MATERNAL/CHILD NURSING CASE STUDY

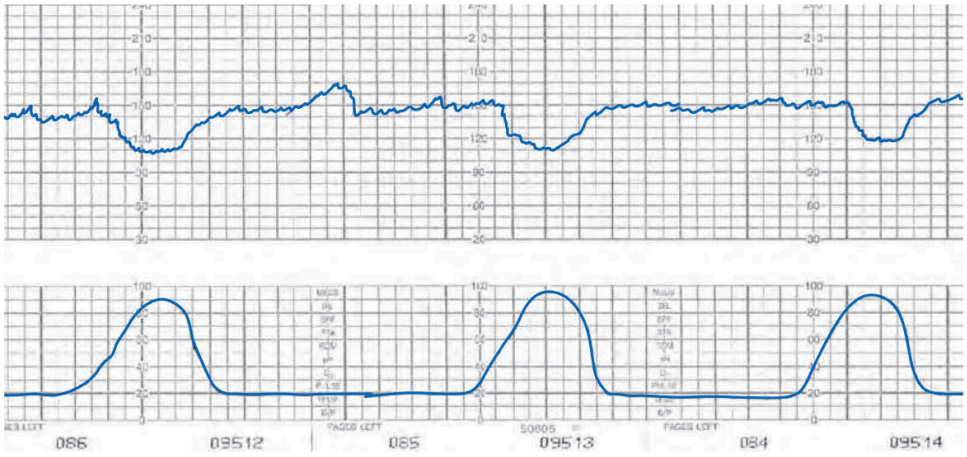
Ms. K.S., a 25-year-old gravida 1, Para 0 client, presents to the Childbirth Center at 39 weeks gestation. Ms. K.S. began regular prenatal care at 8 weeks gestation. She states her uterine contractions started about 4 hours ago and are 5 minutes apart. A sterile vaginal examination indicates the client is 4 centimeters dilated, 100% effaced, and –1 station. The amniotic sac is intact.

1. Ms. K.S. asks the labor and delivery nurse, "What stage of labor am I in?" Which response by the nurse is **most** appropriate?
   1. "You are in the first stage of labor, in the latent phase."
   2. "You are in the first stage of labor, in the active phase."
   3. "You are in the second stage of labor."
   4. "You are in the third stage of labor."

2. Ms. K.S. is having regular contractions and her amniotic membranes rupture spontaneously. Which **priority** action should the nurse implement?
   1. Elevate the head of the bed.
   2. Assess the fetal heart rate.
   3. Administer a tocolytic medication.
   4. Document the color and amount of fluid.

3. Ms. K.S. has received epidural anesthesia. Which **priority** assessment should the labor and delivery nurse perform?
   1. Assess for paresthesia in the feet and legs.
   2. Assess for a drop in maternal blood pressure.
   3. Assess for an increase in maternal temperature.
   4. Assess for presence of fetal heart rate accelerations.

4. The labor and delivery nurse is evaluating Ms. K.S.'s fetal monitor strip, which follows. Which intervention should the labor and delivery nurse perform **first?**



   1. Reposition the client on her left side.
   2. Perform a sterile vaginal examination.
   3. Notify the health-care provider.
   4. Prepare to administer IV oxytocin.

Ms. K.S. is completely dilated. The health-care provider arrives and spontaneously delivers a viable, male newborn. The HCP hands the newborn to the nursery nurse who places the newborn on a prewarmed infant warmer, dries the newborn, and removes the wet linens. The nurse performs the initial assessment:

Assessment	Newborn Finding
Heart rate	110 bpm
Respirations	Slow, weak cry
Muscle tone	Minimal flexion of extremities
Reflex irritability	Grimace with stimulation
Color	Acrocyanosis

5. Which Apgar score should the nurse assign the neonate?
   1. Apgar score of 8
   2. Apgar score of 7
   3. Apgar score of 6
   4. Apgar score of 5

6. Based on the initial assessment, which interventions should the nurse perform? **Select all that apply.**
   1. Suction the mouth and nose.
   2. Provide oxygen via face mask.
   3. Administer epinephrine endotracheally.
   4. Initiate an IV line of normal saline.
   5. Assess the need to administer naloxone.

Following interventions provided by the nurse, the newborn has an Apgar score of 10 at 5 minutes. After breastfeeding and bonding with Ms. K.S., couplet care is assigned. The baby boy and postpartum client are assessed by the nurse and teaching is provided to the mother.

7. The nurse lifts the newborn baby up from the bed, releases the infant briefly, but quickly supports again. The baby responds by extending his head and legs; his arms extend with palms facing upward, thumbs flex, and he cries briefly. Which newborn reflex should the nurse document the newborn is exhibiting?
   1. Walking (stepping) reflex
   2. Tonic-neck (fencing) reflex
   3. Moro (startle) reflex
   4. Palmar grasp reflex

8. The nurse is assessing Ms. K.S.'s uterine fundus and finds it firm, 2 centimeters above the umbilicus, and displaced to the right of midline. Which **priority** intervention should the nurse implement?
   1. Massage the fundus until firm.
   2. Assist the client to void.
   3. Notify the health-care provider.
   4. Start a perineal pad count.

9. The nurse is teaching Ms. K.S. about care of the newborn's umbilical cord. Which assessment indicates to the nurse that Ms. K.S. **understands** proper cord care?
   1. Ms. K.S. views a video on newborn hygiene and umbilical cord care.
   2. Ms. K.S. reads a pamphlet on newborn umbilical cord care.
   3. Ms. K.S. verbalizes she will apply antibiotic ointment to the cord stump daily.
   4. Ms. K.S. folds down the top of the diaper below the cord stump.

10. The nurse is preparing to discharge Ms. K.S. Which teaching interventions should the nurse include in the discharge instructions for this client? **Select all that apply.**
    1. Avoid sexual activity or tampons until your postpartum visit.
    2. Take a daily laxative to avoid straining and constipation.
    3. Cleanse perineal area with warm water after urination.
    4. Notify the health-care provider if you experience heavy bleeding.
    5. Take frequent rest periods, especially when the baby is sleeping.