

Saunders Postpartum Practice Test (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. After administering oxytocin following the delivery of the placenta, what effective response should the nurse monitor for?**
 - A. Increased urinary output**
 - B. Uterine contractions**
 - C. Reduction in bleeding**
 - D. Stable blood pressure**

- 2. Which signs and symptoms would lead a nurse to suspect that a client has a pulmonary embolism?**
 - A. Chest pain and cough**
 - B. Dyspnea, tachypnea, and tachycardia**
 - C. Fever and chills**
 - D. Abdominal pain and nausea**

- 3. What should a nurse do first if the fundus is found above the umbilicus and displaced to the right during a postpartum assessment?**
 - A. Reassess the fundus immediately**
 - B. Assist the client to the bathroom to void**
 - C. Notify the physician of the findings**
 - D. Apply fundal pressure**

- 4. What factor could indicate an increased risk for postpartum hemorrhage?**
 - A. Multiple pregnancies**
 - B. Single infant delivery**
 - C. Short labor duration**
 - D. Prolonged breastfeeding**

- 5. Which findings indicate that placental detachment has occurred after delivery?**
 - A. Lengthening of the umbilical cord**
 - B. Sudden gush of dark blood from the vagina**
 - C. Appearance of fetal membranes at the introitus**
 - D. All of the above**

- 6. Where should the nurse expect the height of the uterine fundus to be located after delivery?**
- A. Below the pubic symphysis.**
 - B. At the level of the umbilicus.**
 - C. Above the umbilicus.**
 - D. Midway between the umbilicus and the xyphoid process.**
- 7. How often should the nurse check the fundus and lochia during the immediate postpartum period?**
- A. Every hour**
 - B. Every four hours**
 - C. Once a shift**
 - D. Only when the mother complains**
- 8. If a pregnant client tests positive for hepatitis B virus, what should the nurse inform her regarding breastfeeding?**
- A. Breastfeeding is not allowed at all**
 - B. Breastfeeding should be postponed for one month**
 - C. Breastfeeding is allowed once the baby has been vaccinated**
 - D. Breastfeeding should be avoided for the first 24 hours**
- 9. What is a potential risk factor for postpartum mood disorders?**
- A. Supportive partner**
 - B. Traumatic birth experience**
 - C. Good nutrition**
 - D. Higher income**
- 10. What is a typical sign of effective breastfeeding the nurse should look for in a new mother?**
- A. Frequent vomiting**
 - B. Redness of the breast**
 - C. Contraction of the uterus**
 - D. Child's audible swallowing**

Answers

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

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Explanations

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1. After administering oxytocin following the delivery of the placenta, what effective response should the nurse monitor for?

- A. Increased urinary output**
- B. Uterine contractions**
- C. Reduction in bleeding**
- D. Stable blood pressure**

Monitoring for uterine contractions after administering oxytocin is crucial because this medication is primarily used to stimulate uterine contractions and facilitate uterine involution. The action of oxytocin helps to prevent postpartum hemorrhage by promoting the contraction of the uterine muscles, which compresses the blood vessels that supply the uterus, thereby reducing the risk of excessive bleeding. Assessing the presence and strength of these contractions is a key nursing responsibility after administration, as effective contractions indicate that the medication is working as intended. Increased urinary output, reduction in bleeding, and stable blood pressure may be relevant considerations in a postpartum assessment, but they are not direct indicators of oxytocin's immediate pharmacological effect. Uterine contractions serve as the most direct response to monitor after the administration of oxytocin, aligning with the drug's purpose in managing the postpartum period effectively.

2. Which signs and symptoms would lead a nurse to suspect that a client has a pulmonary embolism?

- A. Chest pain and cough**
- B. Dyspnea, tachypnea, and tachycardia**
- C. Fever and chills**
- D. Abdominal pain and nausea**

When suspecting a pulmonary embolism, specific signs and symptoms are indicative of the condition due to the way that blood clots affect the lungs and overall respiratory function. The presence of dyspnea (shortness of breath), tachypnea (rapid breathing), and tachycardia (increased heart rate) are hallmark signs. Dyspnea arises because a pulmonary embolism can obstruct blood flow to the areas of the lung, leading to inadequate oxygenation of the blood. As a result, individuals may struggle to breathe normally, prompting a feeling of breathlessness. Tachypnea occurs as the body attempts to compensate for inadequate oxygenation by increasing the respiratory rate. Tachycardia, on the other hand, often occurs in response to low oxygen levels or as part of the body's stress response to the sudden event of a pulmonary embolism. Hence, the combination of these symptoms creates a clinical picture that strongly suggests a pulmonary embolism. Other signs, such as chest pain and cough, can be associated with a range of conditions, and while they may occur alongside a pulmonary embolism, they are not specific enough to raise the suspicion without the accompanying respiratory distress signs. Similarly, fever and chills may indicate an infection, and abdominal pain with

3. What should a nurse do first if the fundus is found above the umbilicus and displaced to the right during a postpartum assessment?

- A. Reassess the fundus immediately**
- B. Assist the client to the bathroom to void**
- C. Notify the physician of the findings**
- D. Apply fundal pressure**

After the birth of a child, the assessment of the fundus is a critical component of postpartum care. If the uterus is found above the umbilicus and is displaced to the right, it is often indicative of bladder distention, which can prevent proper uterine contraction and increase the risk of complications such as uterine atony and hemorrhage. Assisting the client to the bathroom to void is the most appropriate initial action in this scenario. By emptying the bladder, the nurse allows for the uterus to return to its proper position as the bladder being full can push the fundus upwards and to the side. Once the bladder is emptied, it is likely that the fundus will be assessed as midline and at the appropriate height. This action directly addresses the underlying issue contributing to the abnormal fundal position. Following this, the nurse can reassess the fundus to confirm repositioning and firmness. Notifying the physician or applying pressure to the fundus would not address the immediate cause of the displacement and could lead to delays in managing the patient effectively.

4. What factor could indicate an increased risk for postpartum hemorrhage?

- A. Multiple pregnancies**
- B. Single infant delivery**
- C. Short labor duration**
- D. Prolonged breastfeeding**

Multiple pregnancies, such as twins or triplets, can significantly increase the risk for postpartum hemorrhage. This is attributed to several factors associated with carrying multiple fetuses. The uterus is not only larger but also experiences more distension, which can lead to difficulties in contraction after delivery. Effective uterine contractions are essential to clamp down on blood vessels following the separation of the placenta. If the uterus does not contract effectively, there is an increased risk of hemorrhage. In contrast, a single infant delivery typically presents a lower risk of postpartum hemorrhage, as the uterus is better able to contract effectively. Similarly, a short labor duration generally means the body has not been under prolonged stress, which can also positively impact the risk for hemorrhage. Prolonged breastfeeding, while associated with numerous benefits, does not relate directly to increasing the risk of hemorrhage post-delivery. Thus, multiple pregnancies stand out as a significant factor contributing to this risk.

5. Which findings indicate that placental detachment has occurred after delivery?

- A. Lengthening of the umbilical cord**
- B. Sudden gush of dark blood from the vagina**
- C. Appearance of fetal membranes at the introitus**
- D. All of the above**

The correct answer indicates that all the provided findings can signify placental detachment after delivery. Lengthening of the umbilical cord occurs as the placenta separates from the uterine wall; as the cord pulls away from the placenta, it appears longer because the placenta begins to descend into the vagina. This observation is one of the initial signs that the placenta is moving away from the uterus. The sudden gush of dark blood from the vagina is another classic indicator of placental detachment. This blood typically appears as the placenta separates from the uterine wall and is no longer contained within the uterus, allowing the blood to exit the body. The dark color indicates that it is older blood, which can be a result of the detachment process. Lastly, the appearance of fetal membranes at the introitus is a definitive sign that the placenta has detached. As the membranes descend into the birth canal, they signal that the placenta is ready to be expelled. Considering all these criteria, it's evident that each finding contributes to the overall understanding that placental detachment has occurred. Thus, the inclusion of all the findings as indicators supports the conclusion that they collectively signal this critical step in the postpartum process.

6. Where should the nurse expect the height of the uterine fundus to be located after delivery?

- A. Below the pubic symphysis.**
- B. At the level of the umbilicus.**
- C. Above the umbilicus.**
- D. Midway between the umbilicus and the xyphoid process.**

After delivery, the expected location of the uterine fundus is typically at the level of the umbilicus. This occurs approximately 24 hours postpartum when the uterus begins to contract and descend into the pelvis following the expulsion of the placenta. The position at the umbilicus is significant because it indicates that the uterus is effectively responding to the involution process. Involution is the process where the uterus returns to its pre-pregnancy size and position. By the end of the first day postpartum, it is common for the fundus to be palpable at the umbilicus, indicating that the uterus is shrinking appropriately. If the fundus is above the umbilicus, it may suggest that the uterus is not contracting effectively or that there may be retained placental tissue. Conversely, if the fundus is below the pubic symphysis, it would be concerning as it could indicate uterine atony or a delay in uterine involution. Being mindful of these positions can help nurses assess the mother's recovery and intervene if there are deviations from expected norms.

7. How often should the nurse check the fundus and lochia during the immediate postpartum period?

- A. Every hour**
- B. Every four hours**
- C. Once a shift**
- D. Only when the mother complains**

In the immediate postpartum period, it is crucial for the nurse to monitor the fundus and lochia every hour. This frequent assessment is essential for identifying any complications early, such as uterine atony (failure of the uterus to contract effectively) or excessive bleeding. The condition and firmness of the fundus provide important information about the mother's recovery and the status of her involution. Lochia assessment is equally important, as changes in color, consistency, and quantity can indicate potential complications, including hemorrhage or retained placental fragments. By checking these vital signs every hour, healthcare providers can ensure prompt intervention if abnormalities arise, thereby promoting maternal safety and recovery. The immediate postpartum period is a critical time when close monitoring can positively impact outcomes.

8. If a pregnant client tests positive for hepatitis B virus, what should the nurse inform her regarding breastfeeding?

- A. Breastfeeding is not allowed at all**
- B. Breastfeeding should be postponed for one month**
- C. Breastfeeding is allowed once the baby has been vaccinated**
- D. Breastfeeding should be avoided for the first 24 hours**

When a pregnant client tests positive for the hepatitis B virus, it is important for her to know that breastfeeding is not contraindicated. In fact, breastfeeding is allowed and encouraged after the baby has received the hepatitis B vaccine and the hepatitis B immune globulin (HBIG) within the appropriate timeframe after birth. These interventions significantly reduce the risk of the newborn contracting the virus through breastfeeding. The rationale behind this guidance is based on the understanding that the benefit of breastfeeding—providing essential nutrients and antibodies to the infant—outweighs the risks associated with the hepatitis B virus when proper preventive measures are in place. Additionally, the virus is not transmitted through breast milk but rather through blood and certain bodily fluids. Other choices do not align with the best practices informed by current public health guidelines regarding hepatitis B and breastfeeding, as they either completely restrict breastfeeding or suggest unnecessary delays that could deprive the infant of its benefits.

9. What is a potential risk factor for postpartum mood disorders?

- A. Supportive partner**
- B. Traumatic birth experience**
- C. Good nutrition**
- D. Higher income**

A traumatic birth experience is a significant risk factor for postpartum mood disorders due to the emotional and psychological impact such an event can have on a new mother. Experiencing complications during delivery, feeling a lack of control, or facing unexpected outcomes can lead to feelings of anxiety and distress that persist after childbirth. This heightened stress response can contribute to the development of conditions such as postpartum depression or anxiety. Other factors, such as having a supportive partner, good nutrition, or a higher income, typically serve as protective factors that can help mitigate the risk of developing mood disorders. In contrast, a traumatic birth represents a negative experience which can disrupt a woman's emotional well-being during the vulnerable postpartum period. Recognizing the implications of such experiences is crucial for healthcare providers in order to offer appropriate support and interventions for those at risk.

10. What is a typical sign of effective breastfeeding the nurse should look for in a new mother?

- A. Frequent vomiting**
- B. Redness of the breast**
- C. Contraction of the uterus**
- D. Child's audible swallowing**

A typical sign of effective breastfeeding that the nurse should look for in a new mother is the child's audible swallowing. This indicates that the baby is latching properly and transferring milk effectively. When the baby swallows, it demonstrates that milk is being delivered from the mother's breast, which is essential for the baby's nutrition and hydration. In addition to audible swallowing, other signs of effective breastfeeding include the baby appearing satisfied after feedings, the mother's breasts feeling softer post-feeding, and the presence of regular wet and dirty diapers, reflecting sufficient intake. It's crucial for healthcare providers to monitor these indicators to ensure both the mother and the baby are successfully establishing breastfeeding. Frequent vomiting, redness of the breast, and contraction of the uterus do not indicate effective breastfeeding. Vomiting may indicate an issue with feeding or intolerance, redness of the breast may suggest mastitis or an infection, and uterine contractions are a normal postpartum phenomenon but not directly related to successful breastfeeding.

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://saunderspostpartum.examzify.com>

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

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