

A nurse is caring for a client who is pregnant in an antepartum clinic. Which of the following findings should the nurse report to the provider? - ANSWER-- Uterine contractions.

The client is experiencing regular uterine contractions and cervical change, which are indicators of preterm labor; therefore, the nurse should notify the provider about this finding.

- Gestational age.

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

- Vaginal examination.

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

## EXAM

### ATI HESI RN PHARMACOLOGY REVIEW 2023 / 2024 GRADED

## A+

The client's blood pressure is within the expected reference range . Blood pressure 130/70 mm Hg? what is normal.

A nurse is caring for a client who is at 22 weeks of gestation and is HIV positive. Which of the following actions should the nurse take? - ANSWER-Report the client's condition to the local health department.

Rationale:

The nurse should report the condition to the local health department. HIV is one of the conditions on the list of Nationally Notifiable Infectious Conditions that is required to be reported.

Other considerations:

The nurse should tell the client that treatment for HIV will be during the prenatal and perinatal periods. Treatment with antiretroviral prophylaxis such as zidovudine, triple-drug antiretroviral therapy (ART), or

highly active antiretroviral therapy (HAART) during pregnancy have been reported to decrease the transmission of the virus to the newborn.

A nurse is assessing a client who is postpartum and has idiopathic thrombocytopenia purpura (ITP). Which of the following findings should the nurse expect? - ANSWER-Decreased platelet count

Rationale:

A client who has ITP has an autoimmune response that results in a decreased platelet count.

Other considerations:

- An increased ESR is an indication of chronic renal failure.
- An increased WBC is an indication of infection.

A nurse in the antepartum clinic is assessing a client's adaptation to pregnancy. The client states that they are "happy one minute and crying the next." The nurse should interpret the client's statement as an indication of which of the following? - ANSWER-Emotional lability

Rationale:

The nurse should recognize and interpret the client's statement as an indication of emotional lability. Many clients experience rapid and unpredictable changes in mood during pregnancy. Intense hormonal changes may be responsible for mood changes that occur during pregnancy. Tears and anger alternate with feelings of joy or cheerfulness for little or no reason.

A nurse is assessing the newborn of a client who took a selective serotonin reuptake inhibitor (SSRI) during pregnancy. Which of the following manifestations should the nurse identify as an indication of withdrawal from an SSRI? - ANSWER-Vomiting

Rationale:

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

Manifestations of fetal exposure to SSRIs. include: Low birth weight, Hypoglycemia, Tachypnea.

A nurse is assessing four newborns. Which of the following findings should the nurse report to the provider? - ANSWER-A newborn who is 18 hr old and has an axillary temperature of 37.7° C (99.9° F)

#### Rationale

An axillary temperature greater than 37.5° C (99.5° F) is above the expected reference range of 36.5 - 37.5 ° C for a newborn and can be an indication of sepsis. Therefore, the nurse should report this finding to the provider.

other considerations:

- A newborn should pass the first meconium stool within the first 24 to 48 hr following birth. Failure to pass a meconium stool can indicate a bowel obstruction or congenital disorder.
- Pink-tinged urine is an indication of uric acid crystals and is an expected finding for a newborn during the first week following birth.
- Erythema toxicum is a transient rash that can appear anywhere on a newborn's body during the first 24 to 72 hr following birth and can last up to 3 weeks. This finding requires no treatment.

A nurse is performing a routine assessment on a client who is at 18 weeks of gestation. Which of the following findings should the nurse expect? - ANSWER-FHR 152/min

#### Rationale:

The expected range for the FHR is 110/min to 160/min. The FHR is higher earlier in gestation with an average of approximately 160/min at 20 weeks of gestation.

Other considerations:

- The nurse should expect the client's DTR to be 2+
- From gestational weeks 18 to 32, the height of the fundus is approximately equal to the number of weeks of gestation plus or minus 2 cm. Therefore, the nurse should expect the fundal height for this client to be 16 to 20 cm.
- An elevated blood pressure greater or equal to 140/90, may be an indication of preeclampsia.

A nurse is observing a new guardian caring for their crying newborn who is bottle feeding. Which of the following actions by the guardian should the nurse recognize as a positive parenting behavior? -

ANSWER-Lays the newborn across their lap and gently sways

Rationale:

This is a correct technique for quieting a newborn. This tactile stimulation promotes a sense of security for the newborn.

Other considerations:

- The guardian should place the infant in the supine position, not a prone position, in the bassinet or crib because of the risk of sudden infant death syndrome.
- Rice cereal should not be added to the bottle of a newborn because solids should not be introduced until 4 to 6 months of age.
- Pacifiers may be used for a newborn who needs extra sucking for self-soothing. However, formula should not be placed on the tip of the pacifier because the newborn might become accustomed to it and refuse to take the pacifier in the future without added supplement.

A nurse is caring for a newborn who was transferred to the nursery 30 min after birth because of mild respiratory distress. Which of the following actions should the nurse take first? - ANSWER-Verify the newborn's identification.

Rationale:

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

Other considerations:

- The Apgar score is a physiological assessment that occurs 1 min following birth and again at 5 min. The nurse should confirm the score when the newborn arrives in the nursery.
- The nurse should administer IM vitamin K to the newborn soon after birth to increase clotting factors and prevent bleeding. However, the injection can be delayed until after initial bonding time and the first breastfeeding if necessary.
- The nurse should identify obstetrical risk factors to determine if interventions are required for the newborn.