her side.

50. A pregnant woman's last menstrual period began on April 8, 2005, and ended on April 13. Using Naegele's rule her estimated date of birth would be:

- A. January 15, 2006
- B. January 20, 2006
- C. July 1, 2006
- D. November 5, 2005

Answers and Rationales

1. Answer: A. FSH and LH are released from the anterior pituitary gland. FSH and LH, when stimulated by gonadotropin-releasing hormone from the hypothalamus, are released from the anterior pituitary gland to stimulate follicular growth and development, growth of the graafian follicle, and production of progesterone.
2. Answer: B. Two umbilical arteries and one umbilical vein. Blood pumped by the embryo's heart leaves the embryo through two umbilical arteries. Once oxygenated, the blood then is returned by one umbilical vein. Arteries carry deoxygenated blood and waste products from the fetus, and veins carry oxygenated blood and provide oxygen and nutrients to the fetus.
3. Answer: C. 150 BPM. The fetal heart rate depends in gestational age and ranges from 160-170 BPM in the first trimester but slows with fetal growth to 120-160 BPM near or at term. At or near term, if the fetal heart rate is less than 120 or more than 160 BPM with the uterus at rest, the fetus may be in distress.
4. Answer: C. June 26, 2014. Accurate use of Naegele's rule requires that the woman have a regular 28-day menstrual cycle. Add 7 days to the first day of

the last menstrual period, subtract three months, and then add one year to that date.

5. Answer: B. G = 2, T = 0, P = 1, A = 0, L = 1. Pregnancy outcomes can be described with the acronym GTPAL.

“G” is Gravidity, the number of pregnancies.

“T” is term births, the number of born at term (38 to 41 weeks).

“P” is preterm births, the number born before 38 weeks gestation.

“A” is abortions or miscarriages, included in “G” if before 20 weeks gestation, included in parity if past 20 weeks AOE.

“L” is live births, the number of births of living children.

Therefore, a woman who is pregnant with twins and has a child has a gravida of 2. Because the child was delivered at 37 weeks, the number of preterm births is 1, and the number of term births is 0. The number of abortions is 0, and the number of live births is 1.

6. Answer: B. Fetal heart rate of 180 BPM. The normal range of the fetal heart rate depends on gestational age. The heart rate is usually 160-170 BPM in the first trimester and slows with fetal growth, near and at term, the fetal heart rate ranges from 120-160 BPM. The other options are expected.
7. Answer: A. A softening of the cervix. In the early weeks of pregnancy the cervix becomes softer as a result of increased vascularity and hyperplasia, which causes the Goodell’s sign.
8. Answer: C. “It is the fetal movement that is felt by the mother.” Quickening is fetal movement and may occur as early as the 16th and 18th week of gestation, and the mother first notices subtle fetal movements that gradually increase in intensity. Braxton Hicks contractions are irregular, painless contractions that may occur throughout the pregnancy. A thinning of the lower uterine segment occurs about the 6th week of pregnancy and is called Hegar’s sign.
9. Answer: D. Initiating a gentle upward tap on the cervix. Ballottement is a technique of palpating a floating structure by bouncing it gently and feeling it rebound. In the technique used to palpate the fetus, the examiner places a finger in the vagina and taps gently upward, causing the fetus to rise. The fetus then sinks, and the examiner feels a gentle tap on the finger.
10. Answers: A, D, E, and F. The probable signs of pregnancy include:  
 Uterine Enlargement  
 Hegar’s sign or softening and thinning of the uterine segment that occurs at week 6. Goodell’s sign or softening of the cervix that occurs at the beginning of the 2nd month Chadwick’s sign or bluish coloration of the mucous membranes of the cervix, vagina and vulva. Occurs at week 6.

Ballottement or rebounding of the fetus against the examiner’s fingers of palpation

Braxton-Hicks contractions

Positive pregnancy test measuring for hCG.

**Positive signs of pregnancy include:**

**Fetal Heart Rate detected by electronic device (doppler) at 10-12 weeks**

**Fetal Heart rate detected by nonelectronic device (fetoscope) at 20 weeks  
AOG**

**Active fetal movement palpable by the examiners**

**Outline of the fetus via radiography or ultrasound**

- 11. Answer: A. Dorsiflex the foot while extending the knee when the cramps occur. Legs cramps occur when the pregnant woman stretches the leg and plantar flexes the foot. Dorsiflexion of the foot while extending the knee stretches the affected muscle, prevents the muscle from contracting, and stops the cramping.**
- 12. Answer: D. Wash the breasts with warm water and keep them dry. The pregnant woman should be instructed to wash the breasts with warm water and keep them dry. The woman should be instructed to avoid using soap on the nipples and areola area to prevent the drying of tissues. Wearing a supportive bra with wide adjustable straps can decrease breast tenderness. Tight-fitting blouses or dresses will cause discomfort.**
- 13. Answer: A. Any bleeding, such as in the gums, petechiae, and purpura. Severe Preeclampsia can trigger disseminated intravascular coagulation because of the widespread damage to vascular integrity. Bleeding is an early sign of DIC and should be reported to the M.D.**
- 14. Answer: A. "I will maintain strict bedrest throughout the remainder of pregnancy." Strict bed rest throughout the remainder of pregnancy is not required. The woman is advised to curtail sexual activities until the bleeding has ceased, and for 2 weeks following the last evidence of bleeding or as recommended by the physician. The woman is instructed to count the number of perineal pads used daily and to note the quantity and color of blood on the pad. The woman also should watch for the evidence of the passage of tissue.**
- 15. Answer: C. "I need to drink unpasteurized milk only." All pregnant women should be advised to do the following to prevent the development of toxoplasmosis. Women should be instructed to cook meats thoroughly, avoid touching mucous membranes and eyes while handling raw meat; thoroughly wash all kitchen surfaces that come into contact with uncooked meat, wash the hands thoroughly after handling raw meat; avoid uncooked eggs and unpasteurized milk; wash fruits and vegetables before consumption, and avoid contact with materials that possibly are contaminated with cat feces, such as cat litter boxes, sandboxes, and garden soil.**
- 16. Answer: C. The client complains of a headache and blurred vision. If the client complains of a headache and blurred vision, the physician should be notified because these are signs of worsening Preeclampsia.**
- 17. Answer: C. "I need to avoid exercise because of the negative effects of insulin production." Exercise is safe for the client with gestational diabetes and is helpful in lowering the blood glucose level.**

18. Answer: C. Respiratory rate of 10 BPM. Magnesium sulfate depresses the respiratory rate. If the respiratory rate is less than 12 breaths per minute, the physician or other health care provider needs to be notified, and continuation of the medication needs to be reassessed. A urinary output of 20 ml in a 30 minute period is adequate; less than 30 ml in one hour needs to be reported. Deep tendon reflexes of 2+ are normal. The fetal heart rate is WNL for a resting fetus.
19. Answer: C. Clean and maintain an open airway. The immediate care during a seizure (eclampsia) is to ensure a patent airway. The other options are actions that follow or will be implemented after the seizure has ceased.
20. Answers: A Elevated blood pressure and 3 Facial edema. The three classic signs of preeclampsia are hypertension, generalized edema, and proteinuria. Increased respirations are not a sign of preeclampsia.
21. Answer: A. Being affected by Rh incompatibility. Rh incompatibility can occur when an Rh-negative mom becomes sensitized to the Rh antigen. Sensitization may develop when an Rh-negative woman becomes pregnant with a fetus who is Rh positive. During pregnancy and at delivery, some of the baby's Rh positive blood can enter the maternal circulation, causing the woman's immune system to form antibodies against Rh positive blood. Administration of Rho(D) immune globulin prevents the woman from developing antibodies against Rh positive blood by providing passive antibody protection against the Rh antigen.
22. Answer: D. Respirations of 10 per minute. Magnesium toxicity can occur from magnesium sulfate therapy. Signs of toxicity relate to the central nervous system depressant effects of the medication and include respiratory depression, loss of deep tendon reflexes, and a sudden drop in the fetal heart rate and maternal heart rate and blood pressure. Therapeutic levels of magnesium are 4-7 mEq/L. Proteinuria of +3 would be noted in a client with preeclampsia.
23. Answer: C. Seizures do not occur. For a client with preeclampsia, the goal of care is directed at preventing eclampsia (seizures). Magnesium sulfate is an anticonvulsant, not an antihypertensive agent. Although a decrease in blood pressure may be noted initially, this effect is usually transient. Ankle clonus indicated hyperreflexia and may precede the onset of eclampsia. Scotomas are areas of complete or partial blindness. Visual disturbances, such as scotomas, often precede an eclamptic seizure.
24. Answers: C, D, E, F, and G. When caring for a client receiving magnesium sulfate therapy, the nurse would monitor maternal vital signs, especially respirations, every 30-60 minutes and notify the physician if respirations are less than 12, because this would indicate respiratory depression. Calcium gluconate is kept on hand in case of magnesium sulfate overdose, because calcium gluconate is the antidote for magnesium sulfate toxicity. Deep tendon reflexes are assessed hourly. Cardiac and renal function is monitored

closely. The urine output should be maintained at 30 ml per hour because the medication is eliminated through the kidneys.

25. Answer: A. Administer RhoGAM within 72 hours. RhoGAM is given within 72 hours postpartum if the client has not been sensitized already.
26. Answer: B. Blood level of LH is too high. It is the surge of LH secretion in mid cycle that is responsible for ovulation.
27. Answer: C. Preparation of the uterus to receive a fertilized egg. Progesterone stimulates differentiation of the endometrium into a secretory type of tissue.
28. Answer: B. Eighth week to the time of birth. In the first 7-14 days the ovum is known as a blastocyst; it is called an embryo until the eighth week; the developing cells are then called a fetus until birth.
29. Answer: A. Placenta. When placental formation is complete, around the 16th week of pregnancy; it produces estrogen and progesterone.
30. Answer: C. An increase in blood volume. The blood volume increases by approximately 40-50% during pregnancy. The peak blood volume occurs between 30 and 34 weeks of gestation. The hematocrit decreases as a result of the increased blood volume.
31. Answer: D. Chadwick's sign. A purplish color results from the increased vascularity and blood vessel engorgement of the vagina.
32. Answer: C. G5 T2 P1 A1 L4. 5 pregnancies; 2 term births; twins count as 1; one abortion; 4 living children.
33. Answer: D. Shortness of breath on exertion. This is an expected cardiopulmonary adaptation during pregnancy; it is caused by an increased ventricular rate and elevated diaphragm.
34. Answer: B. An increase of 300 calories a day. This is the recommended caloric increase for adult women to meet the increased metabolic demands of pregnancy.
35. Answer: A. Acute hemolytic disease. When an Rh negative mother carries an Rh positive fetus there is a risk for maternal antibodies against Rh positive blood; antibodies cross the placenta and destroy the fetal RBC's.
36. Answer: B. Production of estrogen. The increase of estrogen during pregnancy causes hyperplasia of the vaginal mucosa, which leads to increased production of mucus by the endocervical glands. The mucus contains exfoliated epithelial cells.
37. Answer: C. Neural tube defects. The alpha-fetoprotein test detects neural tube defects and Down syndrome.
38. Answer: B. Walk around until they subside. Ambulation relieves Braxton Hicks.
39. Answer: B. Cause decreased placental perfusion. This is because impedance of venous return by the gravid uterus, which causes hypotension and decreased systemic perfusion.
40. Answer: A. Prolactin. Prolactin is the hormone from the anterior pituitary gland that stimulates mammary gland secretion. Oxytocin, a posterior

pituitary hormone, stimulates the uterine musculature to contract and causes the “let down” reflex.

41. Answer: D. “Snowstorm” pattern on ultrasound with no fetus or gestational sac. The chorionic villi of a molar pregnancy resemble a snowstorm pattern on ultrasound. Bleeding with a hydatidiform mole is often dark brown and may occur erratically for weeks or months.
42. Answer: D. Telangiectasias. The dilated arterioles that occur during pregnancy are due to the elevated level of circulating estrogen. The linea nigra is a pigmented line extending from the symphysis pubis to the top of the fundus during pregnancy.
43. Answer: C. Physiologic anemia. Hemoglobin and hematocrit levels decrease during pregnancy as the increase in plasma volume exceeds the increase in red blood cell production.
44. Answer: B. Electrolyte imbalance. Excessive vomiting in clients with hyperemesis gravidarum often causes weight loss and fluid, electrolyte, and acid-base imbalances.
45. Answer: A. Diet. Clients with gestational diabetes are usually managed by diet alone to control their glucose intolerance. Oral hypoglycemic agents are contraindicated in pregnancy. NPH isn’t usually needed for blood glucose control for GDM.
46. Answer: A. Calcium gluconate. Calcium gluconate is the antidote for magnesium toxicity. Ten ml of 10% calcium gluconate is given IV push over 3-5 minutes. Hydralazine is given for sustained elevated blood pressures in preeclamptic clients.
47. Answer: D. maternal and fetal blood are never exchanged. Only nutrients and waste products are transferred across the placenta. Blood exchange only occurs in complications and some medical procedures accidentally.
48. Answer: B. Number of times a female has been pregnant. Gravida refers to the number of times a female has been pregnant, regardless of pregnancy outcome or the number of neonates delivered.
49. Answer: D. Turn the woman on her side. During a fundal height measurement the woman is placed in a supine position. This woman is experiencing supine hypotension as a result of uterine compression of the vena cava and abdominal aorta. Turning her on her side will remove the compression and restore cardiac output and blood pressure. Then vital signs can be assessed. Raising her legs will not solve the problem since pressure will still remain on the major abdominal blood vessels, thereby continuing to impede cardiac output. Breathing into a paper bag is the solution for dizziness related to respiratory alkalosis associated with hyperventilation.
50. Answer: A. January 15, 2006. Naegele’s rule requires subtracting 3 months and adding 7 days and 1 year if appropriate to the first day of a pregnant woman’s last menstrual period. When this rule, is used with April 8, 2005, the estimated date of birth is January 15, 2006.

## MIDWIFERY 9 (Intrapartum)

**1. A nurse is caring for a client in labor. The nurse determines that the client is beginning in the 2nd stage of labor when which of the following assessments is noted?**

- A. The client begins to expel clear vaginal fluid**
- B. The contractions are regular**
- C. The membranes have ruptured**
- D. The cervix is dilated completely**

**2. 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:**

- A. Place the mother in the supine position**
- B. Document the findings and continue to monitor the fetal patterns**
- C. Administer oxygen via face mask**

**D. Increase the rate of pitocin IV infusion**

**3. 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?**

- A. Fetal heart rate of 180 beats per minute**
- B. White blood cell count of 12,000**
- C. Maternal pulse rate of 85 beats per minute**
- D. Hemoglobin of 11.0 g/dL**

**4. 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:**

- A. Trendelenburg's position with the legs in stirrups**
- B. Semi-Fowler position with a pillow under the knees**
- C. Prone position with the legs separated and elevated**
- D. Supine position with a wedge under the right hip**

**5. A nurse is caring for a client in labor and prepares to auscultate the fetal heart rate by using a Doppler ultrasound device. The nurse most accurately determines that the fetal heart sounds are heard by:**

- A. Noting if the heart rate is greater than 140 BPM**
- B. Placing the diaphragm of the Doppler on the mother abdomen**
- C. Performing Leopold's maneuvers first to determine the location of the fetal heart**
- D. Palpating the maternal radial pulse while listening to the fetal heart rate**

**6. 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?**

- A. Three contractions occurring within a 10-minute period**
- B. A fetal heart rate of 90 beats per minute**
- C. Adequate resting tone of the uterus palpated between contractions**
- D. Increased urinary output**

**7. 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?**

- A. Placing the client on complete bed rest
- B. Continuous electronic fetal monitoring
- C. An IV infusion of antibiotics
- D. Placing a code cart at the client's bedside

8. A nurse is monitoring a client in active labor and notes that the client is having contractions every 3 minutes that last 45 seconds. The nurse notes that the fetal heart rate between contractions is 100 BPM. Which of the following nursing actions is most appropriate?

- A. Encourage the client's coach to continue to encourage breathing exercises
- B. Encourage the client to continue pushing with each contraction
- C. Continue monitoring the fetal heart rate
- D. Notify the physician or nurse midwife

9. 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?

- A. Document the findings and tell the mother that the monitor indicates fetal well-being
- B. Take the mother's vital signs and tell the mother that bed rest is required to conserve oxygen.
- C. Notify the physician or nurse midwife of the findings.
- D. Reposition the mother and check the monitor for changes in the fetal tracing

10. 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?

- A. Identifying the types of accelerations
- B. Assessing the baseline fetal heart rate
- C. Determining the frequency of the contractions
- D. Determining the intensity of the contractions

11. A nurse is reviewing the record of a client in the labor room and notes that the nurse midwife has documented that the fetus is at (-1) station. The nurse determines that the fetal presenting part is:

- A. 1 cm above the ischial spine
- B. 1 fingerbreadth below the symphysis pubis
- C. 1 inch below the coccyx

**D. 1 inch below the iliac crest**

**12. 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?**

- A. A loud mouth**
- B. Low self-esteem**
- C. Hemorrhage**
- D. Postpartum infections**

**13. 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:**

- A. Hematoma**
- B. Placenta previa**
- C. Uterine atony**
- D. Placental separation**

**14. 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:**

- A. Less pressure on her cervix**
- B. Increased efficiency of contractions**
- C. Decreased number of contractions**
- D. The need for increased maternal blood pressure monitoring**

**15. 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?**

- A. Early decelerations**
- B. Variable decelerations**
- C. Late decelerations**
- D. Short-term variability**

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

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

17. A nurse is caring for a client in the second stage of labor. The client is experiencing uterine contractions every 2 minutes and cries out in pain with each contraction. The nurse recognizes this behavior as:

- A. Exhaustion
- B. Fear of losing control
- C. Involuntary grunting
- D. Valsalva's maneuver

18. A nurse is monitoring a client in labor who is receiving Pitocin and notes that the client is experiencing hypertonic uterine contractions. List in order of priority the actions that the nurse takes.

- A. Stop of Pitocin infusion
- B. Perform a vaginal examination
- C. Reposition the client
- D. Check the client's blood pressure and heart rate
- E. Administer oxygen by face mask at 8 to 10 L/min

19. 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?

- A. Medication that will provide sedation
- B. Increased hydration
- C. Oxytocin (Pitocin) infusion
- D. Administration of a tocolytic medication

20. A nurse in the labor room is preparing to care for a client with hypertonic uterine dysfunction. The nurse is told that the client is experiencing uncoordinated contractions that are erratic in their frequency, duration, and intensity. The priority nursing intervention would be to:

- A. Monitor the Pitocin infusion closely
- B. Provide pain relief measures
- C. Prepare the client for an amniotomy
- D. Promote ambulation every 30 minutes

21. 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?

- A. Keeping the significant other informed of the progress of the labor
- B. Providing comfort measures
- C. Monitoring fetal heart rate
- D. Changing the client's position frequently

22. A maternity nurse is preparing to care for a pregnant client in labor who will be delivering twins. The nurse monitors the fetal heart rates by placing the external fetal monitor:

- A. Over the fetus that is most anterior to the mother's abdomen
- B. Over the fetus that is most posterior to the mother's abdomen
- C. So that each fetal heart rate is monitored separately
- D. So that one fetus is monitored for a 15-minute period followed by a 15 minute fetal monitoring period for the second fetus

23. 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?

- A. Disseminated intravascular coagulation
- B. Chronic hypertension
- C. Infection
- D. Hemorrhage

24. A nurse in the delivery room is assisting with the delivery of a newborn infant. After the delivery of the newborn, the nurse assists in delivering the placenta. Which observation would indicate that the placenta has separated from the uterine wall and is ready for delivery?

- A. The umbilical cord shortens in length and changes in color
- B. A soft and boggy uterus
- C. Maternal complaints of severe uterine cramping

**D. Changes in the shape of the uterus**

25. 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?

- A. Place the client in Trendelenburg's position
- B. Call the delivery room to notify the staff that the client will be transported immediately
- C. Gently push the cord into the vagina
- D. Find the closest telephone and stat page the physician

26. 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?

- A. Swelling of the calf in one leg
- B. Prolonged clotting times
- C. Decreased platelet count
- D. Petechiae, oozing from injection sites, and hematuria

27. 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?

- A. Absence of abdominal pain
- B. A soft abdomen
- C. Uterine tenderness/pain
- D. Painless, bright red vaginal bleeding

28. A maternity nurse is preparing for the admission of a client in the 3rd trimester of pregnancy that is experiencing vaginal bleeding and has a suspected diagnosis of placenta previa. The nurse reviews the physician's orders and would question which order?

- A. Prepare the client for an ultrasound
- B. Obtain equipment for external electronic fetal heart monitoring
- C. Obtain equipment for a manual pelvic examination
- D. Prepare to draw a Hgb and Hct blood sample

29. 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:

- A. Complete bed rest for the remainder of the pregnancy
- B. Delivery of the fetus
- C. Strict monitoring of intake and output
- D. The need for weekly monitoring of coagulation studies until the time of delivery

30. A nurse in a labor room is assisting with the vaginal delivery of a newborn infant. The nurse would monitor the client closely for the risk of uterine rupture if which of the following occurred?

- A. Hypotonic contractions
- B. Forceps delivery
- C. Schultz delivery
- D. Weak bearing down efforts

31. A client is admitted to the birthing suite in early active labor. The priority nursing intervention on admission of this client would be:

- A. Auscultating the fetal heart
- B. Taking an obstetric history
- C. Asking the client when she last ate
- D. Ascertaining whether the membranes were ruptured

32. 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:

- A. Not yet engaged
- B. Entering the pelvic inlet
- C. Below the ischial spines
- D. Visible at the vaginal opening

33. 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:

- A. Above the umbilicus at the midline
- B. Above the umbilicus on the left side

- C. Below the umbilicus on the right side
- D. Below the umbilicus near the left groin

34. 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:

- A. Until the time it is completely over
- B. To the end of a second contraction
- C. To the beginning of the next contraction
- D. Until the time that the uterus becomes very firm

35. The nurse observes the client's amniotic fluid and decides that it appears normal, because it is:

- A. Clear and dark amber in color
- B. Milky, greenish yellow, containing shreds of mucus
- C. Clear, almost colorless, and containing little white specks
- D. Cloudy, greenish-yellow, and containing little white specks

36. At 38 weeks gestation, a client is having late decelerations. The fetal pulse oximeter shows 75% to 85%. The nurse should:

- A. Discontinue the catheter, if the reading is not above 80%
- B. Discontinue the catheter, if the reading does not go below 30%
- C. Advance the catheter until the reading is above 90% and continue monitoring
- D. Reposition the catheter, recheck the reading, and if it is 55%, keep monitoring

37. 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:

- A. Stop the oxytocin infusion
- B. Change the client's position
- C. Prepare for immediate delivery
- D. Take the client's blood pressure

38. 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:

- A. An acceleration
- B. An early elevation
- C. A sonographic motion
- D. A tachycardic heart rate

39. A laboring client complains of low back pain. The nurse replies that this pain occurs most when the position of the fetus is:

- A. Breech
- B. Transverse
- C. Occiput anterior
- D. Occiput posterior

40. The breathing technique that the mother should be instructed to use as the fetus' head is crowning is:

- A. Blowing
- B. Slow chest
- C. Shallow
- D. Accelerated-decelerated

41. During the period of induction of labor, a client should be observed carefully for signs of:

- A. Severe pain
- B. Uterine tetany
- C. Hypoglycemia
- D. Umbilical cord prolapse

42. A client arrives at the hospital in the second stage of labor. The fetus' head is crowning, the client is bearing down, and the birth appears imminent. The nurse should:

- A. Transfer her immediately by stretcher to the birthing unit
- B. Tell her to breathe through her mouth and not to bear down
- C. Instruct the client to pant during contractions and to breathe through her mouth
- D. Support the perineum with the hand to prevent tearing and tell the client to pant

43. A laboring client is to have a pudendal block. The nurse plans to tell the client that once the block is working she:

- A. Will not feel the episiotomy
- B. May lose bladder sensation
- C. May lose the ability to push
- D. Will no longer feel contractions

44. Which of the following observations indicates fetal distress?

- A. Fetal scalp pH of 7.14
- B. Fetal heart rate of 144 beats/minute
- C. Acceleration of fetal heart rate with contractions
- D. Presence of long term variability

45. Which of the following fetal positions is most favorable for birth?

- A. Vertex presentation
- B. Transverse lie
- C. Frank breech presentation
- D. Posterior position of the fetal head

46. A laboring client has external electronic fetal monitoring in place. Which of the following assessment data can be determined by examining the fetal heart rate strip produced by the external electronic fetal monitor?

- A. Gender of the fetus
- B. Fetal position
- C. Labor progress
- D. Oxygenation

47. A laboring client is in the first stage of labor and has progressed from 4 to 7 cm in cervical dilation. In which of the following phases of the first stage does cervical dilation occur most rapidly?

- A. Preparatory phase
- B. Latent phase
- C. Active phase
- D. Transition phase

48. A multiparous client who has been in labor for 2 hours states that she feels the urge to move her bowels. How should the nurse respond?

- A. Let the client get up to use the potty
  - B. Allow the client to use a bedpan
  - C. Perform a pelvic examination
  - D. Check the fetal heart rate
49. Labor is a series of events affected by the coordination of the five essential factors. One of these is the passenger (fetus). Which are the other four factors?
- A. Contractions, passageway, placental position and function, pattern of care
  - B. Contractions, maternal response, placental position, psychological response
  - C. Passageway, contractions, placental position and function, psychological response
  - D. Passageway, placental position and function, paternal response, psychological response
50. Fetal presentation refers to which of the following descriptions?
- A. Fetal body part that enters the maternal pelvis first
  - B. Relationship of the presenting part to the maternal pelvis
  - C. Relationship of the long axis of the fetus to the long axis of the mother
  - D. A classification according to the fetal part
51. A client is admitted to the L & D suite at 36 weeks' gestation. She has a history of C-section and complains of severe abdominal pain that started less than 1 hour earlier. When the nurse palpates tetanic contractions, the client again complains of severe pain. After the client vomits, she states that the pain is better and then passes out. Which is the probable cause of her signs and symptoms?
- A. Hysteria compounded by the flu
  - B. Placental abruption
  - C. Uterine rupture
  - D. Dysfunctional labor
52. Upon completion of a vaginal examination on a laboring woman, the nurse records: 50%, 6 cm, -1. Which of the following is a correct interpretation of the data?
- A. Fetal presenting part is 1 cm above the ischial spines
  - B. Effacement is 4 cm from completion
  - C. Dilation is 50% completed
  - D. Fetus has achieved passage through the ischial spines
53. Which of the following findings meets the criteria of a reassuring FHR pattern?

- A. FHR does not change as a result of fetal activity
- B. Average baseline rate ranges between 100 – 140 BPM
- C. Mild late deceleration patterns occur with some contractions
- D. Variability averages between 6 – 10 BPM

54. Late deceleration patterns are noted when assessing the monitor tracing of a woman whose labor is being induced with an infusion of Pitocin. The woman is in a side-lying position, and her vital signs are stable and fall within a normal range. Contractions are intense, last 90 seconds, and occur every 1 1/2 to 2 minutes. The nurse's immediate action would be to:

- A. Change the woman's position
- B. Stop the Pitocin
- C. Elevate the woman's legs
- D. Administer oxygen via a tight mask at 8 to 10 liters/minute

55. The nurse should realize that the most common and potentially harmful maternal complication of epidural anesthesia would be:

- A. Severe postpartum headache
- B. Limited perception of bladder fullness
- C. Increase in respiratory rate
- D. Hypotension

56. Perineal care is an important infection control measure. When evaluating a postpartum woman's perineal care technique, the nurse would recognize the need for further instruction if the woman:

- A. Uses soap and warm water to wash the vulva and perineum
- B. Washes from symphysis pubis back to episiotomy
- C. Changes her perineal pad every 2 – 3 hours
- D. Uses the peribottle to rinse upward into her vagina

57. Which measure would be least effective in preventing postpartum hemorrhage?

- A. Administer Methergine 0.2 mg every 6 hours for 4 doses as ordered
- B. Encourage the woman to void every 2 hours
- C. Massage the fundus every hour for the first 24 hours following birth
- D. Teach the woman the importance of rest and nutrition to enhance healing

58. When making a visit to the home of a postpartum woman one week after birth, the nurse should recognize that the woman would characteristically:

- A. Express a strong need to review events and her behavior during the process of labor and birth
- B. Exhibit a reduced attention span, limiting readiness to learn
- C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn
- D. Have reestablished her role as a spouse/partner

59. Four hours after a difficult labor and birth, a primiparous woman refuses to feed her baby, stating that she is too tired and just wants to sleep. The nurse should:

- A. Tell the woman she can rest after she feeds her baby
- B. Recognize this as a behavior of the taking-hold stage
- C. Record the behavior as ineffective maternal-newborn attachment
- D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time

60. Parents can facilitate the adjustment of their other children to a new baby by:

- A. Having the children choose or make a gift to give to the new baby upon its arrival home
- B. Emphasizing activities that keep the new baby and other children together
- C. Having the mother carry the new baby into the home so she can show the other children the new baby
- D. Reducing stress on other children by limiting their involvement in the care of the new baby

Answers and Rationales

1. Answer: D. The cervix is dilated completely. The second stage of labor begins when the cervix is dilated completely and ends with the birth of the neonate.
2. Answer: C. Administer oxygen via face mask. Late decelerations are due to uteroplacental insufficiency as the result of decreased blood flow and oxygen to the fetus during the uterine contractions. This causes hypoxemia; therefore oxygen is necessary. The supine position is avoided because it decreases uterine blood flow to the fetus. The client should be turned to her side to displace pressure of the gravid uterus on the inferior vena cava. An intravenous pitocin infusion is discontinued when a late deceleration is noted.
3. Answer: A. Fetal heart rate of 180 beats per minute. A normal fetal heart rate is 120-160 beats per minute. A count of 180 beats per minute could indicate

fetal distress and would warrant physician notification. By full term, a normal maternal hemoglobin range is 11-13 g/dL as a result of the hemodilution caused by an increase in plasma volume during pregnancy.

4. Answer: D. Supine position with a wedge under the right hip. Vena cava and descending aorta compression by the pregnant uterus impedes blood return from the lower trunk and extremities. This leads to decreasing cardiac return, cardiac output, and blood flow to the uterus and the fetus. The best position to prevent this would be side-lying with the uterus displaced off of abdominal vessels. Positioning for abdominal surgery necessitates a supine position; however, a wedge placed under the right hip provides displacement of the uterus.
5. Answer: D. Palpating the maternal radial pulse while listening to the fetal heart rate. The nurse simultaneously should palpate the maternal radial or carotid pulse and auscultate the fetal heart rate to differentiate the two. If the fetal and maternal heart rates are similar, the nurse may mistake the maternal heart rate for the fetal heart rate. Leopold's maneuvers may help the examiner locate the position of the fetus but will not ensure a distinction between the two rates.
6. Answer: B. A fetal heart rate of 90 beats per minute. A normal fetal heart rate is 120-160 BPM. Bradycardia or late or variable decelerations indicate fetal distress and the need to discontinue to pitocin. The goal of labor augmentation is to achieve three good-quality contractions in a 10-minute period.
7. Answer: B. Continuous electronic fetal monitoring. Continuous electronic fetal monitoring should be implemented during an IV infusion of Pitocin.
8. Answer: D. Notify the physician or nurse midwife. A normal fetal heart rate is 120-160 beats per minute. Fetal bradycardia between contractions may indicate the need for immediate medical management, and the physician or nurse midwife needs to be notified.
9. Answer: A. Document the findings and tell the mother that the monitor indicates fetal well-being. Accelerations are transient increases in the fetal heart rate that often accompany contractions or are caused by fetal movement. Episodic accelerations are thought to be a sign of fetal-well being and adequate oxygen reserve.
10. Answer: B. Assessing the baseline fetal heart rate. Assessing the baseline fetal heart rate is important so that abnormal variations of the baseline rate will be identified if they occur. Identifying the types of accelerations and determining the frequency of the contractions are important to assess, but not as the first priority.
11. Answer: A. 1 cm above the ischial spine. Station is the relationship of the presenting part to an imaginary line drawn between the ischial spines, is measured in centimeters, and is noted as a negative number above the line and a positive number below the line. At -1 station, the fetal presenting part is 1 cm above the ischial spines.

12. Answer: D. Postpartum infections. Anemic women have a greater likelihood of cardiac decompensation during labor, postpartum infection, and poor wound healing. Anemia does not specifically present a risk for hemorrhage.
13. Answer: D. Placental separation. As the placenta separates, it settles downward into the lower uterine segment. The umbilical cord lengthens, and a sudden trickle or spurt of blood appears.
14. Answer: B. Increased efficiency of contractions. Amniotomy can be used to induce labor when the condition of the cervix is favorable (ripe) or to augment labor if the process begins to slow. Rupturing of membranes allows the fetal head to contact the cervix more directly and may increase the efficiency of contractions.
15. Answer: B. Variable decelerations. Variable decelerations occur if the umbilical cord becomes compressed, thus reducing blood flow between the placenta and the fetus. Early decelerations result from pressure on the fetal head during a contraction. Late decelerations are an ominous pattern in labor because it suggests uteroplacental insufficiency during a contraction. Short-term variability refers to the beat-to-beat range in the fetal heart rate.
16. Answer: B. Light stroking of the abdomen to facilitate relaxation during labor and provide tactile stimulation to the fetus. Effleurage is a specific type of cutaneous stimulation involving light stroking of the abdomen and is used before transition to promote relaxation and relieve mild to moderate pain. Effleurage provides tactile stimulation to the fetus.
17. Answer: B. Fear of losing control. Pains, helplessness, panicking, and fear of losing control are possible behaviors in the 2nd stage of labor.
18. Answer: A, D, B, E, C. If uterine hypertonicity occurs, the nurse immediately would intervene to reduce uterine activity and increase fetal oxygenation. The nurse would stop the Pitocin infusion and increase the rate of the nonadditive solution, check maternal BP for hyper or hypotension, position the woman in a side-lying position, and administer oxygen by snug face mask at 8-10 L/min. The nurse then would attempt to determine the cause of the uterine hypertonicity and perform a vaginal exam to check for prolapsed cord.
19. Answer: C. Oxytocin (Pitocin) infusion. Therapeutic management for hypotonic uterine dysfunction includes oxytocin augmentation and amniotomy to stimulate a labor that slows.
20. Answer: B. Provide pain relief measures. Management of hypertonic labor depends on the cause. Relief of pain is the primary intervention to promote a normal labor pattern.
21. Answer: C. Monitoring fetal heart rate. The priority is to monitor the fetal heart rate.
22. Answer: C. So that each fetal heart rate is monitored separately. In a client with a multi-fetal pregnancy, each fetal heart rate is monitored separately.

23. Answer: D. Hemorrhage. Because the placenta is implanted in the lower uterine segment, which does not contain the same intertwining musculature as the fundus of the uterus, this site is more prone to bleeding.
24. Answer: D. Changes in the shape of the uterus. Signs of placental separation include lengthening of the umbilical cord, a sudden gush of dark blood from the introitus (vagina), a firmly contracted uterus, and the uterus changing from a discoid (like a disk) to a globular (like a globe) shape. The client may experience vaginal fullness, but not severe uterine cramping.
25. Answer: A. Place the client in Trendelenburg's position. When cord prolapse occurs, prompt actions are taken to relieve cord compression and increase fetal oxygenation. The mother should be positioned with the hips higher than the head to shift the fetal presenting part toward the diaphragm. The nurse should push the call light to summon help, and other staff members should call the physician and notify the delivery room. No attempt should be made to replace the cord. The examiner, however, may place a gloved hand into the vagina and hold the presenting part off of the umbilical cord. Oxygen at 8 to 10 L/min by face mask is delivered to the mother to increase fetal oxygenation.
26. Answer: A. Swelling of the calf in one leg. DIC is a state of diffuse clotting in which clotting factors are consumed, leading to widespread bleeding. Platelets are decreased because they are consumed by the process; coagulation studies show no clot formation (and are thus normal to prolonged); and fibrin plugs may clog the microvasculature diffusely, rather than in an isolated area. The presence of petechiae, oozing from injection sites, and hematuria are signs associated with DIC. Swelling and pain in the calf of one leg are more likely to be associated with thrombophlebitis.
27. Answer: C. Uterine tenderness/pain. In abruptio placentae, acute abdominal pain is present. Uterine tenderness and pain accompanies placental abruption, especially with a central abruption and trapped blood behind the placenta. The abdomen will feel hard and boardlike on palpation as the blood penetrates the myometrium and causes uterine irritability. Observation of the fetal monitoring often reveals increased uterine resting tone, caused by failure of the uterus to relax in attempt to constrict blood vessels and control bleeding.
28. Answer: C. Obtain equipment for a manual pelvic examination. Manual pelvic examinations are contraindicated when vaginal bleeding is apparent in the 3rd trimester until a diagnosis is made and placental previa is ruled out. Digital examination of the cervix can lead to maternal and fetal hemorrhage. A diagnosis of placenta previa is made by ultrasound. The H/H levels are monitored, and external electronic fetal heart rate monitoring is initiated. External fetal monitoring is crucial in evaluating the fetus that is at risk for severe hypoxia.
29. Answer: B. Delivery of the fetus. The goal of management in abruptio placentae is to control the hemorrhage and deliver the fetus as soon as

- possible. Delivery is the treatment of choice if the fetus is at term gestation or if the bleeding is moderate to severe and the mother or fetus is in jeopardy.
30. Answer: B. Forceps delivery. Excessive fundal pressure, forceps delivery, violent bearing down efforts, tumultuous labor, and shoulder dystocia can place a woman at risk for traumatic uterine rupture. Hypotonic contractions and weak bearing down efforts do not alone add to the risk of rupture because they do not add to the stress on the uterine wall.
31. Answer: A. Auscultating the fetal heart. Determining the fetal well-being supersedes all other measures. If the FHR is absent or persistently decelerating, immediate intervention is required.
32. Answer: C. Below the ischial spines. A station of +1 indicates that the fetal head is 1 cm below the ischial spines.
33. Answer: C. Below the umbilicus on the right side. Fetal heart tones are best auscultated through the fetal back; because the position is ROP (right occiput presenting), the back would be below the umbilicus and on the right side.
34. Answer: C. To the beginning of the next contraction. This is the way to determine the frequency of the contractions
35. Answer: C. Clear, almost colorless, and containing little white specks. By 36 weeks' gestation, normal amniotic fluid is colorless with small particles of vernix caseosa present.
36. Answer: D. Reposition the catheter, recheck the reading, and if it is 55%, keep monitoring. Adjusting the catheter would be indicated. Normal fetal pulse oximetry should be between 30% and 70%. 75% to 85% would indicate maternal readings.
37. Answer: B. Change the client's position. Variable decelerations usually are seen as a result of cord compression; a change of position will relieve pressure on the cord.
38. Answer: A. An acceleration. An acceleration is an abrupt elevation above the baseline of 15 beats per minute for 15 seconds; if the acceleration persists for more than 10 minutes it is considered a change in baseline rate. A tachycardic FHR is above 160 beats per minute.
39. Answer: D. Occiput posterior. A persistent occiput-posterior position causes intense back pain because of fetal compression of the sacral nerves. Occiput anterior is the most common fetal position and does not cause back pain.
40. Answer: A. Blowing. Blowing forcefully through the mouth controls the strong urge to push and allows for a more controlled birth of the head.
41. Answer: B. Uterine tetany. Uterine tetany could result from the use of oxytocin to induce labor. Because oxytocin promotes powerful uterine contractions, uterine tetany may occur. The oxytocin infusion must be stopped to prevent uterine rupture and fetal compromise.
42. Answer: D. Support the perineum with the hand to prevent tearing and tell the client to pant. Gentle pressure is applied to the baby's head as it emerges so it is not born too rapidly. The head is never held back, and it should be

supported as it emerges so there will be no vaginal lacerations. It is impossible to push and pant at the same time.

43. Answer: A. Will not feel the episiotomy. A pudendal block provides anesthesia to the perineum.
44. Answer: A. Fetal scalp pH of 7.14. A fetal scalp pH below 7.25 indicates acidosis and fetal hypoxia.
45. Answer: A. Vertex presentation. Vertex presentation (flexion of the fetal head) is the optimal presentation for passage through the birth canal. Transverse lie is an unacceptable fetal position for vaginal birth and requires a C-section. Frank breech presentation, in which the buttocks present first, can be a difficult vaginal delivery. Posterior positioning of the fetal head can make it difficult for the fetal head to pass under the maternal symphysis pubis.
46. Answer: D. Oxygenation. Oxygenation of the fetus may be indirectly assessed through fetal monitoring by closely examining the fetal heart rate strip. Accelerations in the fetal heart rate strip indicate good oxygenation, while decelerations in the fetal heart rate sometimes indicate poor fetal oxygenation.
47. Answer: C. Active phase. Cervical dilation occurs more rapidly during the active phase than any of the previous phases. The active phase is characterized by cervical dilation that progresses from 4 to 7 cm. The preparatory, or latent, phase begins with the onset of regular uterine contractions and ends when rapid cervical dilation begins. Transition is defined as cervical dilation beginning at 8 cm and lasting until 10 cm or complete dilation.
48. Answer: C. Perform a pelvic examination. A complaint of rectal pressure usually indicates a low presenting fetal part, signaling imminent delivery. The nurse should perform a pelvic examination to assess the dilation of the cervix and station of the presenting fetal part.
49. Answer: C. Passageway, contractions, placental position and function, psychological response. The five essential factors (5 P's) are passenger (fetus), passageway (pelvis), powers (contractions), placental position and function, and psyche (psychological response of the mother).
50. Answer: A. Fetal body part that enters the maternal pelvis first. Presentation is the fetal body part that enters the pelvis first; it's classified by the presenting part; the three main presentations are cephalic/occipital, breech, and shoulder. The relationship of the presenting fetal part to the maternal pelvis refers to fetal position. The relationship of the long axis to the fetus to the long axis of the mother refers to fetal lie; the three possible lies are longitudinal, transverse, and oblique.
51. Answer: C. Uterine rupture. Uterine rupture is a medical emergency that may occur before or during labor. Signs and symptoms typically include abdominal pain that may ease after uterine rupture, vomiting, vaginal bleeding,

hypovolemic shock, and fetal distress. With placental abruption, the client typically complains of vaginal bleeding and constant abdominal pain.

52. Answer: A. Fetal presenting part is 1 cm above the ischial spines. Station of – 1 indicates that the fetal presenting part is above the ischial spines and has not yet passed through the pelvic inlet. A station of zero would indicate that the presenting part has passed through the inlet and is at the level of the ischial spines or is engaged. Passage through the ischial spines with internal rotation would be indicated by a plus station, such as + 1. Progress of effacement is referred to by percentages with 100% indicating full effacement and dilation by centimeters (cm) with 10 cm indicating full dilation.
53. Answer: D. Variability averages between 6 – 10 BPM. Variability indicates a well oxygenated fetus with a functioning autonomic nervous system. FHR should accelerate with fetal movement. Baseline range for the FHR is 120 to 160 beats per minute. Late deceleration patterns are never reassuring, though early and mild variable decelerations are expected, reassuring findings.
54. Answer: B. Stop the Pitocin. Late deceleration patterns noted are most likely related to alteration in uteroplacental perfusion associated with the strong contractions described. The immediate action would be to stop the Pitocin infusion since Pitocin is an oxytocic which stimulates the uterus to contract. The woman is already in an appropriate position for uteroplacental perfusion. Elevation of her legs would be appropriate if hypotension were present. Oxygen is appropriate but not the immediate action.
55. Answer: D. Hypotension. Epidural anesthesia can lead to vasodilation and a drop in blood pressure that could interfere with adequate placental perfusion. The woman must be well hydrated before and during epidural anesthesia to prevent this problem and maintain an adequate blood pressure. Headache is not a side effect since the spinal fluid is not disturbed by this anesthetic as it would be with a low spinal (saddle block) anesthesia; 2 is an effect of epidural anesthesia but is not the most harmful. Respiratory depression is a potentially serious complication.
56. Answer: D. Uses the peribottle to rinse upward into her vagina. Responses A, B, and C are all appropriate measures. The peri bottle should be used in a backward direction over the perineum. The flow should never be directed upward into the vagina since debris would be forced upward into the uterus through the still-open cervix.
57. Answer: C. Massage the fundus every hour for the first 24 hours following birth. The fundus should be massaged only when boggy or soft. Massaging a firm fundus could cause it to relax. Responses A, B, and D are all effective measures to enhance and maintain contraction of the uterus and to facilitate healing.
58. Answer: C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn. One week after birth the woman should exhibit behaviors characteristic of the

taking-hold stage as described in response C. This stage lasts for as long as 4 to 5 weeks after birth. Responses A and B are characteristic of the taking-in stage, which lasts for the first few days after birth. Response D reflects the letting-go stage, which indicates that psychosocial recovery is complete.

59. Answer: D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time. Response A does not take into consideration the need for the new mother to be nurtured and have her needs met during the taking-in stage. The behavior described is typical of this stage and not a reflection of ineffective attachment unless the behavior persists. Mothers need to reestablish their own well-being in order to effectively care for their baby.
60. Answer: A. Having the children choose or make a gift to give to the new baby upon its arrival home. Special time should be set aside just for the other children without interruption from the newborn. Someone other than the mother should carry the baby into the home so she can give full attention to greeting her other children. Children should be actively involved in the care of the baby according to their ability without overwhelming them.

## MIDWIFERY 10 (Postpartum)

**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:**

- A. Every 30 minutes during the first hour and then every hour for the next two hours.**
- B. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.**
- C. Every hour for the first 2 hours and then every 4 hours**
- D. 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?**

- A. Retake the temperature in 15 minutes**
- B. Notify the physician**
- C. Document the findings**
- D. 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?**

- A. Obtain hemoglobin and hematocrit levels**
- B. Instruct the mother to request help when getting out of bed**
- C. Elevate the mother's legs**

- D. Inform the nursery room nurse to avoid bringing the newborn infant to the mother until the feelings of lightheadedness 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?
- A. Ask the client to turn on her side
  - B. Ask the client to lie flat on her back with the knees and legs flat and straight.
  - C. Ask the mother to urinate and empty her bladder
  - D. 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:
- A. Normal
  - B. Indicates the presence of infection
  - C. Indicates the need for increasing oral fluids
  - D. 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?
- A. Document the findings
  - B. Notify the physician
  - C. Reassess the client in 2 hours
  - D. 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:
- A. One peripad per day
  - B. Two peripads per day
  - C. Three peripads per day
  - D. Eight peripads 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:

- A. One the day of the delivery
- B. 3 days PP
- C. 7 days PP
- D. within 2 weeks PP

9. Select all of the physiological maternal changes that occur during the PP period.

- A. Cervical involution ceases immediately
- B. Vaginal distention decreases slowly
- C. Fundus begins to descend into the pelvis after 24 hours
- D. Cardiac output decreases with resultant tachycardia in the first 24 hours
- E. Digestive processes slow immediately.

10. 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?

- A. Complaints of a tearing sensation
- B. Complaints of intense pain
- C. Changes in vital signs
- D. Signs of heavy bruising

11. 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?

- A. Assess vital signs every 4 hours
- B. Inform health care provider of assessment findings
- C. Measure fundal height every 4 hours
- D. 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:

- A. Monitor fundal height
- B. Apply perineal pressure
- C. Prepare the client for surgery.
- D. 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?

- A. A temperature of 100.4°F
- B. An increase in the pulse from 88 to 102 BPM
- C. An increase in the respiratory rate from 18 to 22 breaths per minute
- D. 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?

- A. Massage the fundus until it is firm
- B. Elevate the mother's legs
- C. Push on the uterus to assist in expressing clots
- D. 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?

- A. Paleness of the calf area
- B. Enlarged, hardened veins
- C. Coolness of the calf area
- D. 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?

- A. "I need to take antibiotics, and I should begin to feel better in 24-48 hours."
- B. "I can use analgesics to assist in alleviating some of the discomfort."
- C. "I need to wear a supportive bra to relieve the discomfort."
- D. "I need to stop breastfeeding until this condition resolves."

17. A PP client is being treated for DVT. The nurse understands that the client's response to treatment will be evaluated by regularly assessing the client for:

- A. Dysuria, ecchymosis, and vertigo
- B. Epistaxis, hematuria, and dysuria
- C. Hematuria, ecchymosis, and epistaxis
- D. Hematuria, ecchymosis, and vertigo

18. A nurse performs an assessment on a client who is 4 hours PP. The nurse notes that the client has cool, clammy skin and is restless and excessively thirsty. The nurse prepares immediately to:

- A. Assess for hypovolemia and notify the health care provider
- B. Begin hourly pad counts and reassure the client
- C. Begin fundal massage and start oxygen by mask
- D. Elevate the head of the bed and assess vital signs

19. A nurse is assessing a client in the 4th stage of labor and notes that the fundus is firm but that bleeding is excessive. The initial nursing action would be which of the following?

- A. Massage the fundus
- B. Place the mother in the Trendelenburg's position
- C. Notify the physician
- D. Record the findings

20. 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?

- A. Prothrombin time
- B. International normalized ratio
- C. Activated partial thromboplastin time
- D. Platelet count

21. A nurse is preparing a list of self-care instructions for a PP client who was diagnosed with mastitis. Select all instructions that would be included on the list.

- A. Take the prescribed antibiotics until the soreness subsides.
- B. Wear supportive bra
- C. Avoid decompression of the breasts by breastfeeding or breast pump
- D. Rest during the acute phase
- E. Continue to breastfeed if the breasts are not too sore.

22. 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:

- A. Amount of lochia
- B. Blood pressure
- C. Deep tendon reflexes
- D. Uterine tone

23. 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?

- A. Peripheral vascular disease
- B. Hypothyroidism
- C. Hypotension
- D. Type 1 diabetes

24. Which of the following factors might result in a decreased supply of breastmilk in a PP mother?

- A. Supplemental feedings with formula
- B. Maternal diet high in vitamin C
- C. An alcoholic drink
- D. Frequent feedings

25. Which of the following interventions would be helpful to a breastfeeding mother who is experiencing engorged breasts?

- A. Applying ice
- B. Applying a breast binder
- C. Teaching how to express her breasts in a warm shower
- D. Administering bromocriptine (Parlodel)

26. 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?

- A. Ask the client to empty her bladder
- B. Straight catheterize the client immediately
- C. Call the client's health provider for direction
- D. Straight catheterize the client for half of her uterine volume

27. The nurse is about to give a Type 2 diabetic her insulin before breakfast on her first day postpartum. Which of the following answers best describes insulin requirements immediately postpartum?

- A. Lower than during her pregnancy
- B. Higher than during her pregnancy
- C. Lower than before she became pregnant
- D. Higher than before she became pregnant

28. Which of the following findings would be expected when assessing the postpartum client?

- A. Fundus 1 cm above the umbilicus 1 hour postpartum
- B. Fundus 1 cm above the umbilicus on postpartum day 3
- C. Fundus palpable in the abdomen at 2 weeks postpartum
- D. Fundus slightly to the right; 2 cm above umbilicus on postpartum day 2

29. A client is complaining of painful contractions, or afterpains, on postpartum day 2. Which of the following conditions could increase the severity of afterpains?

- A. Bottle-feeding
- B. Diabetes
- C. Multiple gestation
- D. Primiparity

30. On which of the postpartum days can the client expect lochia serosa?

- A. Days 3 and 4 PP
- B. Days 3 to 10 PP
- C. Days 10-14 PP
- D. Days 14 to 42 PP

31. Which of the following behaviors characterizes the PP mother in the taking in phase?

- A. Passive and dependant
- B. Striving for independence and autonomy
- C. Curious and interested in care of the baby
- D. Exhibiting maximum readiness for new learning

**32. Which of the following complications may be indicated by continuous seepage of blood from the vagina of a PP client, when palpation of the uterus reveals a firm uterus 1 cm below the umbilicus?**

- A. Retained placental fragments**
- B. Urinary tract infection**
- C. Cervical laceration**
- D. Uterine atony**

**33. What type of milk is present in the breasts 7 to 10 days PP?**

- A. Colostrum**
- B. Hind milk**
- C. Mature milk**
- D. Transitional milk**

**34. Which of the following complications is most likely responsible for a delayed postpartum hemorrhage?**

- A. Cervical laceration**
- B. Clotting deficiency**
- C. Perineal laceration**
- D. Uterine subinvolution**

**35. Before giving a PP client the rubella vaccine, which of the following facts should the nurse include in client teaching?**

- A. The vaccine is safe in clients with egg allergies**
- B. Breast-feeding isn't compatible with the vaccine**
- C. Transient arthralgia and rash are common adverse effects**
- D. The client should avoid getting pregnant for 3 months after the vaccine because the vaccine has teratogenic effects**

**36. Which of the following changes best described the insulin needs of a client with type 1 diabetes who has just delivered an infant vaginally without complications?**

- A. Increase**
- B. Decrease**
- C. Remain the same as before pregnancy**
- D. Remain the same as during pregnancy**

**37. Which of the following responses is most appropriate for a mother with diabetes who wants to breastfeed her infant but is concerned about the effects of breastfeeding on her health?**

- A. Mothers with diabetes who breastfeed have a hard time controlling their insulin needs**
- B. Mothers with diabetes shouldn't breastfeed because of potential complications**
- C. Mothers with diabetes shouldn't breastfeed; insulin requirements are doubled.**
- D. Mothers with diabetes may breastfeed; insulin requirements may decrease from breastfeeding.**

**38. 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?**

- A. Depression phase**
- B. Letting-go phase**
- C. Taking-hold phase**
- D. Taking-in phase**

**39. Which of the following physiological responses is considered normal in the early postpartum period?**

- A. Urinary urgency and dysuria**
- B. Rapid diuresis**
- C. Decrease in blood pressure**
- D. Increase motility of the GI system**

**40. During the 3rd PP day, which of the following observations about the client would the nurse be most likely to make?**

- A. The client appears interested in learning about neonatal care**
- B. The client talks a lot about her birth experience**
- C. The client sleeps whenever the neonate isn't present**
- D. The client requests help in choosing a name for the neonate.**

**41. Which of the following circumstances is most likely to cause uterine atony and lead to PP hemorrhage?**

- A. Hypertension**

- B. Cervical and vaginal tears
- C. Urine retention
- D. Endometritis

42. Which type of lochia should the nurse expect to find in a client 2 days PP?

- A. Foul-smelling
- B. Lochia serosa
- C. Lochia alba
- D. Lochia rubra

43. After expulsion of the placenta in a client who has six living children, an infusion of lactated ringer's solution with 10 units of pitocin is ordered. The nurse understands that this is indicated for this client because:

- A. She had a precipitate birth
- B. This was an extramural birth
- C. Retained placental fragments must be expelled
- D. Multigravidas are at increased risk for uterine atony.

44. As part of the postpartum assessment, the nurse examines the breasts of a primiparous breastfeeding woman who is one day postpartum. An expected finding would be:

- A. Soft, non-tender; colostrum is present
- B. Leakage of milk at let down
- C. Swollen, warm, and tender upon palpation
- D. A few blisters and a bruise on each areola

45. Following the birth of her baby, a woman expresses concern about the weight she gained during pregnancy and how quickly she can lose it now that the baby is born. The nurse, in describing the expected pattern of weight loss, should begin by telling this woman that:

- A. Return to pre pregnant weight is usually achieved by the end of the postpartum period
- B. Fluid loss from diuresis, diaphoresis, and bleeding accounts for about a 3 pound weight loss
- C. The expected weight loss immediately after birth averages about 11 to 13 pounds
- D. Lactation will inhibit weight loss since caloric intake must increase to support milk production

46. Which of the following findings would be a source of concern if noted during the assessment of a woman who is 12 hours postpartum?

- A. Postural hypotension
- B. Temperature of 100.4°F
- C. Bradycardia — pulse rate of 55 BPM
- D. Pain in left calf with dorsiflexion of left foot

47. 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:

- A. Place her on a bedpan to empty her bladder
- B. Massage her fundus
- C. Call the physician
- D. Administer Methergine 0.2 mg IM which has been ordered prn

48. When performing a postpartum check, the nurse should:

- A. Assist the woman into a lateral position with upper leg flexed forward to facilitate the examination of her perineum
- B. Assist the woman into a supine position with her arms above her head and her legs extended for the examination of her abdomen
- C. Instruct the woman to avoid urinating just before the examination since a full bladder will facilitate fundal palpation
- D. Wash hands and put on sterile gloves before beginning the check

49. Perineal care is an important infection control measure. When evaluating a postpartum woman's perineal care technique, the nurse would recognize the need for further instruction if the woman:

- A. Uses soap and warm water to wash the vulva and perineum
- B. Washes from symphysis pubis back to episiotomy
- C. Changes her perineal pad every 2 – 3 hours
- D. Uses the peribottle to rinse upward into her vagina

50. Which measure would be least effective in preventing postpartum hemorrhage?

- A. Administer Methergine 0.2 mg every 6 hours for 4 doses as ordered
- B. Encourage the woman to void every 2 hours
- C. Massage the fundus every hour for the first 24 hours following birth

**D. Teach the woman the importance of rest and nutrition to enhance healing**

**51. When making a visit to the home of a postpartum woman one week after birth, the nurse should recognize that the woman would characteristically:**

- A. Express a strong need to review events and her behavior during the process of labor and birth**
- B. Exhibit a reduced attention span, limiting readiness to learn**
- C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn**
- D. Have reestablished her role as a spouse/partner**

**52. Four hours after a difficult labor and birth, a primiparous woman refuses to feed her baby, stating that she is too tired and just wants to sleep. The nurse should:**

- A. Tell the woman she can rest after she feeds her baby**
- B. Recognize this as a behavior of the taking-hold stage**
- C. Record the behavior as ineffective maternal-newborn attachment**
- D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time**

**53. Parents can facilitate the adjustment of their other children to a new baby by:**

- A. Having the children choose or make a gift to give to the new baby upon its arrival home**
- B. Emphasizing activities that keep the new baby and other children together**
- C. Having the mother carry the new baby into the home so she can show the other children the new baby**
- D. Reducing stress on other children by limiting their involvement in the care of the new baby**

**54. 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:**

- A. Foster an active role in the baby's care**
- B. Provide time for the mother to reflect on the events of and her behavior during childbirth**
- C. 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**
- D. Promote maternal independence by encouraging her to meet her own hygiene and comfort needs**

55. All of the following are important in the immediate care of the premature neonate. Which nursing activity should have the greatest priority?

- A. Instillation of antibiotic in the eyes
- B. Identification by bracelet and foot prints
- C. Placement in a warm environment
- D. Neurological assessment to determine gestational age

Answers and Rationales

1. Answer: B. Every 15 minutes during the first hour and then every 30 minutes for the next two hours.
2. Answer: D. Increase hydration by encouraging oral fluids. The mother's temperature may be taken every 4 hours while she is awake. Temperatures up to 100.4 (38 C) in the first 24 hours after birth are often related to the dehydrating effects of labor. The most appropriate action is to increase hydration by encouraging oral fluids, which should bring the temperature to a normal reading. Although the nurse would document the findings, the most appropriate action would be to increase the hydration.
3. Answer: B. Instruct the mother to request help when getting out of bed. Orthostatic hypotension may be evident during the first 8 hours after birth. Feelings of faintness or dizziness are signs that should caution the nurse to be aware of the client's safety. The nurse should advise the mother to get help the first few times the mother gets out of bed. Obtaining an H/H requires a physician's order.
4. Answer: C. Ask the mother to urinate and empty her bladder. Before starting the fundal assessment, the nurse should ask the mother to empty her bladder so that an accurate assessment can be done. When the nurse is performing fundal assessment, the nurse asks the woman to lie flat on her back with the knees flexed. Massaging the fundus is not appropriate unless the fundus is boggy and soft, and then it should be massaged gently until firm.
5. Answer: B. Indicates the presence of infection. Lochia, the discharge present after birth, is red for the first 1 to 3 days and gradually decreases in amount. Normal lochia has a fleshy odor. Foul smelling or purulent lochia usually indicates infection, and these findings are not normal. Encouraging the woman to drink fluids or increase ambulation is not an accurate nursing intervention.
6. Answer: B. Notify the physician. Normally, one may find a few small clots in the first 1 to 2 days after birth from pooling of blood in the vagina. Clots larger than 1 cm are considered abnormal. The cause of these clots, such as uterine atony or retained placental fragments, needs to be determined and treated to prevent further blood loss. Although the findings would be documented, the most appropriate action is to notify the physician.

7. **Answer: D. Eight peripads per day. 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. **Answer: B. 3 days PP. After birth, the nurse should auscultate the woman's abdomen in all four quadrants to determine the return of bowel sounds. Normal bowel elimination usually returns 2 to 3 days PP. Surgery, anesthesia, and the use of narcotics and pain control agents also contribute to the longer period of altered bowel function.**
9. **Answer: A and C. In the PP period, cervical healing occurs rapidly and cervical involution occurs. After 1 week the muscle begins to regenerate and the cervix feels firm and the external os is the width of a pencil. Although the vaginal mucosa heals and vaginal distention decreases, it takes the entire PP period for complete involution to occur and muscle tone is never restored to the pregravid state. The fundus begins to descend into the pelvic cavity after 24 hours, a process known as involution. Despite blood loss that occurs during delivery of the baby, a transient increase in cardiac output occurs. The increase in cardiac output, which persists about 48 hours after childbirth, is probably caused by an increase in stroke volume because Bradycardia is often noted during the PP period. Soon after childbirth, digestion begins to begin to be active and the new mother is usually hungry because of the energy expended during labor.**
10. **Answer: C. Changes in vital signs. Because the woman has had epidural anesthesia and is anesthetized, she cannot feel pain, pressure, or a tearing sensation. Changes in vitals indicate hypovolemia in the anesthetized PP woman with vulvar hematoma. Heavy bruising may be visualized, but vital sign changes indicate hematoma caused by blood collection in the perineal tissues.**
11. **Answer: D. Prepare an ice pack for application to the area. Application of ice will reduce swelling caused by hematoma formation in the vulvar area. The other options are not interventions that are specific to the plan of care for a client with a small vulvar hematoma.**
12. **Answer: C. Prepare the client for surgery. The use of an epidural, prolonged second stage labor and forceps delivery are predisposing factors for hematoma formation, and a collection of up to 500 ml of blood can occur in the vaginal area. Although the other options may be implemented, the immediate action would be to prepare the client for surgery to stop the bleeding.**
13. **Answer: B. An increase in the pulse from 88 to 102 BPM. During the 4th stage of labor, the maternal blood pressure, pulse, and respiration should be checked every 15 minutes during the first hour. A rising pulse is an early sign of excessive blood loss because the heart pumps faster to compensate for reduced blood volume. The blood pressure will fall as the blood volume diminishes, but a decreased blood pressure would not be the earliest sign of**

hemorrhage. A slight rise in temperature is normal. The respiratory rate is increased slightly.

14. Answer: A. Massage the fundus until it is firm. If the uterus is not contracted firmly, the first intervention is to massage the fundus until it is firm and to express clots that may have accumulated in the uterus. Pushing on an uncontracted uterus can invert the uterus and cause massive hemorrhage. Elevating the client's legs and encouraging the client to void will not assist in managing uterine atony. If the uterus does not remain contracted as a result of the uterine massage, the problem may be distended bladder and the nurse should assist the mother to urinate, but this would not be the initial action.
15. Answer: B. Enlarged, hardened veins. Thrombosis of the superficial veins is usually accompanied by signs and symptoms of inflammation. These include swelling of the involved extremity and redness, tenderness, and warmth.
16. Answer: D. "I need to stop breastfeeding until this condition resolves." In most cases, the mother can continue to breastfeed with both breasts. If the affected breast is too sore, the mother can pump the breast gently. Regular emptying of the breast is important to prevent abscess formation. Antibiotic therapy assists in resolving the mastitis within 24-48 hours. Additional supportive measures include ice packs, breast supports, and analgesics.
17. Answer: C. Hematuria, ecchymosis, and epistaxis. The treatment for DVT is anticoagulant therapy. The nurse assesses for bleeding, which is an adverse effect of anticoagulants. This includes hematuria, ecchymosis, and epistaxis. Dysuria and vertigo are not associated specifically with bleeding.
18. Answer: A. Assess for hypovolemia and notify the health care provider. Symptoms of hypovolemia include cool, clammy, pale skin, sensations of anxiety or impending doom, restlessness, and thirst. When these symptoms are present, the nurse should further assess for hypovolemia and notify the health care provider.
19. Answer: C. Notify the physician. If the bleeding is excessive, the cause may be laceration of the cervix or birth canal. Massaging the fundus if it is firm will not assist in controlling the bleeding. Trendelenburg's position is to be avoided because it may interfere with cardiac function.
20. Answer: C. Activated partial thromboplastin time. Anticoagulation therapy may be used to prevent the extension of thrombus by delaying the clotting time of the blood. Activated partial thromboplastin time should be monitored, and a heparin dose should be adjusted to maintain a therapeutic level of 1.5 to 2.5 times the control. The prothrombin time and the INR are used to monitor coagulation time when warfarin (Coumadin) is used.
21. Answer: B, D, and E. Mastitis are an infection of the lactating breast. Client instructions include resting during the acute phase, maintaining a fluid intake of at least 3 L a day, and taking analgesics to relieve discomfort. Antibiotics may be prescribed and are taken until the complete prescribed course is finished. They are not stopped when the soreness subsides. Additional supportive measures include the use of moist heat or ice packs and wearing

- a supportive bra. Continued decompression of the breast by breastfeeding or pumping is important to empty the breast and prevent formation of an abscess.
22. Answer: B. Blood pressure. Methergine and pitocin are agents that are used to prevent or control postpartum hemorrhage by contracting the uterus. They cause continuous uterine contractions and may elevate blood pressure. A priority nursing intervention is to check blood pressure. The physician should be notified if hypertension is present.
23. Answer: A. Peripheral vascular disease. These medications are avoided in clients with significant cardiovascular disease, peripheral disease, hypertension, eclampsia, or preeclampsia. These conditions are worsened by the vasoconstriction effects of these medications.
24. Answer: A. Supplemental feedings with formula. Routine formula supplementation may interfere with establishing an adequate milk volume because decreased stimulation to the mother's nipples affects hormonal levels and milk production.
25. Answer: C. Teaching how to express her breasts in a warm shower. Teaching the client how to express her breasts in a warm shower aids with let-down and will give temporary relief. Ice can promote comfort by vasoconstriction, numbing, and discouraging further letdown of milk.
26. Answer: A. Ask the client to empty her bladder. A full bladder may displace the uterine fundus to the left or right side of the abdomen. Catheterization is unnecessary invasive if the woman can void on her own.
27. Answer: C. Lower than before she became pregnant. PP insulin requirements are usually significantly lower than pre pregnancy requirements. Occasionally, clients may require little to no insulin during the first 24 to 48 hours postpartum.
28. Answer: A. Fundus 1 cm above the umbilicus 1 hour postpartum. Within the first 12 hours postpartum, the fundus usually is approximately 1 cm above the umbilicus. The fundus should be below the umbilicus by PP day 3. The fundus shouldn't be palpated in the abdomen after day 10.
29. Answer: C. Multiple gestation. Multiple gestation, breastfeeding, multiparity, and conditions that cause overdistention of the uterus will increase the intensity of after-pains. Bottle-feeding and diabetes aren't directly associated with increasing severity of afterpains unless the client has delivered a macrosomic infant.
30. Answer: B. Days 3 to 10 PP. On the third and fourth PP days, the lochia becomes a pale pink or brown and contains old blood, serum, leukocytes, and tissue debris. This type of lochia usually lasts until PP day 10. Lochia rubra usually last for the first 3 to 4 days PP. Lochia alba, which contain leukocytes, decidua, epithelial cells, mucus, and bacteria, may continue for 2 to 6 weeks PP.
31. Answer: A. Passive and dependant. During the taking in phase, which usually lasts 1-3 days, the mother is passive and dependent and expresses her own

needs rather than the neonate's needs. The taking hold phase usually lasts from days 3-10 PP. During this stage, the mother strives for independence and autonomy; she also becomes curious and interested in the care of the baby and is most ready to learn.

32. Answer: C. Cervical laceration. Continuous seepage of blood may be due to cervical or vaginal lacerations if the uterus is firm and contracting. Retained placental fragments and uterine atony may cause subinvolution of the uterus, making it soft, boggy, and larger than expected. UTI won't cause vaginal bleeding, although hematuria may be present.
33. Answer: D. Transitional milk. Transitional milk comes after colostrum and usually lasts until 2 weeks PP.
34. Answer: D. Uterine subinvolution. Late postpartum bleeding is often the result of subinvolution of the uterus. Retained products of conception or infection often cause subinvolution. Cervical or perineal lacerations can cause an immediate postpartum hemorrhage. A client with a clotting deficiency may also have an immediate PP hemorrhage if the deficiency isn't corrected at the time of delivery.
35. Answer: D. The client should avoid getting pregnant for 3 months after the vaccine because the vaccine has teratogenic effects. The client must understand that she must not become pregnant for 3 months after the vaccination because of its potential teratogenic effects. The rubella vaccine is made from duck eggs so an allergic reaction may occur in clients with egg allergies. The virus is not transmitted into the breast milk, so clients may continue to breastfeed after the vaccination. Transient arthralgia and rash are common adverse effects of the vaccine.
36. Answer: B. Decrease. The placenta produces the hormone human placental lactogen, an insulin antagonist. After birth, the placenta, the major source of insulin resistance, is gone. Insulin needs decrease and women with type 1 diabetes may only need one-half to two-thirds of the prenatal insulin during the first few PP days.
37. Answer: D. Mothers with diabetes may breastfeed; insulin requirements may decrease from breastfeeding. Breastfeeding has an antidiabetogenic effect. Insulin needs are decreased because carbohydrates are used in milk production. Breastfeeding mothers are at a higher risk of hypoglycemia in the first PP days after birth because the glucose levels are lower. Mothers with diabetes should be encouraged to breastfeed.
38. Answer: D. Taking-in phase. The taking-in phase occurs in the first 24 hours after birth. The mother is concerned with her own needs and requires support from staff and relatives. The taking-hold phase occurs when the mother is ready to take responsibility for her care as well as the infant's care. The letting-go phase begins several weeks later, when the mother incorporates the new infant into the family unit.
39. Answer: B. Rapid diuresis. In the early PP period, there's an increase in the glomerular filtration rate and a drop in the progesterone levels, which result

in rapid diuresis. There should be no urinary urgency, though a woman may feel anxious about voiding. There's a minimal change in blood pressure following childbirth, and a residual decrease in GI motility.

40. Answer: A. The client appears interested in learning about neonatal care. The third to tenth days of PP care are the "taking-hold" phase, in which the new mother strives for independence and is eager for her neonate. The other options describe the phase in which the mother relives her birth experience.
41. Answer: C. Urine retention. Urine retention causes a distended bladder to displace the uterus above the umbilicus and to the side, which prevents the uterus from contracting. The uterus needs to remain contracted if bleeding is to stay within normal limits. Cervical and vaginal tears can cause PP hemorrhage but are less common occurrences in the PP period.
42. Answer: D. Lochia rubra
43. Answer: D. Multigravidas are at increased risk for uterine atony. Multiple full-term pregnancies and deliveries result in overstretched uterine muscles that do not contract efficiently and bleeding may ensue.
44. Answer: A. Soft, non-tender; colostrum is present. Breasts are essentially unchanged for the first two to three days after birth. Colostrum is present and may leak from the nipples.
45. Answer: C. The expected weight loss immediately after birth averages about 11 to 13 pounds. Prepregnant weight is usually achieved by 2 to 3 months after birth, not within the 6-week postpartum period. Weight loss from diuresis, diaphoresis, and bleeding is about 9 pounds. Weight loss continues during breastfeeding since fat stores developed during pregnancy and extra calories consumed are used as part of the lactation process.
46. Answer: D. Pain in left calf with dorsiflexion of left foot. Responses A and C are expected related to circulatory changes after birth. A temperature of 100.4°F in the first 24 hours is most likely indicative of dehydration which is easily corrected by increasing oral fluid intake. The findings in response D indicate a positive Homan sign and are suggestive of thrombophlebitis and should be investigated further.
47. Answer: B. Massage her fundus. A boggy or soft fundus indicates that uterine atony is present. This is confirmed by the profuse lochia and passage of clots. The first action would be to massage the fundus until firm, followed by 3 and 4, especially if the fundus does not become or remain firm with massage. There is no indication of a distended bladder since the fundus is midline and below the umbilicus.
48. Answer: A. Assist the woman into a lateral position with upper leg flexed forward to facilitate the examination of her perineum. While the supine position is best for examining the abdomen, the woman should keep her arms at her sides and slightly flex her knees in order to relax abdominal muscles and facilitate palpation of the fundus. The bladder should be emptied before the check. A full bladder alters the position of the fundus and makes the findings inaccurate. Although hands are washed before starting

the check, clean (not sterile) gloves are put on just before the perineum and pad are assessed to protect from contact with blood and secretions.

49. Answer: D. Uses the peribottle to rinse upward into her vagina. Responses A, B, and C are all appropriate measures. The peribottle should be used in a backward direction over the perineum. The flow should never be directed upward into the vagina since debris would be forced upward into the uterus through the still-open cervix.
50. Answer: C. Massage the fundus every hour for the first 24 hours following birth. The fundus should be massaged only when boggy or soft. Massaging a firm fundus could cause it to relax. Responses A, B, and D are all effective measures to enhance and maintain contraction of the uterus and to facilitate healing.
51. Answer: C. Vacillate between the desire to have her own nurturing needs met and the need to take charge of her own care and that of her newborn. One week after birth the woman should exhibit behaviors characteristic of the taking-hold stage as described in response C. This stage lasts for as long as 4 to 5 weeks after birth. Responses A and B are characteristic of the taking-in stage, which lasts for the first few days after birth. Response D reflects the letting-go stage, which indicates that psychosocial recovery is complete.
52. Answer: D. Take the baby back to the nursery, reassuring the woman that her rest is a priority at this time. Response A does not take into consideration the need for the new mother to be nurtured and have her needs met during the taking-in stage. The behavior described is typical of this stage and not a reflection of ineffective attachment unless the behavior persists. Mothers need to reestablish their own well-being in order to effectively care for their baby.
53. Answer: A. Having the children choose or make a gift to give to the new baby upon its arrival home. Special time should be set aside just for the other children without interruption from the newborn. Someone other than the mother should carry the baby into the home so she can give full attention to greeting her other children. Children should be actively involved in the care of the baby according to their ability without overwhelming them.
54. Answer: B. Provide time for the mother to reflect on the events of and her behavior during childbirth. The focus of the taking-in stage is nurturing the new mother by meeting her dependency needs for rest, comfort, hygiene, and nutrition. Once they are met, she is more able to take an active role, not only in her own care but also the care of her newborn. Women express a need to review their childbirth experience and evaluate their performance. Short teaching sessions, using written materials to reinforce the content presented, are a more effective approach.
55. Answer: C. Placement in a warm environment

1) A nurse in a delivery room is assisting with the delivery of a newborn infant. After the delivery, the nurse prepares to prevent heat loss in the newborn resulting from evaporation by:

- A. Warming the crib pad
- B. Turning on the overhead radiant warmer
- C. Closing the doors to the room
- D. Drying the infant in a warm blanket

2) A nurse is assessing a newborn infant following circumcision and notes that the circumcised area is red with a small amount of bloody drainage. Which of the following nursing actions would be most appropriate?

- A. Document the findings
- B. Contact the physician
- C. Circle the amount of bloody drainage on the dressing and reassess in 30 minutes
- D. Reinforce the dressing

3) A nurse in the newborn nursery is monitoring a preterm newborn infant for respiratory distress syndrome. Which assessment signs if noted in the newborn infant would alert the nurse to the possibility of this syndrome?

- A. Hypotension and Bradycardia
- B. Tachypnea and retractions
- C. Acrocyanosis and grunting
- D. The presence of a barrel chest with grunting

4) A nurse in a newborn nursery is performing an assessment of a newborn infant. The nurse is preparing to measure the head circumference of the infant. The nurse would most appropriately:

- A. Wrap the tape measure around the infant's head and measure just above the eyebrows.
- B. Place the tape measure under the infants head at the base of the skull and wrap around to the front just above the eyes
- C. Place the tape measure under the infants head, wrap around the occiput, and measure just above the eyes

- D. Place the tape measure at the back of the infant's head, wrap around across the ears, and measure across the infant's mouth.
- 5) A postpartum nurse is providing instructions to the mother of a newborn infant with hyperbilirubinemia who is being breastfed. The nurse provides which most appropriate instructions to the mother?
- A. Switch to bottle feeding the baby for 2 weeks
  - B. Stop the breast feedings and switch to bottle-feeding permanently
  - C. Feed the newborn infant less frequently
  - D. Continue to breast-feed every 2-4 hours
- 6) A nurse on the newborn nursery floor is caring for a neonate. On assessment the infant is exhibiting signs of cyanosis, tachypnea, nasal flaring, and grunting. Respiratory distress syndrome is diagnosed, and the physician prescribes surfactant replacement therapy. The nurse would prepare to administer this therapy by:
- A. Subcutaneous injection
  - B. Intravenous injection
  - C. Instillation of the preparation into the lungs through an endotracheal tube
  - D. Intramuscular injection
- 7) A nurse is assessing a newborn infant who was born to a mother who is addicted to drugs. Which of the following assessment findings would the nurse expect to note during the assessment of this newborn?
- A. Sleepiness
  - B. Cuddles when being held
  - C. Lethargy
  - D. Incessant crying
- 8) A nurse prepares to administer a vitamin K injection to a newborn infant. The mother asks the nurse why her newborn infant needs the injection. The best response by the nurse would be:
- A. "Your infant needs vitamin K to develop immunity."
  - B. "The vitamin K will protect your infant from being jaundiced."
  - C. "Newborn infants are deficient in vitamin K, and this injection prevents your infant from abnormal bleeding."
  - D. "Newborn infants have sterile bowels, and vitamin K promotes the growth of bacteria in the bowel."

9) A nurse in a newborn nursery receives a phone call to prepare for the admission of a 43-week-gestation newborn with Apgar scores of 1 and 4. In planning for the admission of this infant, the nurse's highest priority should be to:

- A. Connect the resuscitation bag to the oxygen outlet
- B. Turn on the apnea and cardiorespiratory monitors
- C. Set up the intravenous line with 5% dextrose in water
- D. Set the radiant warmer control temperature at 36.5\* C (97.6\*F)

10) Vitamin K is prescribed for a neonate. A nurse prepares to administer the medication in which muscle site?

- A. Deltoid
- B. Triceps
- C. Vastus lateralis
- D. Biceps

11) A nursing instructor asks a nursing student to describe the procedure for administering erythromycin ointment into the eyes of a neonate. The instructor determines that the student needs to research this procedure further if the student states:

- A. "I will cleanse the neonate's eyes before instilling ointment."
- B. "I will flush the eyes after instilling the ointment."
- C. "I will instill the eye ointment into each of the neonate's conjunctival sacs within one hour after birth."
- D. "Administration of the eye ointment may be delayed until an hour or so after birth so that eye contact and parent-infant attachment and bonding can occur."

12) A baby is born precipitously in the ER. The nurse's initial action should be to:

- A. Establish an airway for the baby
- B. Ascertain the condition of the fundus
- C. Quickly tie and cut the umbilical cord
- D. Move mother and baby to the birthing unit

13) The primary critical observation for Apgar scoring is the:

- A. Heart rate
- B. Respiratory rate

- C. Presence of meconium
- D. Evaluation of the Moro reflex

14) When performing a newborn assessment, the nurse should measure the vital signs in the following sequence:

- A. Pulse, respirations, temperature
- B. Temperature, pulse, respirations
- C. Respirations, temperature, pulse
- D. Respirations, pulse, temperature

15) Within 3 minutes after birth the normal heart rate of the infant may range between:

- A. 100 and 180
- B. 130 and 170
- C. 120 and 160
- D. 100 and 130

16) The expected respiratory rate of a neonate within 3 minutes of birth may be as high as:

- A. 50
- B. 60
- C. 80
- D. 100

17) The nurse is aware that a healthy newborn's respirations are:

- A. Regular, abdominal, 40-50 per minute, deep
- B. Irregular, abdominal, 30-60 per minute, shallow
- C. Irregular, initiated by chest wall, 30-60 per minute, deep
- D. Regular, initiated by the chest wall, 40-60 per minute, shallow

18) To help limit the development of hyperbilirubinemia in the neonate, the plan of care should include:

- A. Monitoring for the passage of meconium each shift
- B. Instituting phototherapy for 30 minutes every 6 hours
- C. Substituting breastfeeding for formula during the 2nd day after birth
- D. Supplementing breastfeeding with glucose water during the first 24 hours

19) A newborn has small, whitish, pinpoint spots over the nose, which the nurse knows are caused by retained sebaceous secretions. When charting this observation, the nurse identifies it as:

- A. Milia
- B. Lanugo
- C. Whiteheads
- D. Mongolian spots

20) When newborns have been on formula for 36-48 hours, they should have a:

- A. Screening for PKU
- B. Vitamin K injection
- C. Test for necrotizing enterocolitis
- D. Heel stick for blood glucose level

21) The nurse decides on a teaching plan for a new mother and her infant. The plan should include:

- A. Discussing the matter with her in a non-threatening manner
- B. Showing by example and explanation how to care for the infant
- C. Setting up a schedule for teaching the mother how to care for her baby
- D. Supplying the emotional support to the mother and encouraging her independence

22) Which action best explains the main role of surfactant in the neonate?

- A. Assists with ciliary body maturation in the upper airways
- B. Helps maintain a rhythmic breathing pattern
- C. Promotes clearing mucus from the respiratory tract
- D. Helps the lungs remain expanded after the initiation of breathing

23) While assessing a 2-hour old neonate, the nurse observes the neonate to have acrocyanosis. Which of the following nursing actions should be performed initially?

- A. Activate the code blue or emergency system
- B. Do nothing because acrocyanosis is normal in the neonate
- C. Immediately take the newborn's temperature according to hospital policy
- D. Notify the physician of the need for a cardiac consult

24) The nurse is aware that a neonate of a mother with diabetes is at risk for what complication?

- A. Anemia
- B. Hypoglycemia
- C. Nitrogen loss
- D. Thrombosis

25) A client with group AB blood whose husband has group O has just given birth. The major sign of ABO blood incompatibility in the neonate is which complication or test result?

- A. Negative Coombs test
- B. Bleeding from the nose and ear
- C. Jaundice after the first 24 hours of life
- D. Jaundice within the first 24 hours of life

26) A client has just given birth at 42 weeks' gestation. When assessing the neonate, which physical finding is expected?

- A. A sleepy, lethargic baby
- B. Lanugo covering the body
- C. Desquamation of the epidermis
- D. Vernix caseosa covering the body

27) After reviewing the client's maternal history of magnesium sulfate during labor, which condition would the nurse anticipate as a potential problem in the neonate?

- A. Hypoglycemia
- B. Jitteriness
- C. Respiratory depression
- D. Tachycardia

28) Neonates of mothers with diabetes are at risk for which complication following birth?

- A. Atelectasis
- B. Microcephaly
- C. Pneumothorax
- D. Macrosomia

29) By keeping the nursery temperature warm and wrapping the neonate in blankets, the nurse is preventing which type of heat loss?

- A. Conduction
- B. Convection
- C. Evaporation
- D. Radiation

30) A neonate has been diagnosed with caput succedaneum. Which statement is correct about this condition?

- A. It usually resolves in 3-6 weeks
- B. It doesn't cross the cranial suture line
- C. It's a collection of blood between the skull and the periosteum
- D. It involves swelling of tissue over the presenting part of the presenting head

31) The most common neonatal sepsis and meningitis infections seen within 24 hours after birth are caused by which organism?

- A. *Candida albicans*
- B. *Chlamydia trachomatis*
- C. *Escherichia coli*
- D. Group B beta-hemolytic streptococci

32) When attempting to interact with a neonate experiencing drug withdrawal, which behavior would indicate that the neonate is willing to interact?

- A. Gaze aversion
- B. Hiccups
- C. Quiet alert state
- D. Yawning

33) When teaching umbilical cord care to a new mother, the nurse would include which information?

- A. Apply peroxide to the cord with each diaper change
- B. Cover the cord with petroleum jelly after bathing
- C. Keep the cord dry and open to air
- D. Wash the cord with soap and water each day during a tub bath

34) A mother of a term neonate asks what the thick, white, cheesy coating is on his skin. Which correctly describes this finding?

- A. Lanugo
- B. Milia
- C. Nevus flammeus
- D. Vernix

35) Which condition or treatment best ensures lung maturity in an infant?

- A. Meconium in the amniotic fluid
- B. Glucocorticoid treatment just before delivery
- C. Lecithin to sphingomyelin ratio more than 2:1
- D. Absence of phosphatidylglycerol in amniotic fluid

36) When performing nursing care for a neonate after a birth, which intervention has the highest nursing priority?

- A. Obtain a dextrostix
- B. Give the initial bath
- C. Give the vitamin K injection
- D. Cover the neonates head with a cap

37) When performing an assessment on a neonate, which assessment finding is most suggestive of hypothermia?

- A. Bradycardia
- B. Hyperglycemia
- C. Metabolic alkalosis
- D. Shivering

38) A woman delivers a 3.250 g neonate at 42 weeks' gestation. Which physical finding is expected during an examination if this neonate?

- A. Abundant lanugo
- B. Absence of sole creases
- C. Breast bud of 1-2 mm in diameter
- D. Leathery, cracked, and wrinkled skin

39) A healthy term neonate born by C-section was admitted to the transitional nursery 30 minutes ago and placed under a radiant warmer. The neonate has an

axillary temperature of 99.5°F, a respiratory rate of 80 breaths/minute, and a heel stick glucose value of 60 mg/dl. Which action should the nurse take?

- A. Wrap the neonate warmly and place her in an open crib
- B. Administer an oral glucose feeding of 10% dextrose in water
- C. Increase the temperature setting on the radiant warmer
- D. Obtain an order for IV fluid administration

40) Which neonatal behavior is most commonly associated with fetal alcohol syndrome (FAS)?

- A. Hypoactivity
- B. High birth weight
- C. Poor wake and sleep patterns
- D. High threshold of stimulation

#### Answers and Rationales

1. Answer: D. Drying the infant in a warm blanket. Evaporation of moisture from a wet body dissipates heat along with the moisture. Keeping the newborn dry by drying the wet newborn infant will prevent hypothermia via evaporation.
2. Answer: A. Document the findings. The penis is normally red during the healing process. A yellow exudate may be noted in 24 hours, and this is a part of normal healing. The nurse would expect that the area would be red with a small amount of bloody drainage. If the bleeding is excessive, the nurse would apply gentle pressure with sterile gauze. If bleeding is not controlled, then the blood vessel may need to be ligated, and the nurse would contact the physician. Because the findings identified in the question are normal, the nurse would document the assessment.
3. Answer: B. Tachypnea and retractions. The infant with respiratory distress syndrome may present with signs of cyanosis, tachypnea or apnea, nasal flaring, chest wall retractions, or audible grunts.
4. Answer: C. Place the tape measure under the infant's head, wrap around the occiput, and measure just above the eyes. To measure the head circumference, the nurse should place the tape measure under the infant's head, wrap the tape around the occiput, and measure just above the eyebrows so that the largest area of the occiput is included.
5. Answer: D. Continue to breastfeed every 2-4 hours. Breast feeding should be initiated within 2 hours after birth and every 2-4 hours thereafter. The other options are not necessary.
6. Answer: C. Instillation of the preparation into the lungs through an endotracheal tube. The aim of therapy in RDS is to support the disease until the disease runs its course with the subsequent development of surfactant.

The infant may benefit from surfactant replacement therapy. In surfactant replacement, an exogenous surfactant preparation is instilled into the lungs through an endotracheal tube.

7. Answer: D. Incessant crying. A newborn infant born to a woman using drugs is irritable. The infant is overloaded easily by sensory stimulation. The infant may cry incessantly and posture rather than cuddle when being held.
8. Answer: C. "Newborn infants are deficient in vitamin K, and this injection prevents your infant from abnormal bleeding." Vitamin K is necessary for the body to synthesize coagulation factors. Vitamin K is administered to the newborn infant to prevent abnormal bleeding. Newborn infants are vitamin K deficient because the bowel does not have the bacteria necessary for synthesizing fat-soluble vitamin K. The infant's bowel does not have support the production of vitamin K until bacteria adequately colonizes it by food ingestion.
9. Answer: A. Connect the resuscitation bag to the oxygen outlet. The highest priority on admission to the nursery for a newborn with low Apgar scores is airway, which would involve preparing respiratory resuscitation equipment. The other options are also important, although they are of lower priority.
10. Answer: C. Vastus lateralis.
11. Answer: B. "I will flush the eyes after instilling the ointment." Eye prophylaxis protects the neonate against *Neisseria gonorrhoeae* and *Chlamydia trachomatis*. The eyes are not flushed after instillation of the medication because the flush will wash away the administered medication.
12. Answer: A. Establish an airway for the baby. The nurse should position the baby with head lower than chest and rub the infant's back to stimulate crying to promote oxygenation. There is no haste in cutting the cord.
13. Answer: A. Heart rate. The heart rate is vital for life and is the most critical observation in Apgar scoring. Respiratory effect rather than rate is included in the Apgar score; the rate is very erratic.
14. Answer: D. Respirations, pulse, temperature. This sequence is least disturbing. Touching with the stethoscope and inserting the thermometer increase anxiety and elevate vital signs.
15. Answer: C. 120 and 160. The heart rate varies with activity; crying will increase the rate, whereas deep sleep will lower it; a rate between 120 and 160 is expected.
16. Answer: B. 60. The respiratory rate is associated with activity and can be as rapid as 60 breaths per minute; over 60 breaths per minute are considered tachypneic in the infant.
17. Answer: B. Irregular, abdominal, 30-60 per minute, shallow. Normally the newborn's breathing is abdominal and irregular in depth and rhythm; the rate ranges from 30-60 breaths per minute.
18. Answer: A. Monitoring for the passage of meconium each shift. Bilirubin is excreted via the GI tract; if meconium is retained, the bilirubin is reabsorbed.

19. Answer: A. Milia. Milia occur commonly, are not indicative of any illness, and eventually disappear.
20. Answer: A. Screening for PKU. By now the newborn will have ingested an ample amount of the amino acid phenylalanine, which, if not metabolized because of a lack of the liver enzyme, can deposit injurious metabolites into the bloodstream and brain; early detection can determine if the liver enzyme is absent.
21. Answer: B. Showing by example and explanation how to care for the infant. Teaching the mother by example is a non-threatening approach that allows her to proceed at her own pace.
22. Answer: D. Helps the lungs remain expanded after the initiation of breathing. Surfactant works by reducing surface tension in the lung. Surfactant allows the lung to remain slightly expanded, decreasing the amount of work required for inspiration.
23. Answer: B. Do nothing because acrocyanosis is normal in the neonate. Acrocyanosis, or bluish discoloration of the hands and feet in the neonate (also called peripheral cyanosis), is a normal finding and shouldn't last more than 24 hours after birth.
24. Answer: B. Hypoglycemia. Neonates of mothers with diabetes are at risk for hypoglycemia due to increased insulin levels. During gestation, an increased amount of glucose is transferred to the fetus across the placenta. The neonate's liver cannot initially adjust to the changing glucose levels after birth. This may result in an overabundance of insulin in the neonate, resulting in hypoglycemia.
25. Answer: D. Jaundice within the first 24 hours of life. The neonate with ABO blood incompatibility with its mother will have jaundice (pathologic) within the first 24 hours of life. The neonate would have a positive Coombs test result.
26. Answer: C. Desquamation of the epidermis. Postdate fetuses lose the vernix caseosa, and the epidermis may become desquamated. These neonates are usually very alert. Lanugo is missing in the postdate neonate.
27. Answer: C. Respiratory depression. Magnesium sulfate crosses the placenta and adverse neonatal effects are respiratory depression, hypotonia, and Bradycardia.
28. Answer: D. Macrosomia. Neonates of mothers with diabetes are at increased risk for macrosomia (excessive fetal growth) as a result of the combination of the increased supply of maternal glucose and an increase in fetal insulin.
29. Answer: B. Convection. Convection heat loss is the flow of heat from the body surface to the cooler air.
30. Answer: D. It involves swelling of tissue over the presenting part of the presenting head. Caput succedaneum is the swelling of tissue over the presenting part of the fetal scalp due to sustained pressure; it resolves in 3-4 days.

31. Answer: D. Group B beta-hemolytic streptococci. Transmission of Group B beta-hemolytic streptococci to the fetus results in respiratory distress that can rapidly lead to septic shock.
32. Answer: C. Quiet alert state. When caring for a neonate experiencing drug withdrawal, the nurse needs to be alert for distress signals from the neonate. Stimuli should be introduced one at a time when the neonate is in a quiet and alert state. Gaze aversion, yawning, sneezing, hiccups, and body arching are distress signals that the neonate cannot handle stimuli at that time.
33. Answer: C. Keep the cord dry and open to air. Keeping the cord dry and open to air helps reduce infection and hastens drying.
34. Answer: D. Vernix.
35. Answer: C. Lecithin to sphingomyelin ratio more than 2:1. Lecithin and sphingomyelin are phospholipids that help compose surfactant in the lungs; lecithin peaks at 36 weeks and sphingomyelin concentrations remain stable.
36. Answer: D. Cover the neonates head with a cap. Covering the neonates head with a cap helps prevent cold stress due to excessive evaporative heat loss from the neonate's wet head. Vitamin K can be given up to 4 hours after birth.
37. Answer: A. Bradycardia. Hypothermic neonates become bradycardic proportional to the degree of core temperature. Hypoglycemia is seen in hypothermic neonates.
38. Answer: D. Leathery, cracked, and wrinkled skin. Neonatal skin thickens with maturity and is often peeling by post term.
39. Answer: D. Obtain an order for IV fluid administration. Assessment findings indicate that the neonate is in respiratory distress—most likely from transient tachypnea, which is common after cesarean delivery. A neonate with a rate of 80 breaths a minute shouldn't be fed but should receive IV fluids until the respiratory rate returns to normal. To allow for close observation for worsening respiratory distress, the neonate should be kept unclothed in the radiant warmer.
40. Answer: C. Poor wake and sleep patterns. Altered sleep patterns are caused by disturbances in the CNS from alcohol exposure in utero. Hyperactivity is a characteristic generally noted. Low birth weight is a physical defect seen in neonates with FAS. Neonates with FAS generally have a low threshold for stimulation.

MIDWIFERY 9 NEWBORN