Evolve Maternity Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What is the primary cause of phenylketonuria (PKU) in a neonate?

A. Genetic predisposition

B. Inborn error of metabolism

C. Environmental factors

D. Inadequate prenatal care

2. Which blood type is required for a pregnant woman to receive RhoGAM after giving birth?

A. Rh-positive and Coombs negative

B. Rh-negative and Coombs negative

C. Rh-positive and Coombs positive

D. Rh-negative and Coombs positive

3. A primigravida unsure of her last menstrual period is estimated to be at 22 weeks' gestation. What data supports this conclusion?

A. Presence of fetal heart tones

B. Fundus at the umbilicus

C. Measurement of the abdomen

D. Positive pregnancy test

4. What is the primary action of phototherapy for a preterm neonate with physiological jaundice?

A. Increases bilirubin levels

B. Balances electrolytes

C. Breaks down bilirubin into a conjugated form

D. Promotes enzyme activity

5. What is the immediate nursing action for a newborn with an Apgar score of 3 at 1 minute?

A. Monitor temperature

B. Start resuscitation

C. Administer oxygen therapy

D. Provide skin-to-skin contact

6. Which client profile is most concerning for the potential of placenta previa?

A. 25 years old, gravida 2, para 1

B. 30 years old, gravida 6, para 5

C. 28 years old, gravida 4, para 3

D. 32 years old, gravida 1, para 0

7. What sign should the nurse look for to assess potential congenital abnormalities in the newborn during the first examination?

A. Symmetrical features

B. Missing reflexes

C. Abnormal skin markings

D. Translucent skin

8. What behavior indicates a need for further education in breast self-examination?

A. Palpating each breast while lying down

B. Palpating each breast while in the standing position

C. Palpating each breast while in the sitting position

D. Checking for lumps using a visual inspection

9. In addition to chest pain, which of the following should clients be alert to as potential adverse effects of estrogen-progestin contraceptives?

A. Dry eyes

B. Breast soreness

C. Frequent urination

D. Headaches

10. Why does a nurse help a client to void frequently during the first stage of labor?

A. A full bladder may inhibit the progress of labor

B. It is required protocol for all clients

C. To ensure the client remains hydrated

D. A full bladder actually helps with contractions

Answers

1. B
2. B
3. B
4. C
5. B
6. B
7. C
8. C
9. B
10. A

Explanations

1. What is the primary cause of phenylketonuria (PKU) in a neonate?

A. Genetic predisposition

B. Inborn error of metabolism

C. Environmental factors

D. Inadequate prenatal care

Phenylketonuria (PKU) in a neonate is primarily caused by an inborn error of metabolism, specifically a deficiency in the enzyme phenylalanine hydroxylase. This enzyme is necessary for the conversion of phenylalanine, an amino acid found in many protein-containing foods, into tyrosine. When this conversion is impaired due to the enzyme deficiency, phenylalanine accumulates to toxic levels in the body, which can lead to serious neurological damage if not identified and managed early. Since PKU is a genetic condition, the inborn error directly ties back to the genetic mutations affecting the production or function of the phenylalanine hydroxylase enzyme. Although genetic predisposition plays a role, it is the metabolic error that defines the condition and leads to the clinical manifestations observed in neonates diagnosed with PKU. The other options, while relevant to healthcare and development, do not directly cause PKU: environmental factors and inadequate prenatal care do not stem from the metabolic dysfunction that characterizes PKU, and while genetic predisposition is related, it is the metabolic error that is the defining characteristic of the disorder.

2. Which blood type is required for a pregnant woman to receive RhoGAM after giving birth?

A. Rh-positive and Coombs negative

B. Rh-negative and Coombs negative

C. Rh-positive and Coombs positive

D. Rh-negative and Coombs positive

RhoGAM is an injection of Rh immunoglobulin given to Rh-negative mothers after they give birth to an Rh-positive baby. The purpose of administering RhoGAM is to prevent the mother from developing antibodies against Rh-positive blood cells, which could affect future pregnancies. For a woman to receive RhoGAM, she must be Rh-negative and Coombs negative. Being Rh-negative indicates that the mother does not have the Rh factor protein on her red blood cells. A Coombs negative result indicates that she has not already developed antibodies against Rh-positive blood. If the mother were Rh-positive, she would not need RhoGAM as her body would not react against Rh-positive blood. Similarly, if she were Coombs positive, it would indicate that she has already formed antibodies, and RhoGAM would not be effective in preventing any potential complications in future pregnancies. Therefore, the correct context for administering RhoGAM is specifically when the mother is Rh-negative and Coombs negative.

3. A primigravida unsure of her last menstrual period is estimated to be at 22 weeks' gestation. What data supports this conclusion?

A. Presence of fetal heart tones

B. Fundus at the umbilicus

C. Measurement of the abdomen

D. Positive pregnancy test

The fundal height measurement is a reliable indicator of gestational age, especially when the uterus grows and ascends in the abdomen. At approximately 20 weeks of gestation, the fundus is typically at the level of the umbilicus. Therefore, if the fundus is at the umbilicus, this supports the estimation that the pregnancy is around 22 weeks along, as it indicates that fetal development is consistent with that timeframe. While the presence of fetal heart tones is a positive sign of pregnancy and fetal well-being, it does not provide a specific measurement correlating to gestational age. Similarly, abdominal measurements can provide some information, but they are less standardized and can vary significantly among individuals. A positive pregnancy test is also a sign of pregnancy but does not indicate the gestational age. Thus, the fundal height at the umbilicus is the most direct piece of evidence for estimating gestational age in this scenario.

4. What is the primary action of phototherapy for a preterm neonate with physiological jaundice?

A. Increases bilirubin levels

B. Balances electrolytes

C. Breaks down bilirubin into a conjugated form

D. Promotes enzyme activity

Phototherapy is a common treatment for preterm neonates experiencing physiological jaundice, and its primary action is to break down bilirubin into a conjugated form. In newborns, particularly preterm infants, jaundice occurs when there's an accumulation of bilirubin in the blood due to the immature liver's inability to process it effectively. The un conjugated bilirubin is the form that can be harmful at high levels. The light used in phototherapy, particularly blue light, penetrates the skin and causes the bilirubin molecules to undergo a transformation. This photochemical reaction converts un conjugated (indirect) bilirubin into a water-soluble form, which is conjugated bilirubin. This conjugated form can then be excreted more easily through urine and bile. Thus, this conversion is crucial as it helps to prevent the potential complications associated with high levels of un conjugated bilirubin, such as kernicterus, which is a type of brain damage. The other options do not accurately reflect the main purpose of phototherapy. For example, phototherapy does not increase bilirubin levels, nor is it primarily focused on balancing electrolytes or promoting general enzyme activity. The key mechanism is the transformation of bilirubin, making option C the

5. What is the immediate nursing action for a newborn with an Apgar score of 3 at 1 minute?

A. Monitor temperature

B. Start resuscitation

C. Administer oxygen therapy

D. Provide skin-to-skin contact

When a newborn has an Apgar score of 3 at 1 minute, it indicates that the baby is in a state of significant distress and requires immediate medical intervention. An Apgar score assesses five criteria: heart rate, respiratory effort, muscle tone, reflex response, and color. A score of 3 is classified as low, suggesting critical conditions, such as poor respiratory effort and possibly poor heart rate or muscle tone. In this context, the most immediate nursing action is to start resuscitation. This could involve providing positive pressure ventilation, chest compressions, and administering medications as necessary. Rapid resuscitation is vital to improve the newborn's respiratory and circulatory status and to prevent potential long-term complications or death. While monitoring temperature, administering oxygen therapy, and providing skin-to-skin contact are important aspects of neonatal care, they are not the priority actions when a newborn exhibits such a low Apgar score. Immediate resuscitation is the most crucial step needed to stabilize the infant before any other care can be effectively implemented.

6. Which client profile is most concerning for the potential of placenta previa?

A. 25 years old, gravida 2, para 1

B. 30 years old, gravida 6, para 5

C. 28 years old, gravida 4, para 3

D. 32 years old, gravida 1, para 0

The client profile that raises the most concern for the potential of placenta previa is one who is 30 years old, gravida 6, and para 5. Several factors contribute to this increased risk. Firstly, a higher number of previous pregnancies (gravida) and live births (para) correlates with a greater likelihood of experiencing placental abnormalities, including placenta previa. This is particularly true because with each pregnancy, the uterus undergoes changes that can affect the implantation of the placenta in subsequent pregnancies, making it more likely for the placenta to attach unusually low in the uterus. Secondly, the age of the client also plays a role; while advanced maternal age is a consideration, in combination with multiple previous pregnancies, the likelihood of placenta previa can further increase. This profile indicates a significant reproductive history, which is a risk factor for placenta previa due to the likelihood of uterine scarring or abnormalities resulting from prior pregnancies. Understanding these elements helps in recognizing why this specific client profile is most concerning regarding the potential for placenta previa. In contrast, profiles with fewer pregnancies and births are generally associated with lower risk for this condition.

7. What sign should the nurse look for to assess potential congenital abnormalities in the newborn during the first examination?

A. Symmetrical features

B. Missing reflexes

C. Abnormal skin markings

D. Translucent skin

Assessing potential congenital abnormalities in a newborn during the first examination involves looking for various physical signs that may indicate underlying issues. Abnormal skin markings can be significant indicators of congenital abnormalities. Conditions such as cutaneous lesions, vascular markings, or pigmented lesions may suggest chromosomal abnormalities or syndromes. For instance, certain skin markings, like café-au-lait spots, may be associated with neurofibromatosis, while congenital dermal melanocytosis can indicate conditions like spina bifida. While symmetrical features are generally a sign of normal development and can indicate overall health, they do not specifically indicate abnormalities. Similarly, missing reflexes may suggest neurological issues but are not as directly associated with congenital structural defects. Translucent skin typically relates to prematurity rather than congenital abnormalities and does not provide a clear indication of structural malformations that can be assessed during the initial examination. Hence, looking for abnormal skin markings is crucial in evaluating the possibility of congenital conditions in newborns.

8. What behavior indicates a need for further education in breast self-examination?

A. Palpating each breast while lying down

B. Palpating each breast while in the standing position

C. Palpating each breast while in the sitting position

D. Checking for lumps using a visual inspection

The behavior that suggests a need for further education in breast self-examination involves palpating each breast while in a sitting position. It is generally recommended to perform breast self-examination while lying down, as this position allows for more effective palpation of breast tissue. Lying down distributes the breast tissue more evenly across the chest wall, making it easier to detect any abnormalities, such as lumps. While some women may feel comfortable checking their breasts while standing or sitting, these positions can limit the thoroughness of the examination. The most effective way to ensure complete coverage of the breast area is to lie down. Therefore, the choice that indicates a potential gap in knowledge about breast self-examination techniques is palpating while sitting, as this approach could lead to missed abnormal findings. In contrast, the other behaviors mentioned, such as palpating while lying down or standing, align with accepted practices for breast self-examination, and using visual inspection can complement the palpation process to enhance awareness of breast changes.

9. In addition to chest pain, which of the following should clients be alert to as potential adverse effects of estrogen-progestin contraceptives?

A. Dry eyes

B. Breast soreness

C. Frequent urination

D. Headaches

Breast soreness is an important potential adverse effect associated with estrogen-progestin contraceptives. This is due to the hormonal changes that these contraceptives induce in the body, which can lead to changes in breast tissue and sensitivity. Hormonal fluctuations can result in symptoms like breast tenderness or soreness, making it a key concern for clients using these contraceptives. Clients should be informed about this effect, as it can impact their comfort and willingness to continue using the method. Monitoring for breast soreness along with any other symptoms such as chest pain can help ensure the safe use of these contraceptives and prompt clients to consult their healthcare provider if they experience significant discomfort. While other symptoms might also occur with the use of hormonal contraceptives, breast soreness is particularly notable and directly linked to the hormonal influence of estrogen and progestin. Managing and understanding these side effects is crucial for clients to make informed decisions regarding their contraceptive options.

10. Why does a nurse help a client to void frequently during the first stage of labor?

A. A full bladder may inhibit the progress of labor

B. It is required protocol for all clients

C. To ensure the client remains hydrated

D. A full bladder actually helps with contractions

Helping a client to void frequently during the first stage of labor is crucial because a full bladder can obstruct the descent of the fetal head and inhibit the progress of labor. When the bladder is distended, it can take up space in the pelvis, thereby reducing the area available for the baby's head to move down the birth canal. Additionally, a full bladder may also cause discomfort and can lead to ineffective contractions. It is important for nurses to assess the client's bladder status and encourage voiding regularly to minimize these complications. This proactive approach helps ensure that labor can progress smoothly, maintaining both the mother's and baby's well-being throughout the process. Other choices involve aspects that aren't necessarily relevant or accurate regarding labor management. Protocols may guide general behaviors but do not specifically necessitate frequent voiding as a routine indiscriminately applied to all clients. Keeping the client hydrated is vital for overall health, yet it does not directly relate to the need for frequent voiding during labor. Lastly, a full bladder does not assist with contractions; rather, it generally has the opposite effect by creating additional physical constraints.