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Question: 1

A common complication in the newborn infant of a diabetic mother is

- A. hyperglycemia
- B. anemia
- C. hypoglycemia

Answer: C

Explanation:

Infants born to a diabetic mother (IDM) are at increased risk for multiple complications in the newborn period. Maternal hyperglycemia causes fetal hyperglycemia as glucose freely crosses the placenta. Fetal hyperglycemia leads to increased fetal insulin production, which exerts a growth hormone-like effect (causing macrosomia). After birth (when the infant is no longer exposed to maternal hyperglycemia), the newborn's elevated insulin level causes a rapid fall in serum glucose, typically within 1-6 hours after birth. Symptoms of neonatal hypoglycemia include temperature instability, tremors, and poor feeding. Other complications in the newborn period of the IDM include hyperbilirubinemia, birth trauma, polycythemia, and respiratory distress syndrome.

Question: 2

Hindmilk (milk that flows later in a feeding) has a higher concentration of which of the following substances than foremilk?

- A. fat
- B. protein
- C. colostrum

Answer: A

Explanation:

The composition of mature human milk varies significantly as a single feeding progresses. The milk that flows at the beginning of a feeding is called foremilk. The milk that flows beginning at let-down (milk-ejection reflex) is called hindmilk. Foremilk is high in protein and low in fat while hindmilk is high in fat (and calories) but with a low protein content. The let-down reflex typically occurs 1-2 minutes after the infant begins sucking. Hindmilk is released from the breast alveoli into the ducts in response to oxytocin release. Colostrum is the milk that is present immediately after birth and until the mother's mature milk "comes in." Colostrum is a thick, yellow fluid with large amounts of immunoglobulin and protein and is relatively low in fat compared with mature milk.

Question: 3

The postpartum patient who has undergone a forceps-assisted vaginal delivery is at increased risk for

- A. postpartum hemorrhage
- B. eclampsia
- C. postpartum depression

Answer: A

Explanation:

A significant amount of blood loss can occur in the postpartum period before it becomes clinically apparent. As a result, the postpartum nurse needs to be aware of risk factors for postpartum hemorrhage and early signs of significant blood loss. Early postpartum hemorrhage (within 24 hours of delivery) may be caused by a combination of factors. Uterine atony (inappropriate relaxation of the uterine musculature) is a common cause of early postpartum hemorrhage. Risk factors for uterine atony include uterine distension (e.g., multiple gestation, macrosomic infant), preeclampsia, retained placental fragments, bladder distension, medication (e.g., magnesium sulfate), and instrumented delivery (e.g., forceps and vacuum extraction). Genital lacerations (e.g., perineum, cervix, vagina) can also cause significant postpartum blood loss. Risk factors for genital lacerations include instrumented delivery, macrosomic infant, nulliparous mother, and precipitous vaginal delivery. Retained placental fragments, vulvar or pelvic hematomas, and uterine inversion are additional causes of early postpartum hemorrhage.

Question: 4

Early decelerations with a normal fetal heart rate variability during labor have which of the following indications?

- A. they often indicate fetal congenital heart disease
- B. they do not indicate fetal hypoxia
- C. they may indicate fetal acidemia

Answer: B

Explanation:

Intrapartum fetal heart rate monitoring requires documentation and interpretation of five variables: baseline fetal heart rate, baseline heart rate variability, presence or absence of fetal heart rate accelerations, fetal heart rate decelerations, and changes in the fetal heart rate pattern as labor progresses. Interpretation of fetal heart rate monitoring can be complex and challenging but is an important component of intrapartum fetal monitoring. In general, when fetal heart rate monitoring demonstrates a normal baseline rate with accelerations, moderate variability, and no late or variable decelerations, the fetus is neither hypoxemic nor acidotic. Early decelerations with normal variability are associated with uterine contractions; fetal head compression, which occurs with the uterine contraction, leads to stimulation of the vagus nerve, leading to a decrease in fetal heart rate,

which resolves as the contraction subsides. Early decelerations are not associated with fetal hypoxia and require no intervention.

Question: 5

A cephalohematoma in the newborn infant has which of the following characteristics?

- A. it does not cross suture lines
- B. it typically resolves within 12 hours of birth
- C. it is more common after a cesarean birth

Answer: A

Explanation:

Cephalohematoma may occur in up to 2% of births and is far more common in vertex vaginal delivery than cesarean births. Blood vessels between the cranial bone and the periosteal layer rupture, leading to the formation of a hematoma in the subperiosteal space, which is limited in its extension by cranial suture lines. Cephalohematoma typically becomes clinically apparent in the first 1-2 days after birth and may take weeks to months to resolve. This is in contrast to a caput succedaneum, a subcutaneous collection of edematous fluid, which crosses suture lines, is typically present at birth, and resolves within hours to days after birth.

Question: 6

Infectious mastitis in the breastfeeding mother has which of the following characteristics?

- A. It is treated by cessation of breastfeeding
- B. it usually occurs within 48 hours of delivery
- C. it can often be prevented with proper breastfeeding technique

Answer: C

Explanation:

Mastitis is an infection of the connective tissue of the breast that occurs almost exclusively in lactating women. Mastitis is unusual in the immediate postpartum period, and is typically seen beginning 2-3 weeks after delivery in the breastfeeding patient. Human milk is an excellent medium for bacterial (and fungal) growth and typically becomes infected when bacteria from the infant's mouth or maternal skin ascend through a traumatized nipple. Mastitis typically presents with focal, unilateral breast pain and may be accompanied by fever and flu-like symptoms. The affected breast region is typically warm, red, and tender. Treatment of mastitis includes frequent breastfeeding, warm packs, pain relievers, and systemic antibiotics. Increased breast-emptying by frequent nursing or pumping leads to a rapid resolution of symptoms and a decreased risk of progression to breast abscess. Because nipple trauma and milk stasis are major contributing causes of mastitis, proper nipple care and breastfeeding technique can prevent many cases of mastitis. The postpartum patient who is breastfeeding her newborn should be instructed in proper infant latch, nipple care, and positioning techniques, which enhance complete emptying of both breasts.

Question: 7

Neonatal jaundice that is present in the first 24 hours of life is considered

- A. physiologic
- B. pathologic
- C. unconjugated

Answer: B

Explanation:

Jaundice is common in the neonatal period, occurring in up to 50% of full-term newborns and 80% of preterm infants. Prenatally, fetal unconjugated bilirubin crosses the placenta to be conjugated and excreted. Postnatally, unconjugated bilirubin is converted in the liver to its water-soluble form and then excreted in the infant's urine and stool. The infant is physiologically vulnerable to hyperbilirubinemia in the first several weeks of life for several reasons: there are low levels of hepatic enzymes necessary to convert bilirubin to its water-soluble form: there is a large unconjugated bilirubin load as a result of an increased rate of red blood cell destruction (in the newborn), and there is an increased reabsorption of bilirubin from the immature gastrointestinal tract. Physiologic jaundice as a result of these expected factors does not become clinically apparent until after 24 hours of life. Jaundice that is present in the first 24 hours after birth is considered pathologic and may result from abnormal hemolysis (e.g., ABO incompatibility) or underlying liver disease.

Question: 8

A common cause of neonatal sepsis is

- A. neisseria gonorrhoeae
- B. group B Streptococcus
- C. Gardnerella vaginalis

Answer: B

Explanation:

Group B Streptococcus (GBS) remains a common cause of neonatal sepsis and may lead to early-onset illness (within 1 week of birth) or late-onset illness. Infants with early-onset GBS disease are seriously ill and may present with pneumonia, apnea, and shock. Meningitis is more common in late-onset GBS disease. Approximately 20-25% of pregnant women are colonized by GBS in their lower gastrointestinal or urinary tracts and can transmit the infection to the infant during vaginal delivery. Intrapartum antibiotic administration in pregnant women with positive GBS cultures (or other risk factors) at least 4 hours before delivery significantly reduces the incidence of early-onset GBS disease in newborns. Gardnerella vaginalis is the etiologic agent in bacterial vaginosis and is not a cause of neonatal sepsis. Neisseria gonorrhoeae may cause neonatal conjunctivitis but is not a cause of neonatal sepsis.

Question: 9

All of the following clinical features would be expected with "postpartum blues" (adjustment reaction with depressed mood) EXCEPT

- A. frequent tearfulness
- B. irritability
- C. suicidal ideation

Answer: C

Explanation:

Postpartum "blues" (or adjustment reaction with depressed mood) occurs in more than half of postpartum mothers and is characterized by mild depressive symptoms in addition to happier periods. Postpartum "blues" typically occurs within a few days of delivery and lasts approximately 1-2 weeks. The postpartum "blues" are thought to be caused by rapid swings in prolactin, estrogen, and progesterone levels after delivery. Typical features include frequent tearfulness, fatigue, anxiety, irritability, and feelings of being overwhelmed. Signs of major depression (e.g., suicidal ideation) or psychosis are not features of the postpartum "blues."

Question: 10

How much weight is a woman with a pre-pregnancy BMI of 22.0 is expected to gain during pregnancy?

- A. 15 to 20 pounds
- B. 25 to 35 pounds
- C. 28 to 40 pounds

Answer: B

Explanation:

During pregnancy, a woman with BMI of 22.0 (which is classified as a normal weight for the mother) is expected to gain 25-35 pounds. Weight gains are recommended according to the woman's BMI:

BMI	Classified	Recommended weight gain
<18.5	Underweight	28-40 pounds
18.5-24.9	Normal weight	25-35 pounds
25-29.9	Overweight	15-25 pounds
30+	Obese	11-20 pounds

Women pregnant with twins should generally gain about 15-25 pounds more than women with singletons.



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