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ATI PROCTORED EXAM - MATERNAL NEWBORN

A nurse is caring for a client who has eclampsia and just had a tonic-clonic seizure. After turning the client's head to the side, which of the following actions should the nurse take next?

Show Explanation

Correct Answer:

C.

Give oxygen at 10 L/min via face mask

The first action the nurse should take when using the airway, breathing, and circulation (ABC) approach to client care is to administer oxygen to help stabilize the client's respiratory status.

Incorrect Answers:

A. The nurse should administer magnesium sulfate to prevent further seizure activity; however, there is another action the nurse should take first.

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B. The nurse should insert an indwelling urinary catheter to monitor the client's fluid output. Fluids should be restricted for a client who has eclampsia, but the client's output should be at least 25 mL/hr. However, there is another action the nurse should take first.

D. The nurse should reduce environmental stimuli to help prevent further seizure activity and to promote rest following the seizure; however, there is another action the nurse should take first.

A nurse is performing an admission assessment of a client who just arrived at the labor and delivery unit. Which of the following findings should the nurse identify as the priority?

Correct Answer:

D.

The fetal heart rate is 90/min.

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Fetal bradycardia indicates that this client is at greatest risk for fetal consequences due to a cardiac disorder or infection, leading to hypoxia and asphyxiation; therefore, this is the priority finding.

Incorrect Answers:A. The nurse should intervene to help ease the client's pain; however, another assessment finding is the priority.

B. The nurse should recheck the client's blood pressure in 30 minutes after the client has relaxed and between contractions to help rule out preeclampsia; however, another assessment finding is the priority.

C. The nurse should notify the provider and perform a thorough assessment to rule out an infection such as chorioamnionitis; however, another assessment finding is the priority.

A nurse is caring for a recently delivered newborn whose mother had gestational diabetes. What action should the nurse take within 1 hr after birth?

Correct Answer:

B.

Assess the newborn's blood glucose level

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Newborns whose mothers have diabetes have a greater risk of developing hypoglycemia due to the cessation of the fetal blood glucose supply and fetal hyperinsulinemia. Blood glucose levels should be assessed within 1 hour after birth, followed closely, and treated promptly when needed.

Incorrect Answers:A. The nurse should administer the HBV vaccine prior to discharge. There is no indication to administer the vaccine within 1 hour after birth.

C. The nurse should not bathe the newborn until the newborn's temperature has stabilized in the extra-uterine environment. Ideally, the nurse should place the infant in skin-to-skin contact with the mother for at least the first 1 to 2 hours after birth. Alternately, the nurse can place the newborn under a radiant heat source and assess the newborn's temperature every hour until it is stabilized.

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D. The nurse should use a pulse oximeter to screen for congenital heart disease 24 to 48 hours after birth. If the nurse performs the screening prior to 12 hours after birth, acrocyanosis might alter the results.

A nurse is teaching a client who is at 12 weeks gestation and has human immunodeficiency virus (HIV). Which of the following statements should the nurse include in the teaching?

Correct Answer:

D.

"You should continue to take zidovudine throughout the pregnancy."

The nurse should inform the client that taking prescription antiviral medication every day decreases the risk of transmitting HIV to her newborn.

Incorrect Answers:A. The client can transmit HIV through breast milk and should bottle-feed her newborn.

B. The client can continue to have sexual intercourse during pregnancy, as long as a condom is used.

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C. The client and her newborn will only require standard precautions after delivery.

A nurse is caring for a newborn immediately following birth. Which of the following actions should the nurse take first?

Correct Answer:

D.

Dry the newborn

The greatest risk to the newborn immediately after birth is heat loss, which can cause cold stress, respiratory distress, and hypoglycemia. Therefore, the first action the nurse should take is to dry the newborn to prevent heat loss from evaporation.

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Incorrect Answers:A. The nurse should obtain the newborn's weight within 1 to 2 hours after birth. However, there is another action the nurse should take first.

B. The nurse should instill erythromycin ophthalmic ointment in the newborn's eyes after the first breastfeeding to prevent infection. However, there is another action the nurse should take first.

C. The nurse should administer vitamin K to the newborn within 1 to 2 hours after birth to prevent bleeding. However, there is another action the nurse should take first.

A nurse is performing a physical assessment of a newborn. Which of the following actions should the nurse take?

Correct Answer:

C.

Measure the circumference of the newborn's head with a tape measure just above the eyebrows

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Shortly after birth, the nurse should measure the circumference of the newborn's head at its largest diameter, which is around the occipitofrontal area.

Incorrect Answers:A. The nurse should measure the newborn's length from the top of the head to the heel.

B. The nurse should remove the newborn's diaper and clothing to measure weight.

D. The nurse should measure the newborn's chest circumference at the nipple line, not below it.

A nurse is caring for a client who recently gave birth and plans to breastfeed. Which of the following actions should the nurse take?

Correct Answer:

A.

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