

HESI Obstetrics and Maternity Assignment Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. A multiparous client who delivered an 8-lb 7-oz infant 4 hours ago has a completely saturated perineal pad within 15 minutes. What action should the nurse implement next?**
 - A. Perform fundal massage.**
 - B. Assess blood pressure.**
 - C. Notify the healthcare provider.**
 - D. Encourage the client to void.**

- 2. A client in the first stage of active labor is using a shallow pattern of rapid breaths that is twice the normal adult breathing rate. The client complains of feeling light-headed, dizzy, and states that her fingers are tingling. What action should the nurse implement?**
 - A. Notify the healthcare provider.**
 - B. Help her breathe into a paper bag.**
 - C. Administer oxygen via nasal cannula.**
 - D. Tell the client to slow her breathing.**

- 3. Which nursing action should be included in the plan of care for a newborn experiencing symptoms of drug withdrawal?**
 - A. Swaddle the infant snugly and hold tightly**
 - B. Play soft music and talk to soothe the infant**
 - C. Administer chloral hydrate for sedation**
 - D. Feed every 4 to 6 hours to allow extra rest**

- 4. Why is it important to keep a newborn warm in the immediate period after birth?**
 - A. The kidneys and renal function are not fully developed.**
 - B. Warmth promotes sleep so the infant will grow quickly.**
 - C. A large body surface area favors heat loss to the environment.**
 - D. The thick layer of subcutaneous fat is inadequate for insulation.**

5. A client delivers her first infant and asks the nurse if her skin changes from pregnancy are permanent. Which change should the nurse tell the client will remain after pregnancy?
- A. Pruritus.
 - B. Chloasma.
 - C. Vascular spiders.
 - D. Striae gravidarum.
6. Which gastrointestinal finding at 28 weeks gestation should alert the nurse to a potential concern?
- A. Pica
 - B. Pyrosis
 - C. Ptyalism
 - D. Decreased peristalsis
7. A client comes in to the clinic for her six week postpartum check up and complains that her left breast is erythematous and painful. The client asks, "Can I still breastfeed my baby?" What is the best response for the nurse to provide?
- A. Advise to stop breastfeeding until the infection clears.
 - B. Inform the client to continue breastfeeding.
 - C. Begin all feedings with the infected breast.
 - D. Tell the client to pump then discard the milk from the affected breast.
8. A client who is breastfeeding develops engorged breasts on the third postpartum day. Which action should the nurse recommend to relieve breast engorgement?
- A. Avoid pumping her breasts
 - B. Continue breastfeeding every 2 hours
 - C. Skip a feeding to rest the breasts
 - D. Decrease fluid intake for at least 24 hours

- 9. While inspecting a newborn's head, the nurse identifies a swelling of the scalp that does not cross the suture line. Which finding should the nurse document?**
- A. Molding.**
 - B. Cephalohematoma.**
 - C. Caput succedaneum.**
 - D. Bulging fontanel.**
- 10. During labor, which action is most appropriate when the umbilical cord is seen protruding from the vagina and the membranes have ruptured?**
- A. Administer 100% oxygen.**
 - B. Place the patient in Trendelenburg position.**
 - C. Place the patient in a knee-chest position.**
 - D. Call for emergency cesarean delivery immediately.**

Answers

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

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Explanations

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1. A multiparous client who delivered an 8-lb 7-oz infant 4 hours ago has a completely saturated perineal pad within 15 minutes. What action should the nurse implement next?

- A. Perform fundal massage.**
- B. Assess blood pressure.**
- C. Notify the healthcare provider.**
- D. Encourage the client to void.**

A saturated pad within minutes after delivery points to postpartum hemorrhage from uterine atony, where the uterus isn't contracting well enough to close off the placental vessels. The immediate action is fundal massage because massaging the fundus stimulates the myometrium to contract, which helps firm the uterus and compress the bleeding vessels. As you massage, you're checking and improving tone, guiding the uterus to a firm, midline position, which often slows or stops the hemorrhage. After achieving a firm uterus, continue to monitor bleeding and vital signs, and reassess the uterus frequently. If bleeding persists despite a firm uterus, escalate per protocol by notifying the provider and initiating additional hemorrhage-control measures. It's also important to ensure the bladder isn't distended, since a full bladder can impede contraction, but it doesn't replace the need for fundal massage in this urgent situation.

2. A client in the first stage of active labor is using a shallow pattern of rapid breaths that is twice the normal adult breathing rate. The client complains of feeling light-headed, dizzy, and states that her fingers are tingling. What action should the nurse implement?

- A. Notify the healthcare provider.**
- B. Help her breathe into a paper bag.**
- C. Administer oxygen via nasal cannula.**
- D. Tell the client to slow her breathing.**

Hyperventilation during labor lowers carbon dioxide in the blood, causing respiratory alkalosis. The light-headedness, dizziness, and tingling in the fingers are classic signs from cerebral vasoconstriction and decreased ionized calcium. The quickest way to correct this is to increase the amount of CO₂ the client rebreathes. Breathing into a paper bag (or cupped hands) reintroduces expired air, raises PaCO₂, and reverses the symptoms by restoring the acid-base balance. While instructing the patient to slow her breathing can help, it may not rapidly address the underlying CO₂ deficit as effectively as rebreathing expired air. Administering oxygen is not indicated here because the problem isn't lack of oxygen but excessive CO₂ loss. Notifying the provider isn't the immediate action when the patient's symptoms are clearly due to hyperventilation and can be reversed with this technique.

3. Which nursing action should be included in the plan of care for a newborn experiencing symptoms of drug withdrawal?

- A. Swaddle the infant snugly and hold tightly**
- B. Play soft music and talk to soothe the infant**
- C. Administer chloral hydrate for sedation**
- D. Feed every 4 to 6 hours to allow extra rest**

Calming containment and close physical contact are foundational for a newborn experiencing withdrawal. Swaddling the infant snugly and holding the baby tightly provides a womb-like feel, reduces the startle reflex, and gives proprioceptive input that helps regulate the nervous system. This soothing, close contact supports more stable breathing, temperature control, and sleep, which in turn can decrease the infant's irritability and energy expenditure. In NAS, nonpharmacologic soothing is prioritized because it directly addresses the dysregulated autonomic state and high arousal these babies often exhibit. Keeping environmental stimuli low—quiet, dim lights, minimal handling, and clustered care—further helps the infant settle. While gentle comforting methods like soft talking or music can be soothing, they don't replace the primary benefit of containment and close contact. Pharmacologic sedation is not appropriate as a routine plan of care for drug withdrawal in a newborn, as it can mask symptoms and carry risks; treatment is guided by the severity of withdrawal and typically managed with medications only when indicated by clinical assessment. Feeding should be guided by the infant's hunger cues and coordination of suck-swallow-breathe, with smaller, more frequent feeds as needed rather than rigidly spaced intervals.

4. Why is it important to keep a newborn warm in the immediate period after birth?

- A. The kidneys and renal function are not fully developed.**
- B. Warmth promotes sleep so the infant will grow quickly.**
- C. A large body surface area favors heat loss to the environment.**
- D. The thick layer of subcutaneous fat is inadequate for insulation.**

Newborns must stay warm because their bodies lose heat rapidly after birth. They have a high surface-area-to-body-mass ratio, their skin is thin, and they have little insulating fat and limited ability to generate heat through shivering. This combination means heat can escape quickly through evaporation, convection, conduction, and radiation, so keeping them warm minimizes this heat loss and helps preserve energy for breathing and growth. If a baby becomes too cold, the body increases metabolic work to generate warmth, which can lead to hypoglycemia, breathing difficulties, and acidosis. The idea that warmth is crucial because a large body surface area makes heat loss more likely explains why preventing cold stress is a top priority.

5. A client delivers her first infant and asks the nurse if her skin changes from pregnancy are permanent. Which change should the nurse tell the client will remain after pregnancy?

A. Pruritus.

B. Chloasma.

C. Vascular spiders.

D. Striae gravidarum.

Most pregnancy skin changes fade after birth, but stretch marks from rapid skin stretching tend to remain. Striae gravidarum occur when the skin's elastic fibers and collagen are torn as the abdomen and breasts expand quickly. They usually transition from reddish or purplish streaks to pale, silvery lines, but don't disappear completely for many people. The other changes are typically temporary. Pruritus during pregnancy often resolves after delivery as hormone levels normalize. Chloasma (the mask of pregnancy) generally fades once estrogen levels drop postpartum. Vascular spiders are caused by increased blood flow and estrogen and usually diminish after birth as circulation and hormone levels return to pre-pregnancy state. So the one change you'd expect to persist is the stretch marks.

6. Which gastrointestinal finding at 28 weeks gestation should alert the nurse to a potential concern?

A. Pica

B. Pyrosis

C. Ptyalism

D. Decreased peristalsis

Cravings for nonnutritive substances during pregnancy signal a potential iron deficiency anemia, which becomes more likely as iron needs rise with ongoing fetal growth and placental development around the second and third trimesters. Noting pica at 28 weeks should prompt assessment of iron status (checking hemoglobin, hematocrit, ferritin), review of dietary intake, and consideration of iron supplementation if needed. Pica can also lead to GI complications from ingesting nonfood items and may reflect underlying nutritional deficiency that requires treatment. In contrast, heartburn and excessive saliva are common physiological changes in pregnancy due to hormonal effects on the GI tract, and decreased peristalsis is another typical adaptation; these do not alone indicate a new concern in the same way as pica does.

7. A client comes in to the clinic for her six week postpartum check up and complains that her left breast is erythematous and painful. The client asks, "Can I still breastfeed my baby?" What is the best response for the nurse to provide?
- A. Advise to stop breastfeeding until the infection clears.
 - B. Inform the client to continue breastfeeding.**
 - C. Begin all feedings with the infected breast.
 - D. Tell the client to pump then discard the milk from the affected breast.

Breast infections during lactation do not require stopping breastfeeding. Continuing to breastfeed helps drain the affected breast, which reduces milk stasis and speeds healing. The infant's milk remains safe and is not a vehicle for spreading the infection to the baby. The nurse should reassure the patient to keep nursing on demand, ensuring the infected breast is emptied regularly. Supportive care like warm compresses, gentle massage, and safe analgesics can help with pain, and most antibiotics used for mastitis are compatible with breastfeeding if treatment becomes necessary. Seek care if fever develops, redness or swelling spreads, or symptoms persist beyond 24 to 48 hours.

8. A client who is breastfeeding develops engorged breasts on the third postpartum day. Which action should the nurse recommend to relieve breast engorgement?
- A. Avoid pumping her breasts
 - B. Continue breastfeeding every 2 hours**
 - C. Skip a feeding to rest the breasts
 - D. Decrease fluid intake for at least 24 hours

Engorgement happens when milk production outpaces the infant's ability to empty the breasts, causing fullness, tenderness, and swelling. The most effective way to relieve this is to ensure regular, thorough emptying of the breasts through breastfeeding. Nursing every two hours keeps milk flowing, reduces pressure in the ducts, and helps restore comfort and milk supply. Proper latch and effective emptying are key, so encourage the baby to latch well and feed long enough to empty each breast. If the baby isn't draining the breast adequately, gentle milk expression before or after feeds can help soften the tissue and improve milk removal, but the aim is still frequent breastfeeding rather than skipping feeds. Hydration is important, but decreasing fluid intake won't relieve engorgement and can be counterproductive. Warmth before feeds can promote letdown, and cool or ice packs after feeds can reduce swelling.

9. While inspecting a newborn's head, the nurse identifies a swelling of the scalp that does not cross the suture line. Which finding should the nurse document?

- A. Molding.
- B. Cephalohematoma.**
- C. Caput succedaneum.
- D. Bulging fontanel.

A swelling that stays within the boundaries of the skull sutures points to a subperiosteal bleed, because the periosteum sticks to the bone and the sutures act as barriers. This is cephalohematoma. It forms after birth when blood collects beneath the periosteum of a skull bone and is confined by the sutures, so it does not cross them. In contrast, caput succedaneum is diffuse scalp edema from pressure in labor and can extend across sutures, usually resolving in a few days. Molding is temporary shaping of the head from vaginal birth, and a bulging fontanel signals raised intracranial pressure or crying, not a localized scalp swelling.

10. During labor, which action is most appropriate when the umbilical cord is seen protruding from the vagina and the membranes have ruptured?

- A. Administer 100% oxygen.
- B. Place the patient in Trendelenburg position.
- C. Place the patient in a knee-chest position.**
- D. Call for emergency cesarean delivery immediately.

Relieving cord compression is the immediate priority when a prolapsed umbilical cord is seen after the membranes rupture. The knee-chest position uses gravity to shift the uterus and presenting part away from the cord, reducing pressure on the cord and helping to preserve fetal oxygenation while delivery is arranged. This quick maneuver directly addresses the cause of potential fetal hypoxia and buys time for definitive delivery, typically by emergency cesarean. If feasible, one can gently elevate the presenting part with a sterile gloved hand to further relieve pressure, without pushing the cord back. Oxygen might be used as a supportive measure, but it doesn't resolve the compression and isn't the primary action.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://hesiobstetricsmaternityassignment.examzify.com>

We wish you the very best on your exam journey. You've got this!

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