MULTIPLE CHOICE

1. A nurse educator is teaching a group of nursing students about the history of family-centered maternity care. Which statement should the nurse include in the teaching session?
   a. The Sheppard-Towner Act of 1921 promoted family-centered care.
   b. Changes in pharmacologic management of labor prompted family-centered care.
   c. Demands by physicians for family involvement in childbirth increased the practice of family-centered care.
   d. Parental requests that infants be allowed to remain with them rather than in a nursery initiated the practice of family-centered care.

   ANS: D
   As research began to identify the benefits of early, extended parent–infant contact, parents began to insist that the infant remain with them. This gradually developed into the practice of rooming-in and finally to family-centered maternity care. The Sheppard-Towner Act provided funds for state-managed programs for mothers and children but did not promote family-centered care. The changes in pharmacologic management of labor were not a factor in family-centered maternity care. Family-centered care was a request by parents, not physicians.

   DIF: Cognitive Level: Application OBJ: Nursing Process Step: Planning
   MSC: Patient Needs: Health Promotion and Maintenance

2. Expectant parents ask a prenatal nurse educator, "Which setting for childbirth limits the amount of parent–infant interaction?" Which answer should the nurse provide for these parents in order to assist them in choosing an appropriate birth setting?
   a. Birth center
   b. Home birth
   c. Traditional hospital birth
   d. Labor, birth, and recovery room

   ANS: C
   In the traditional hospital setting, the mother may see the infant for only short feeding periods, and the infant is cared for in a separate nursery. Birth centers are set up to allow an increase in parent–infant contact. Home births allow the greatest amount of parent–infant contact. The labor, birth, recovery, and postpartum room setting allows for increased parent–infant contact.

   DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Planning
   MSC: Patient Needs: Health Promotion and Maintenance

3. Which statement best describes the advantage of a labor, birth, recovery, and postpartum (LDRP) room?
   a. The family is in a familiar environment.
   b. They are less expensive than traditional hospital rooms.
   c. The infant is removed to the nursery to allow the mother to rest.

d. The woman's support system is encouraged to stay until discharge.

ANS: D
Sleeping equipment is provided in a private room. A hospital setting is never a familiar environment to new parents. An LDRP room is not less expensive than a traditional hospital room. The baby remains with the mother at all times and is not removed to the nursery for routine care or testing. The father or other designated members of the mother's support system are encouraged to stay at all times.

DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Assessment
MSC: Patient Needs: Health Promotion and Maintenance

4. Which nursing intervention is an independent function of the professional nurse?
   a. Administering oral analgesics
   b. Requesting diagnostic studies
   c. Teaching the patient perineal care
   d. Providing wound care to a surgical incision

ANS: C
Nurses are now responsible for various independent functions, including teaching, counseling, and intervening in nonmedical problems. Interventions initiated by the physician and carried out by the nurse are called dependent functions. Administrating oral analgesics is a dependent function; it is initiated by a physician and carried out by a nurse. Requesting diagnostic studies is a dependent function. Providing wound care is a dependent function; however, the physician prescribes the type of wound care through direct orders or protocol.

DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Assessment
MSC: Patient Needs: Safe and Effective Care Environment

5. Which response by the nurse is the most therapeutic when the patient states, "I'm so afraid to have a cesarean birth"?
   a. "Everything will be OK."
   b. "Don't worry about it. It will be over soon."
   c. "What concerns you most about a cesarean birth?"
   d. "The physician will be in later and you can talk to him."

ANS: C
The response, "What concerns you most about a cesarean birth" focuses on what the patient is saying and asks for clarification, which is the most therapeutic response. The response, "Everything will be ok" is belittling the patient's feelings. The response, "Don't worry about it. It will be over soon" will indicate that the patient's feelings are not important. The response, "The physician will be in later and you can talk to him" does not allow the patient to verbalize her feelings when she wishes to do that.

DIF: Cognitive Level: Application OBJ: Nursing Process Step: Implementation
MSC: Patient Needs: Psychosocial Integrity

6. In which step of the nursing process does the nurse determine the appropriate interventions for the identified nursing diagnosis?
   a. Planning
   b. Evaluation

c. Assessment
d. Intervention

ANS: A
The third step in the nursing process involves planning care for problems that were identified during assessment. The evaluation phase is determining whether the goals have been met. During the assessment phase, data are collected. The intervention phase is when the plan of care is carried out.

DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Planning
MSC: Patient Needs: Safe and Effective Care Environment

7. Which goal is most appropriate for the collaborative problem of wound infection?
   a. The patient will not exhibit further signs of infection.
   b. Maintain the patient's fluid intake at 1000 mL/8 hour.
   c. The patient will have a temperature of 98.6°F within 2 days.
   d. Monitor the patient to detect therapeutic response to antibiotic therapy.

   ANS: D
   In a collaborative problem, the goal should be nurse-oriented and reflect the nursing interventions of monitoring or observing. Monitoring for complications such as further signs of infection is an independent nursing role. Intake and output is an independent nursing role. Monitoring a patient's temperature is an independent nursing role.

   DIF: Cognitive Level: Application OBJ: Nursing Process Step: Planning
   MSC: Patient Needs: Safe and Effective Care Environment

8. Which nursing intervention is written correctly?
   a. Force fluids as necessary.
   b. Observe interaction with the infant.
   c. Encourage turning, coughing, and deep breathing.
   d. Assist to ambulate for 10 minutes at 8 AM, 2 PM, and 6 PM.

   ANS: D
   Interventions might not be carried out if they are not detailed and specific. "Force fluids" is not specific; it does not state how much or how often. Encouraging the patient to turn, cough, and breathe deeply is not detailed or specific. Observing interaction with the infant does not state how often this procedure should be done. Assisting the patient to ambulate for 10 minutes within a certain timeframe is specific.

   DIF: Cognitive Level: Application OBJ: Nursing Process Step: Planning
   MSC: Patient Needs: Safe and Effective Care Environment

9. The patient makes the statement: "I'm afraid to take the baby home tomorrow." Which response by the nurse would be the most therapeutic?
   a. "You're afraid to take the baby home?"
   b. "Don't you have a mother who can come and help?"
   c. "You should read the literature I gave you before you leave."
   d. "I was scared when I took my first baby home, but everything worked out."

   ANS: A

This response uses reflection to show concern and open communication. The other choices are blocks to communication. Asking if the patient has a mother who can come and assist blocks further communication with the patient. Telling the patient to read the literature before leaving does not allow the patient to express her feelings further. Sharing your own birth experience is inappropriate.

DIF: Cognitive Level: Application OBJ: Nursing Process Step: Implementation
MSC: Patient Needs: Psychosocial Integrity

10. The nurse is writing an expected outcome for the nursing diagnosis—acute pain related to tissue trauma, secondary to vaginal birth, as evidenced by patient stating pain of 8 on a scale of 10. Which expected outcome is correctly stated for this problem?
    a. Patient will state that pain is a 2 on a scale of 10.
    b. Patient will have a reduction in pain after administration of the prescribed analgesic.
    c. Patient will state an absence of pain 1 hour after administration of the prescribed analgesic.
    d. Patient will state that pain is a 2 on a scale of 10, 1 hour after the administration of the prescribed analgesic.

    ANS: D
    The outcome should be patient-centered, measurable, realistic, and attainable and within a specified timeframe. Patient stating that her pain is now 2 on a scale of 10 lacks a timeframe. Patient having a reduction in pain after administration of the prescribed analgesic lacks a measurement. Patient stating an absence of pain 1 hour after the administration of prescribed analgesic is unrealistic.

    DIF: Cognitive Level: Application OBJ: Nursing Process Step: Planning
    MSC: Patient Needs: Physiologic Integrity

11. Which nursing diagnosis should the nurse identify as a priority for a patient in active labor?
    a. Risk for anxiety related to upcoming birth
    b. Risk for imbalanced nutrition related to NPO status
    c. Risk for altered family processes related to new addition to the family
    d. Risk for injury (maternal) related to altered sensations and positional or physical changes

    ANS: D
    The nurse should determine which problem needs immediate attention. Risk for injury is the problem that has the priority at this time because it is a safety problem. Risk for anxiety, imbalanced nutrition, and altered family processes are not the priorities at this time.

    DIF: Cognitive Level: Application OBJ: Nursing Process Step: Implementation
    MSC: Patient Needs: Safe and Effective Care Environment

12. Regarding advanced roles of nursing, which statement related to clinical practice is the most accurate?
    a. Family nurse practitioners (FNPs) can assist with childbirth care in the hospital setting.

b. Clinical nurse specialists (CNSs) provide primary care to obstetric patients.
c. Neonatal nurse practitioners provide emergency care in the postbirth setting to high-risk infants.
d. A certified nurse midwife (CNM) is not considered to be an advanced practice nurse.

ANS: C
Neonatal NPs provide care for the high-risk neonate in the birth room and in the neonatal intensive care unit, as needed. FNPs do not participate in childbirth care; however, they can take care of uncomplicated pregnancies and postbirth care outside of the hospital setting. CNSs work in hospital settings but do not provide primary care services to patients. A CNM is an advanced practice nurse who receives additional certification in the specific area of midwifery.

DIF: Cognitive Level: Application OBJ: Nursing Process Step: Evaluation
MSC: Patient Needs: Management of Care: Legal Rights and Responsibilities

13. Which of the following statements highlights the nurse's role as a researcher?
a. Reading peer-reviewed journal articles
b. Working as a member of the interdisciplinary team to provide patient care
c. Helping patient to obtain home care postdischarge from the hospital
d. Delegating tasks to unlicensed personnel to allow for more teaching time with patients

ANS: A
A nurse in a researcher role should look to improve her or his knowledge base by reading and reviewing evidence-based practice information as found in peer-reviewed journals. Working as a member of the interdisciplinary team to provide patient care indicates that the nurse is working as a collaborator. Helping the patient to obtain home care postdischarge from the hospital indicates that the nurse is working as a patient advocate. Delegating tasks to unlicensed personnel in order to allow for more teaching time with patients indicates that the nurse is working as a manager.

DIF: Cognitive Level: Application OBJ: Nursing Process Step: Assessment
MSC: Patient Needs: Health Promotion: Teaching/Learning

14. The nurse states to the newly pregnant patient, "Tell me how you feel about being pregnant." Which communication technique is the nurse using with this patient?
a. Clarifying
b. Paraphrasing
c. Reflection
d. Structuring

ANS: A
The nurse is attempting to follow up and check the accuracy of the patient's message. Paraphrasing is restating words other than those used by the patient. Reflection is verbalizing comprehension of what the patient has said. Structuring takes place when the nurse has set guidelines or set priorities.

DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Analysis
MSC: Patient Needs: Health Promotion and Maintenance

15. When reviewing a new patient's birth plan, the nurse notices that the patient will be bringing a doula to the hospital during labor. What does the nurse think that this means?
    a. The patient will have her grandmother as a support person.
    b. The patient will bring a paid, trained labor support person with her during labor.
    c. The patient will have a special video she will play during labor to assist with relaxation.
    d. The patient will have a bag that contains all the approved equipment that may help with the labor process.

    ANS: B
    A doula is a trained labor support person who is employed by the mother to provide labor support. She gives physical support such as massage, helps with relaxation, and provides emotional support and advocacy throughout labor. A doula is usually not a relative of the woman. A doula is a trained labor support person.

    DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Assessment
    MSC: Patient Needs: Health Promotion and Maintenance

MULTIPLE RESPONSE

1. In consideration of the historic evolution of maternity care, which treatment options were used over the past century? (*Select all that apply.*)
    a. During the nineteenth century, women of privilege were delivered by midwives in a hospital setting.
    b. Granny midwives received their training through a period of apprenticeship.
    c. The recognition of improved obstetric outcomes was related to increased usage of hygienic practices.
    d. A shift to hospital-based births occurred as a result of medical equipment designed to facilitate birth.
    e. The use of chloroform by midwives led to decreased pain during birth.

    ANS: B, C, D
    Training of granny midwives was done by apprenticeship as opposed to formal medical school training. With the advent of usage of hygienic practices, improved health outcomes were seen with regard to a decrease in sepsis. New equipment such as forceps enabled easier birth. Women of privilege in the nineteenth century delivered at home, attended by a midwife. Chloroform was used by physicians and was not available to midwives.

    DIF: Cognitive Level: Analysis OBJ: Nursing Process Step: Implementation
    MSC: Patient Needs: Health Promotion and Maintenance

2. Many communities now offer the availability of free-standing birth centers to provide care for low-risk women during pregnancy, birth, and postpartum. When counseling the newly pregnant patient regarding this option, the nurse should be aware that this type of care setting includes which advantages? (*Select all that apply.*)
    a. Staffing by lay midwives
    b. Equipped for obstetric emergencies
    c. Less expensive than acute care hospitals
    d. Safe, homelike births in a familiar setting
    e. Access to follow-up care for 6 weeks postpartum

ANS: C, D, E

Patients who are at low risk and desire a safe, homelike birth are very satisfied with this type of care setting. The new mother may return to the birth center for postpartum follow-up care, breastfeeding assistance, and family planning information for 6 weeks postpartum. Because birth centers do not incorporate advanced technologies into their services, costs are significantly less than in a hospital setting. The major disadvantage of this care setting is that these facilities are not equipped to handle obstetric emergencies. Should unforeseen difficulties occur, the patient must be transported by ambulance to the nearest hospital. Birth centers are usually staffed by certified nurse-midwives (CNMs).

DIF: Cognitive Level: Understanding OBJ: Nursing Process Step: Planning
MSC: Patient Needs: Safe and Effective Care Environment

3. The nurse is assessing a patient's use of complementary and alternative therapies. Which should the nurse document as an alternative or complementary therapy practice? (*Select all that apply*.)
   a. Practicing yoga daily
   b. Drinking green tea in the morning
   c. Taking omeprazole (Prilosec) once a day
   d. Using aromatherapy during a relaxing bath
   e. Wearing a lower back brace when lifting heavy objects

   ANS: A, B, D

   Complementary and alternative (CAM) therapies can be defined as those systems, practices, interventions, modalities, professions, therapies, applications, theories, and claims that are currently not an integral part of the conventional medical system in North America. Yoga is considered to be a mind–body alternative therapy. Green tea and aromatherapy are biologically based complementary therapies. Prilosec and the use of a lower back brace would be therapies consistent with those used by conventional medicine.

   DIF: Cognitive Level: Analysis OBJ: Nursing Process Step: Assessment
   MSC: Patient Needs: Health Promotion and Maintenance

4. The nurse is formulating a nursing care plan for a postpartum patient. Which actions by the nurse indicate use of critical thinking skills when formulating the care plan? (*Select all that apply*.)
   a. Using a standardized postpartum care plan
   b. Determining priorities for each diagnosis written
   c. Writing interventions from a nursing diagnosis book
   d. Reflecting and suspending judgment when writing the care plan
   e. Clustering data during the assessment process according to normal versus abnormal

   ANS: B, D, E

   Critical thinking focuses on appraisal of the way the individual thinks, and it emphasizes reflective skepticism. Determining priorities, reflecting and suspending judgment, and clustering data are actions that indicate the use of critical thinking. Using a standardized care plan and writing interventions from a nursing diagnosis book do not show that reflection about the patient's individual care is being done.

   DIF: Cognitive Level: Application OBJ: Nursing Process Step: Planning

MSC: Patient Needs: Physiologic Integrity