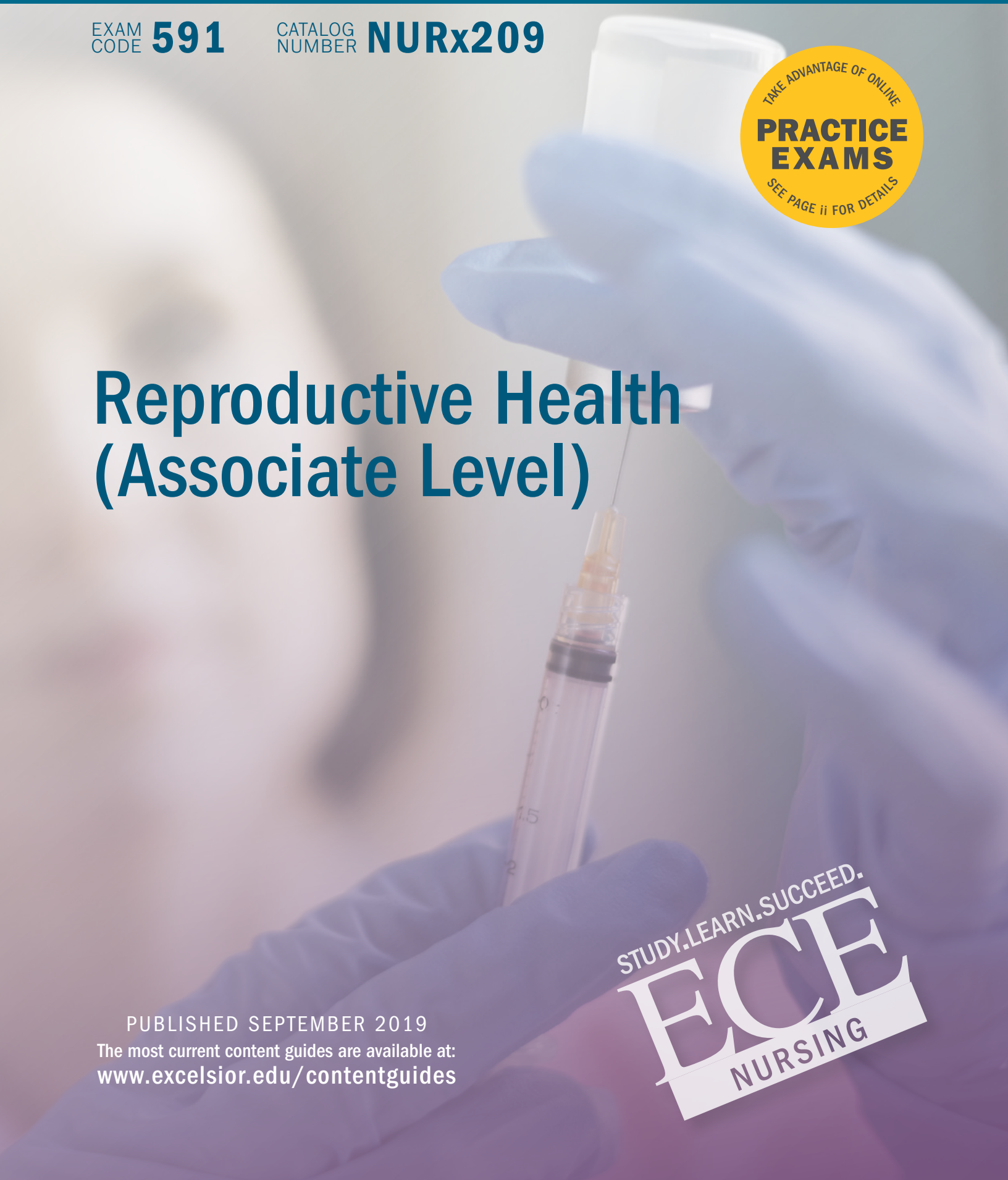
Excelsior College® Examination Official Content Guide

EXAM CODE **591** CATALOG NUMBER **NURx209**

TAKE ADVANTAGE OF ONLINE **PRACTICE EXAMS** SEE PAGE ii FOR DETAILS

Reproductive Health (Associate Level)



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To access it, visit **www.excelsior.edu/library** (login is required).

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MyExcelsior Community

MyExcelsior Community enables Excelsior College students and alumni to interact with their peers online. As members, students can participate in chat groups, join online study groups, buy and sell used textbooks, and share internet resources. Enrolled students have automatic access from their MyExcelsior page.

Online Practice Exams

When you register for your test, why not purchase the corresponding practice exam as well?
Official practice exams give you a "sneak preview" of the credit- bearing exam and types of questions you may encounter. You take your practice exams using any computer with a supported Web browser. Each practice exam purchased includes two forms or exams, that you may take within a 180-day period. After each practice exam, you can check your performance on each question and find out why your answer was right or wrong online. Feedback is not intended to predict your performance on the actual exam; rather, it will help you improve your knowledge of the subject and identify areas of weakness that you should address before taking the exam. We highly recommend that you take the first form of the practice exam before you begin studying—to see how much you already know—and the second form after you have finished studying to determine your degree of readiness.

Studying Independently for This Excelsior College® Examination

General Description of the Examination

The Excelsior College Examination, Reproductive Health, measures knowledge and understanding of material typically taught in a one-semester, three-credit, lower-level undergraduate course in nursing. The content of the examination corresponds with course offerings such as Reproductive Health Nursing, Human Reproductive Health, Sexual and Reproductive Health, and Introduction to Reproductive Health.

The examination tests the concepts and principles related to the nursing roles of provider and manager of care and member of profession when applying the nursing process to the care of patients across the life span with needs related to human sexuality and the reproductive cycle, antepartal care, intrapartal care, postpartal care and congenital anomalies, genetic disorders, and developmental challenges. Critical thinking skills and caring behaviors needed to provide and manage care for these patients are stressed. Evidence-based nursing care and standards for nursing practice, as well as, ethical, legal, and regulatory concerns specific to these patients are addressed.

End of Program Student Learning Outcomes (EPSLO)

EPSLO1. Use a caring holistic approach to provide and advocate for safe quality care for patients and families in an environment that values the uniqueness, dignity, and diversity of patients. *(Patient-Centered Care)*

EPSLO2. Apply the nursing process to make nursing judgments, substantiated with evidence to provide safe, quality patient care across the lifespan. *(Nursing Judgment)*

EPSLO3. Use principles of management and delegation to implement plans of care with members of the intra-professional team to achieve safe, quality patient outcomes. *(Nursing Judgment)*

EPSLO4. Demonstrate the standards of professional nursing practice and core values within an ethical and legal framework. *(Professional Identity)*

EPSLO5. Apply principles of leadership and inter-professional collaboration to improve patient outcomes. *(Professional Identity)*

EPSLO6. Use evidence-based findings and information technology to improve the quality of care for patients. *(Spirit of Inquiry)*

Course Level Student Learning Outcomes (SLO)

Upon successful completion, you will be expected to demonstrate the ability to:

SLO1. Demonstrate caring and cultural sensitivity when providing patient-centered care. *(Patient-Centered Care)*

SLO2. Interpret functional health, developmental stages, and illness management to formulate plans of care for patients with pain, discomfort, sensory impairment, chronic illness, and end-of-life needs. *(Nursing Judgment)*

SLO4. Apply ethical and legal principles of professional nursing practice to the care of individuals with pain, discomfort, sensory impairment, chronic illness, or end-of-life needs. *(Professional Identity)*

SLO5. Use principles of interprofessional collaboration to improve patient outcomes in a variety of health care settings. *(Professional Identity)*

SLO6. Identify the use of evidence-based findings and technology related to the nursing skills and competencies to provide safe, quality, patient care in a variety of health care settings. *(Spirit of Inquiry)*

Concepts Associated With The EPSLO and SLO

As you think about the specific **Student Learning Outcomes** (**SLO**) while preparing for this particular examination, also be mindful of how you can incorporate the following **End-of-Program Student Learning Outcomes** (**EPSLO**) to the care of clients by using these questions:

Patient-Centered Care: In what ways does the RN individualize nursing communication and care in a manner that respects each patient's cultural and family beliefs, and that incorporates preferences to meet each patient's individual needs?

Nursing Judgment: What are common problems faced by patients presenting with the specified health disorder or circumstances you are studying? As the RN, in what ways will you apply the nursing process to meet their needs? How will you consider the team members' scopes of practice, in order to decide which nursing tasks you can safely delegate, and to whom you will delegate, to meet the patient's needs?

Professional Identity: What legal and ethical implications arise in the care of patients with the specified health disorder or circumstances you are studying? What does the RN need to consider to address these implications, in a way that maintains the core values of the RN? With which member(s) of the interdisciplinary health team will you collaborate, and on what areas, so the patient achieves their individual outcome(s)?

Spirit of Inquiry: What aspects of the specified health disorder or circumstances you are studying will help you determine which evidence-based data to use, in a way that will support nursing care and assist patients in achieving their outcomes? What professionally-accepted standards of care apply to these patients? What technology will help you and the patient improve the quality of their care?

Examination Length and Scoring

The exam consists of approximately 130 multiple-choice questions, some of which are unscored, pretest questions. The pretest questions are embedded throughout the exam, and they are indistinguishable from the scored questions. It is to your advantage to do your best on all of the questions. You will have three (3) hours to complete the exam. Your score will be reported as a letter grade.

The ECE exams do **not** have a fixed grading scale such as A= 90-100%, B=80-90%, and so forth, as you might have seen on some exams in college courses. Each of the ECE exams has a scale that is set by a faculty committee and is different for each exam. The process is called standard setting and is described in more detail in the Technical Handbook. The reason we do this is that different test questions have different levels of difficulty. Getting 70% of questions correct when the questions are easy does not show the same level of proficiency as getting 70% of questions correct when the questions are hard. Every form of a test (that's the collection of test questions that you see), therefore, has its own specific grading scale tailored to the particular questions on the form.

Please note also that on each form, some of the questions count toward the score and some do not; the grading scale applies only to those questions that count toward the score. Therefore, there is no specific number of questions on the overall form that you need to answer correctly in order to achieve a particular grade.

The area with percentage ratings on the second page of your score report is intended to help identify relative strengths and weaknesses and which content areas to emphasize, should you decide to take the examination again. It is **based on both scored and pretest questions (which are not scored)**, so it will not necessarily reflect the total percentage that counted toward your grade.

Examination Administration

Pearson Testing Centers serve as the administrator for all Excelsior College computer-delivered exams. If you have a question about the administration of your exam, or wish to register for an exam, please contact the Registration Team at excelsior at: **testadmin@excelsior.edu**, Toll free phone: **888-647-2388**, ext. **221**, Fax: **518-464-8777**

The Accessibility Office at Excelsior College considers requests for reasonable accommodations for exam administration. For example, if you have a documented special need or disability, you may put in a request

to receive assistive study aids, an amanuensis, or modification of an exam time to allow for the greatest access possible to taking an exam. Visit the Accessibility Office at Excelsior at www.excelsior.edu/support-resources/accessibility-services, messaging **acs@excelsior.edu** or calling **1-844-427-4356** to learn more and request accommodations.

Please note: The accessibility services contact information is **not** the same as the information to register or schedule an exam. For registering or scheduling an exam, please contact Pearson VUE Candidate Services toll free at **888-926-9488.**

Computer-Delivered Testing

You will take the exam by computer, entering your answers using either the keyboard or the mouse. The system is designed to be as user-friendly as possible, even for those with little or no computer experience. On-screen instructions are similar to those you would see in a paper examination booklet.

We strongly encourage you to use the online tutorial before taking your exam at Pearson Testing Centers. To access the tutorial, go to www.pearsonvue.com/uexcel and click on the **"Pearson VUE testing tutorial and practice exam"** link on the right-hand side of the page.

About Test Preparation Services

Preparation for UExcel® exams and Excelsior College® Examinations, though based on independent study, is supported by Excelsior College with a comprehensive set of exams learning resources and services designed to help you succeed. These learning resources are prepared by Excelsior College so you can be assured that they are current and cover the content you are expected to master for the exams. These resources, and your desire to learn, are usually all that you will need to succeed.

There are test-preparation companies that will offer to help you study for our examinations. Some may imply a relationship with Excelsior College and/or make claims that their products and services are all that you need to prepare for our examinations.

Excelsior College is not affiliated with any test preparation firm and does not endorse the products or services of these companies. No test preparation vendor is authorized to provide admissions counseling or academic advising services, or to collect any payments, on behalf of Excelsior College. Excelsior College does not send authorized representatives to a student's home nor does it review the materials provided by test preparation companies for content or compatibility with Excelsior College examinations.

To help you become a well-informed consumer, we suggest before you make any purchase decision regarding study materials provided by organizations other than Excelsior College, that you consider the points outlined on our website at www.excelsior.edu/exams/advisory.

Preparing with the Content Guides and Related Materials

The Content Outline

The content outline describes the various areas of the test. To fully prepare requires self-direction and discipline. Study involves careful reading, reflection, systematic review, and applying the concepts. For the seven clinically focused exams in Essentials in Nursing Care and Health Differences Across the Life Span series, each content area description has two sections:

Section A, Basic Concepts, includes scientific principles underlying the condition being studied, developmental or cultural aspects of care, and clinical manifestations encountered. You might think of this as the **Who, What, When, and Where.** This section might be considered the facts.

Section B, Nursing Process, details how each step of the nursing process is used, with examples that are specific to the content area being studied. You might think of this as the **How** of nursing care. This section is how to apply the facts with the nursing process.

For the one non-clinically focused exam, Transition to the Professional Nurse Role, the section A and B format is not used, but the content is listed according to topics and how it impacts the RN and how the RN uses or applies the concepts.

NOTE: The examples are used to help clarify the content topic. However, the content of the exam is not limited to the specific examples given.

The Nursing Process is Key

While the nursing process is explicitly studied at the beginning of the Essentials in Nursing Care: Health Safety outline, it is also used as a structure for the "Nursing Process" section in each content guide. The nursing process must be **applied**, not just memorized, and will form the basis of many test questions in the exam series. To encourage a more comprehensive understanding of the Nursing Process, the nursing faculty strongly advise you to review the unit on the Nursing Process in your Fundamentals textbook **and** to complete the online tutorial titled **Critical Thinking and the Nursing Process, NUR3014** listed in your available courses. This tutorial is free of charge and is located on your **MyExcelsior page** under **My Online Courses, Exams & Learning Aids.** It will be available throughout your course of study.

Required Resources

A list of required textbooks and other resources are included in each content guide. The nursing faculty have selected textbooks that are used in all phases of the nursing theory series. Creating a library of these textbooks will provide you with the resources to support your success. The textbooks include online resources such as videos, podcasts, case studies, and NCLEX-style practice questions to enhance your learning.

In order to use the online textbook resources, an access code is required. If you purchase a textbook with an access code that has already been redeemed, you may be able to purchase an "access code only" from the bookstore. Refer to the information inside the front cover of the textbook to use the access code to access the online resources.

It is also recommended that you obtain a current medical or nursing dictionary/encyclopedia such as *Stedman's Medical Dictionary for the Health Professions and Nursing*. You should also have access to

textbooks in anatomy and physiology, microbiology, and laboratory and diagnostic procedures to enhance your learning resources

Reading Assignments

To ensure your success, you must complete the required readings listed under each content area in the content guide. Chapter numbers and titles may differ in subsequent editions of a given textbook. If your edition is different, use the Table of Contents in the textbook to locate the appropriate chapters to read. It is also helpful to review basic anatomy, physiology, and microbiology principles as they apply to each content area.

Web-Based and Professional Journal Resources

These resources include professional standards of nursing practice, evidence-based findings, and practice guidelines and protocols to support the development of your nursing knowledge. You are expected to access these resources as you study to gain a full understanding of what the professional nurse needs to know in order to provide safe, quality patient care. The Excelsior College Library provides access to the full text of each article listed in the content guide. Several professional recommended web site resources are also linked in the resource list of the library. Simply log in to **www.excelsior.edu/library** and look for the Nursing Research guides, then Exam Resource Pages, then the specific exam you are seeking.

Academic Integrity Nondisclosure Statement

All test takers must agree to the terms of the Excelsior College Academic Integrity Policy before taking an exam. The agreement will be presented on screen at the Pearson Testing Center before the start of your exam. Once you accept the terms of the agreement, you can proceed with your exam. If you choose not to accept the terms of the agreement, your exam will be terminated and you will be required to leave the testing center. You will not be eligible for a refund. For more information, review the policy at **www.excelsior.edu/studentpolicyhandbook**.

Student behavior will be monitored during and after the exam. Electronic measures are used to monitor the security of test items and scan for illegal use of intellectual property. This monitoring includes surveillance of internet chat rooms, websites, and other public forums.

Suggestions for Success on the Nursing Theory Examinations

1) Allow yourself enough time to study. Each nursing theory exam you successfully complete earns three (3) semester hours of credit. To earn these credits for an on-campus course, you would be expected to spend **at least** 135 hours attending classes and doing out-of-class assignments. Plan on spending a comparable amount of time preparing for each nursing exam. The percentage of the examination associated with each content area has been calculated for you and listed under the title for each content area. Set aside a specific time for studying, and ask others to respect your need for no interruptions. Make a calendar and plan for your anticipated test date, working backward to include study time and preparation routinely.

2) **Make sure you have the most current content guide available.** Each content guide has a "validity date" on the cover page. Study and prepare from the most recent content guide. After studying for a while, when you start thinking about scheduling your test appointment, again check for the latest content guide for your exam on the College's website (**www.excelsior.edu/contentguides**, login is required), and make you still have the most current content guide to assist your preparation.

3) **Organize your study according to the content outline** in the content guide, rather than working your way systematically through any one textbook. The Reading Assignments will help you to locate the material for each content area.

4) **Complete the required readings for each content area;** this includes web-based and professional journal resources. Reading only one textbook is insufficient preparation for the exams. In order to completely understand the material tested on the examination, it is important to remember that the content covers health issues from birth to death.

5) **Aim for understanding rather than memorization.** Since the exam assesses a student's ability to provide nursing care, the exam questions are written at the application level. While you are required to know facts, such as lab values and medication doses, the exam assesses your ability to apply this information.

6) **Study all relevant age ranges.** Consider how the patient's developmental stage may affect the response to the health issue, as well as the nursing care that is provided.

7) **Use active learning techniques.** It helps to take notes, rephrase what you have read into your own words, or quiz yourself as you study. Some students create flashcards showing important concepts. Others read aloud, recording as they go, so that they can listen to the material as they commute, exercise, etc. Think how will I apply this information or concept as a RN? Consider the Student Learning Program concepts: patient-centered care, nursing judgment, professional identity, and spirit of inquiry. What is the connection between what you are learning and these concepts? Consider if you feel able to demonstrate the associated course level student learning course outcome (SLO) that matches this content and concept.

8) **Use the practice exams appropriately** (see inside covers of this guide for more information). Take the first form of the practice exam early in your study period and use the results to identify areas for further study; create a study plan and follow it; then take the second form and see how much you have improved. If you have done well on the practice exams and are feeling confident, go ahead and schedule your appointment to test. If your score on the second form indicates that you still have some studying to do, check your registration information to confirm how much eligibility time you have remaining, and revise your study plan to complete your learning before your eligibility period expires. You should feel competent to demonstrate the course level Student Learning Outcomes (SLO) to succeed with the exam.

9) **Use the review questions, patient situation scenarios, and recommended web resources in the textbooks** to help you assess your strengths and weaknesses. Review books and workbooks summarize important points but do not provide the depth that is required to learn new content. They are helpful to use as a review after you have studied. Similarly, NCLEX review books that include question-and-answer areas can help you to assess your test-taking ability but they should not be used as your primary method of study.

10) **Use the "Test Your Knowledge"** box after each content area to evaluate how well you have learned and are able to apply the concepts. You should be able to answer these questions and discuss the issues to be successful.

11) **Practice with alternative item formats.** The sample questions in this content guide provide some examples of these item types that may appear on your nursing theory exam or your licensure exam. These sample questions also show the connection with the course level student learning outcomes(SLO) you are to be achieving. You will find more examples in NCLEX review books, at www.ncsbn.org and in the online textbook resources. Probably the most difficult of these types is the multiple-response (select all that apply) question. To receive credit, you must choose all of the correct answers and none of the incorrect ones. When you encounter one of these questions on your exam, focus on what is being asked.

    You may find it helpful to use the noteboard provided at the test center to write down what you can remember about the question topic. Then eliminate any options that are clearly incorrect, and carefully re-read all the remaining options to be sure they are correct. Take advantage of the opportunity to mark this question type for review at the end of the exam.

12) **Don't overschedule yourself.** Remember that taking an exam can be tiring and stressful. Don't overextend yourself by registering for too many exams at once. Students who try to take more than one exam at a time or don't allow enough time between exam appointments often fail at least one of the exams they attempt.

13) **Review computer-based testing procedures.** If you're concerned about taking your exam by computer, look over the Pearson tutorial to get an idea of the exam process.

14) **Assess, refresh, and improve your study skills, as needed.** If you need additional assistance with study strategies and/or test taking skills,

the Excelsior College Bookstore carries several workbooks in these areas. You can find them in the Nursing Study Aids section.

15) **Make sure you are rested and comfortably dressed the day of the examination.** Anything you can do to increase your ability to concentrate during the exam will help.

16) **If you don't pass, don't despair.** Instead, try to determine why you had difficulty with the exam and take steps to correct the problem. Ask yourself, "Did I use the current content guide and the required text books? "Did I know the content well enough?" "Did I study long enough (135 or more hours)?" "Are there particular content areas that I omitted or didn't really understand?" "Did my test-taking skills or stress level interfere with my ability to document my knowledge?" and above all, "What can I do differently next time to help myself succeed?"

    Use the Detailed Score Report you received at the testing center to identify your weaker content areas for more detailed study. Review the scoring data information under Examination Length and Scoring section in this guide to be clear on percentage ratings per content area. Contact the College to set up an appointment to speak with a nurse faculty member about your preparation methods and plans to succeed, learning/applying the information and concepts. You can also join MyExcelsior Community to gain additional information and support.

Nursing Terms in Excelsior College Examinations

The language used in Excelsior College Examinations (ECEs) represents a range of terms used in nursing practice. Depending upon the term being used, the context of a question, and the nature of the exam, many terms may be used interchangeably and synonymously. There is often more than one appropriate term, and students should expect to see different terms throughout the materials they will use to prepare for the exams, and on the exams, themselves.

For example, the abbreviation RN is the standard term used in ECEs for someone fulfilling the role of a professional, registered nurse. However, a question in an exam on the professional development of nursing may show *registered nurse (RN)* spelled out because the context requires that usage. Similarly, a question on another exam may include reference to a *nurse manager* or a *nurse colleague* instead of RN, depending upon the situation.

Similarly, ECEs use the term diagnosis vs. diagnostic to refer to nursing diagnoses, although the terms are interchangeable. An example of a nursing diagnosis label (nursing diagnosis) would be *Acute Pain.* Nursing diagnosis labels are not to be confused with nursing diagnosis statements, which include the etiology of the nursing diagnosis label and the features that define that label for a particular patient. For example, *Acute Pain related to tissue trauma as evidenced by patient report of pain level of 5 on a 0—10 numeric rating scale* would be the entire nursing diagnosis statement. Nursing diagnosis labels appearing either alone or as part of an entire nursing diagnosis statement will always be capitalized.

Other examples of interchangeability include *patient*, the ECE term of choice for denoting the person who receives health care. However, in some questions, it may be appropriate to *use client* or *resident* if the situation takes place in a setting other than an acute care health facility. In still another example from the Reproductive Health ECE, woman may be used interchangeably with the term patient, even within the same item. Using terms interchangeably depends on the context of an item and whether the intent is to capture written or spoken language. An illustration of this could address a question on a nursing intervention for a 2-hour-old patient who is in distress in the NICU. The more clinical term neonate might appear in the question. However, if the answer choices to that question represent responses the parents might verbalize, then the term newborn might be used instead.

The broader term *health care provider* is used instead of *MD* or *physician* and includes practitioners who diagnose medical conditions, write medical prescriptions, and order diagnostic tests. Such practitioners can include physicians, nurse practitioners, or physician assistants.

Most ECEs will use the term *unlicensed assistive personnel (UAP)*. However, others will use *nursing assistive personnel (NAP)* or *assistive personnel (AP)* to reflect the language in the textbook used for that particular exam, such as in Essentials of Nursing Care: Health Safety.

Emergency department (ED) is used interchangeably with *emergency room (ER)*. Again, it is assumed the student will identify such terms as interchangeable.

Our goal is to ensure an exam is understandable, fair, and concise, as well as correct. General language is used so as not to represent any one region or geographical location in the United States. Furthermore, each ECE undergoes a review for sensitivity and fairness. This review ensures our exams are bias-free and accessible to our diverse test-takers. In this review process, item content is "neutralized," meaning factors such as gender, age, race, religion, ethnicity, and/or class are not included, unless they are relevant to the question.

Nursing faculty develop our exam content. Testing professionals then standardize style and usage and, in collaboration with faculty, revise and edit the content. This process ensures a coherent testing experience that measures students' competency and reflects contemporary nursing practice.

Learning Resources for This Exam

Recommended Resources

Nursing Theory Conference Exams (NTCX)

The NTCXs combine an online conference and nursing theory examination so you can retain the flexibility of an independent learner while benefitting from an organized approach to examination preparation. The 8-week, term based experience provides the opportunity for students to become engaged, and stay engaged with the subject matter covered in the nursing curriculum. This option will only be available to students through Spring I/II term 2020. The NTCX will be discontinued after Spring I/II 2020 term.

Activities include assigned readings, participation in weekly discussion questions, weekly quizzes, and feedback from faculty. The NTCXs are delivered asynchronously. Students who meet the Course or Nursing Theory Conference Examination Student Participation Policy will receive an Authorization to Test during the seventh week of the term. You will need to scheduled and take your examination prior to the end of the eighth and final week of the term. For a list of dates and fees, please visit www.excelsior.edu/nursing.

Required Resources For This Examination

Textbooks

Burchum, J. R., & Rosenthal, L.D. (2019). *Lehne's pharmacology for nursing care* (10th ed.). St Louis, MO: Elsevier.

Hinkle, J., & Cheever, L. (2018). *Brunner and Suddarth's textbook of medical-surgical nursing* (14 ed.). Philadelphia, PA: Wolters Kluwer.

Ladwig, G., Ackley, B., & Makic, M. B. F. (2020). *Mosby's guide to nursing diagnosis* (6th ed.). St. Louis, MO: Elsevier.

Silbert-Flagg, J., & Pillitteri, A. (2018). *Maternal and child health nursing: Care of the childbearing and childrearing family* (8th ed.). Philadelphia, PA: Wolters Kluwer.

Web-Based and Professional Journal Resources

For this examination, click the provided link to the web-based and professional journal resources for each content area of this content outline. Articles found in the Excelsior College Library will require you to sign in to your MyExcelsior account.

All web-based and professional journal resources are listed on the Library's page for the Foundations in Nursing Practice exam.

Additional Resources

Students have access to an e-book through the Excelsior College Library! This e-book has unlimited user access. Nugent and Vitale have written an excellent resource for beginning nursing students, which provides information to assist with critical thinking, time management, effective study tips and test-taking techniques. Students will find this book helpful to prepare for NCLEX-RN style questions. Follow the permalink below to explore this resource and develop effective study and test taking strategies.

Nugent, P., & Vitale, B. (2018). Test success: Test-taking techniques for beginning nursing students (8th ed.). Retrieved from https://ebookcentral.proquest.com

For medication calculation formulas, refer to Treas, L. S., Wilkinson, J. M., Barnett, K. L., & Smith, M. H. (2018). *Basic nursing: Thinking, doing, caring* (2nd ed.). Philadelphia, PA: F. A. Davis. or use the Drug Calculation resource found within NUR 3014- Critical Thinking and the Nursing Process Online Tutorial.

Content Outline

The major content areas on the Reproductive Health examination and the percent of the examination devoted to each content area are listed below.

Content Area	Percent of the Examination
I. Human Sexuality and the Reproductive Cycle	20%
II. Antepartal Care	20%
III. Intrapartal Care	20%
IV. Postpartal Care	20%
V. Congenital Anomalies. Genetic Disorders, and Developmental Challenges	20%
Total	100%

Cognitive Activity	Percent of the Examination
Knowledge and Comprehension	10–15%
Application and Higher-Level Abilities	85–90%
Total	100%

The examples provided in the content outline are not intended to be comprehensive. Use the required readings for wide-ranging, current information.

I. Human Sexuality and the Reproductive Cycle

20 PERCENT OF EXAM

In this section you are responsible for studying:

- Sexual health
- Variations in sexual orientation
- Reproductive health
- Alterations in reproductive health
- Contraception
- Preconception health
- Subfertility
- Application of the nursing process (Section B) to the patient and partner while promoting, maintaining and restoring sexual and reproductive health (Section A).

REQUIRED READINGS

Burchum, J. R., & Rosenthal, L.D. (2019). *Lehne's pharmacology for nursing care* (10th ed.)

Chapter 61: Estrogens and Progestins: Basic Pharmacology and Noncontraceptive Applications

Chapter 62: Birth Control

Chapter 63: Drug Therapy of Infertility

Chapter 65: Androgens

Chapter 66: Drugs for Erectile Dysfunction and Benign Prostatic Hyperplasia

Chapter 68: Childhood Immunizations (Section on Human Papillomavirus Vaccine)

Chapter 95: Drug Therapy of Sexually Transmitted Diseases

Hinkle, J., & Cheever, L. (2018). *Brunner and Suddarth's textbook of medical-surgical nursing* (14 ed.)

Chapter 56: Assessment and Management of Female Physiologic Processes

Chapter 57: Management of Patients with Female Reproductive Disorders, (Beginning of chapter until section on "Malignant Conditions" and section on "Hysterectomy")

Chapter 59: Assessment and Management of Problems Related to Male Reproductive Processes (Beginning of Chapter until section on "Cancer of the Prostate," section on "Disorders Affecting the Testes and Adjacent Structures" until end of the chapter).

Ladwig, G., Ackley, B., & Makic, M. B. F. (2020). *Mosby's guide to nursing diagnosis* (6th ed.)

Use Mosby's Guide to Nursing Diagnosis 6th edition to review the nursing diagnoses specific to the content covered in this content area.

Silbert-Flagg, J., & Pillitteri, A. (2018). *Maternal and child health nursing: Care of the childbearing and childrearing family* (8th ed.)

Chapter 1: A Framework for Maternal and Child Health Nursing

Chapter 2: Diversity and Maternal Child Nursing

Chapter 3: The Childbearing and Childrearing Family in the Community

Chapter 5: The Nursing Role in Reproductive and Sexual Health

Chapter 6: Nursing Care of the Family in Need of Reproductive Life Planning

Chapter 7: Nursing Care of the Family having Difficulty Conceiving a Child

Chapter 47: Nursing Care of a Family When a Child Has Reproductive Disorder

Chapter 55: Nursing Care of a Family in Crisis: Maltreatment and Violence in the family

WEB-BASED AND PROFESSIONAL JOURNAL RESOURCES

Click this link to access web-based and professional journal resources through the Excelsior College Library.

Articles found in the Excelsior College Library will require you to sign in to your MyExcelsior account.

A. Sexual and Reproductive Health

1. Sexual Health
   a. Developmental factors (for example: age-related changes occurring through the life cycle).
   b. Cultural diversity (for example: consider how different types of sexual expression are influenced by religious beliefs, consider how male and female roles may differ).
   c. Factors affecting the sexual response cycle (for example: erectile dysfunction, dyspareunia).
   d. Sexually transmitted infections [STIs] (for example: differentiate the signs & symptoms, treatment options and prognosis of viral versus bacterial STIs; patient education relative to practicing safe sex).
   e. Variations in sexual orientation (for example: consider how the sexual and reproductive health care needs are being met for the lesbian, gay, bisexual, transgender [LGBT] population).
   f. Treatment modalities (for example: medications used to treat alterations in the sexual response cycle [androgens, phosphodiesterase (PDE)-5 Inhibitors] and sexually transmitted infections [anti-infectives]).
2. Reproductive Health
   a. Normal female reproductive development (for example: consider the anatomy and physiology of the menstrual cycle including the various hormonal responses).
   b. Alterations in female reproductive function (for example: menstrual disorders, menopause, polycystic ovary syndrome [PCOS] endometriosis, fibroid tumors, cystocele, rectocele, vaginal prolapse).

c. Normal male reproductive development (for example: consider the anatomy and physiology of sperm production, including hormonal responses).

d. Alterations in male reproductive function (for example: benign prostate hypertrophy [BPH], impotence, low sperm count).

e. Contraception methods (for example: consider the advantages and disadvantages of barrier, pharmacological, surgical, and non-pharmacological methods of contraception).

f. Preconception health (for example: life style choices, reproductive life plan).

g. Subfertility (for example: consider the diagnostic evaluation for possible male and female infertility or subfertility, consider the different options for assistive reproductive technology [ART]).

h. Treatment modalities (for example: medical management including non-surgical devices, exercises, and medications used for altered reproductive function; hormone based contraceptives, spermicides, hormone therapy, antiandrogens, alpha-adrenergic blocking agents, ovulation stimulant, surgery, complementary and alternative therapy).

B. Management of patient care: apply the nursing process to make nursing judgments, substantiated with evidence, to provide safe, quality patient care to meet the sexual and reproductive health care needs of clients across the life cycle.

1. Assessment: collection of comprehensive patient-centered data to be used as the basis for identifying sexual and reproductive health needs.

a. Conduct a patient-centered sexual and reproductive health history (for example: consider age, developmental level, gender identification, menarche, age at onset of becoming sexually active, number of sexual partners, pregnancies, consider alcohol consumption, use of drugs, nutrition and exposure to teratogens, elective termination of pregnancy).

b. Conduct focused assessment related to sexual and reproductive health status (for example: reproductive life plan, risk factors for sexual maltreatment, rape or intimate partner violence in a relationship).

c. Assess for presence of potential complications (for example: sexually transmitted infections, difficulty conceiving, history of age related bone fractures).

d. Assess the patient's and partner's readiness for teaching and learning (for example: identify barriers to learning, identify health seeking behaviors, verify understanding of birth control methods).

e. Review laboratory and other diagnostic data. Recognize critical values and when to collaborate with appropriate members of the health care team (for example: complete blood type [CBC], STI cultures, reproductive hormone level, prostate-specific antigen [PSA]).

2. Diagnosis: identification and prioritization of patient problems, labeled as nursing diagnoses, based on analysis of comprehensive assessment.

a. Nursing diagnoses are derived from the nursing assessment data; nursing diagnoses are revised as new and/or additional assessment data becomes available; nursing diagnoses are prioritized based on assessment data.

b. Analyze and synthesize data for patterns and cues to identify nursing diagnosis using NANDA-I classification system (for example: Anxiety, Fear, Powerlessness, Risk for Injury, Deficient Knowledge, Risk for Infection; Risk for Sexual Dysfunction, Risk for Ineffective Sexuality Pattern, Decisional Conflict).

c. Set priorities based on patient assessment and needs using theories and/or guidelines (for example: Maslow's hierarchy of needs).

3. Outcome Identification and Planning: identification of expected outcomes and development of a patient-centered plan of care reflecting nursing interventions that integrate standards of care, protocols, ethics, laws, and regulations.

   a. In collaboration with the patient or patient's family, create a patient-centered plan of care to address the identified patient problems. Use technology when available and appropriate. Include interventions related to health promotion and maintenance, physiologic adaptation, risk reduction and pharmacologic therapies (for example: educate client about use of oral contraceptives, provide culturally sensitive nursing care).

   b. Establish patient-centered expected outcomes that include a time frame for achievement of the outcome (for example: the patient will verbalize that oral contraceptives will not prevent sexually transmitted infections by the end of the teaching session, the patient will state nitrate medications cannot be taken in combination with PDE-5 inhibitors by the end of the clinic visit).

   c. Use established nursing standards, protocols, and evidence-based findings to move the patient toward the achievement of the expected outcome (for example: National Health Goals 2020 for sexually transmitted infections, ANA Standards of Professional Nursing Practice, Association of Women's Health, Obstetric, and Neonatal Nurses [AWHONN], Quality & Safety Education Nurses [QSEN], standards for delegating nursing care to unlicensed assistive personnel).

   d. Integrate ethical and legal standards (for example: practice in accordance with ANA Code of Ethics, practice within legal scope of practice, practice in compliance with AWHONN position statements, adhere to state and federal regulations for mandatory reporting of incidents related to sexual health).

4. Implementation: implement the patient plan of care by performing or delegating the nursing interventions that were previously planned. This includes providing care and collaborating with other members of the health care team.

   a. Establish a collaborative relationship with the patient and partner seeking care related to sexual and reproductive health (for example: use therapeutic communication skills, assess the patient's use of coping mechanisms, assess the adolescent with an unintended pregnancy; provide culturally competent care, support patient and partner to establish reasonable goals when discussing a reproductive life plan, assist client to cope with life cycle changes, provide emotional support to the client in crisis).

b. Promote, maintain, or restore the patient's physiologic and psychosocial changes related to sexual and reproductive health (for example: consider the rape victim, the couple with subfertility issues, provide preoperative and postoperative care for those clients requiring surgical intervention, conduct health screenings).

c. Administer prescribed medications and intravenous therapy (for example: monitor client reaction to prescribed medication, accurately calculate drug dosage, accurately calculate and regulate IV therapy administration for post-surgical patient).

d. Educate patient and partner regarding sexual and reproductive health. Consider health literacy of patient/support person when providing education including educational materials. Incorporate medication regimens, procedures, treatments, and diagnostic tests. Include information on how therapy for a preexisting condition may need to be modified. Consider cultural preferences. Recognize gender roles are influenced by culture and may influence teaching content and how it is presented (for example: age related sexual response changes and reproductive cycle changes, pros and cons of the various pharmacological and non pharmacological birth control methods, teach about anti-infectives for STIs, safe sexual practices, life style choices affecting fertility and the aging process, health screenings relative to sexual and reproductive health across the age continuum, provide preoperative and postoperative education for those clients requiring surgical intervention).

e. Promote continuity of care (for example: provide education and information for follow up care, provide mechanism for contacting health care provider, provide education about preventing spread of STIs and possible re-infection, encourage patient to alert sexual partner for testing and treatment, act as a patient advocate, recognize RN leadership role, identify the need for spiritual support and/ or community resources).

f. Assign, supervise, and communicate the needs of patient and partner seeking care related to sexual and reproductive health to members of the nursing care team including RN, LPN, LVN, and unlicensed assistive personnel (UAP) (for example: use the principles of delegation to make decisions regarding assignments for a patient or for a group of patients, communicate changes in the patient's condition without delay, evaluate effectiveness of patient care provided by other members of the health care team, determine if the unlicensed assistive personnel measured the intake and output of the post operative patient, determine whether the unlicensed assistive personnel reported patient's condition as instructed).

5. Evaluation: evaluate the plan of care by determining whether the expected patient outcomes were achieved.

   a. Evaluate patient response to achievement of the expected outcome (for example: evaluate client understanding of health promotion behaviors related to practicing safe sex).

b. Revise the patient's plan of care based on new or additional patient data (for example: the patient whose goal was to prevent a pregnancy is now hoping to conceive, provide additional information for the patient returning to the clinic with a new STI).

c. Consider areas for quality improvement (for example: use evidence based findings to improve performance such as QSEN competencies, evaluate the process for addressing errors and actions taken to prevent future errors, review adequacy of policies and procedures, incorporate recommendations from AWHONN position Statement - Nursing Care Quality Measurement).

TEST YOUR KNOWLEDGE

What cultural factors should be considered when planning education for safe sex practices? (Patient-Centered Care)

Why is reducing the number of STIs an important goal of the Healthy People 2020 Initiative? (Spirit of Inquiry)

Which ART is most appropriate for the infertility needs of an infertile woman? An infertile man? An infertile couple? (Nursing Judgment)

II. Antepartal Care

20 PERCENT OF EXAM

In this section you are responsible for studying:

- Conception and implantation
- Embryonic and fetal development
- Umbilical cord and placenta
- Antepartum care of the mother and childbearing family
- Potential complications of the antepartum period
- The application of the nursing process (section B) to the patient care associated with the antepartum period (section A).

REQUIRED READINGS:

Ladwig, G., Ackley, B., & Makic, M. B. F. (2020). *Mosby's guide to nursing diagnosis* (6th ed.)

Use Mosby's Guide to Nursing Diagnosis 6th edition to review the nursing diagnoses specific to the content covered in this content area.

Silbert-Flagg, J., & Pillitteri, A. (2018). *Maternal and child health nursing: Care of the childbearing and childrearing family* (8th ed.)

Chapter 9: Nursing Care During Normal Pregnancy and Care of the Developing Fetus

Chapter 10: Nursing Care Related to Psychological and Physiologic Changes of Pregnancy

Chapter 11: Nursing Care Related to Assessment of a Pregnant Family

Chapter 12: Nursing Care to Promote Fetal and Maternal Health

Chapter 13: The Nursing Role in Promoting Nutritional Health During Pregnancy

Chapter 14: Preparing a Family for Childbirth and Parenting

Chapter 20: Nursing Care of a Family Experiencing a Pregnancy Complication From a Preexisting or Newly Acquired Illness

Chapter 21: Nursing Care of a Family Experiencing a Sudden Pregnancy Complication

Chapter 22: Nursing Care of a Pregnant Family With Special Needs

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A. **Concepts related to Antepartal Care**

1. Maternal/Family

   a. Psychosocial aspects of pregnancy for the mother and family (for example: psychological tasks of pregnancy, accepting the pregnancy, accepting the fetus, preparing for the baby and the end of the pregnancy, additional preparation work to complete in pregnancy, reworking developmental tasks, fantasizing, difficulties with adaptation to pregnancy such as grief, stress, depression, body image changes).

   b. Confirmation of pregnancy (for example: presumptive symptoms, probable signs, positive signs).

   c. Physiological changes of pregnancy (for example: consider the changes associated with each body system during each trimester, consider changes that may impact level of comfort such as breast tenderness, urinary frequency, dyspnea).

   d. Health promotion during pregnancy (for example: self care needs, managing common problems, preventing fetal exposure to teratogens, preliminary signs of labor).

   e. Preparing a family for childbirth and parenting (for example: childbirth education, childbirth plan, sibling education, breastfeeding classes, preparation for childbirth classes; methods to manage pain in childbirth using gating control theory of pain perception, The Bradley [partner-coached] Method, the Lamaze Philosophy [the birth setting, choosing a birth attendant and support person, choosing a birth setting, children attending birth]; alternative methods of birth [hydrotherapy and water birth], woman with unique needs, woman with a disability, woman with cultural concerns, woman who is morbidly obese).

   f. Care of the pregnant family with special needs (for example: pregnant adolescent, pregnant woman over 40 years of age, pregnant woman physically or cognitively challenged, substance dependent, multiple gestation).

   g. Complications or collaborative problems. (for example: hyperemesis gravidarum, diabetes mellitus and pregnancy, spontaneous miscarriage [types]; ectopic pregnancy; gestational trophoblastic disease – Hydatiform Mole; premature cervical dilatation, coagulation disorders and pregnancy, preterm labor, preterm rupture of membranes, gestational hypertension, HELLP syndrome, hydramnios, oligohydramnios, postterm pregnancy, Rh incompatibility, infections, trauma, fetal death).

   h. Treatment modalities (for example: medications such as antibiotics, anticonvulsants, insulin, tocolytic agents, magnesium sulfate, betamethasone, antihypertensives, methotrexate, RhoGAM [if necessary], misoprostol, oxytocin [for any medications - potential teratogenic effects], surgical intervention [dilatation and curettage or dilatation and evacuation, cervical cerclage], blood transfusion).

2. Fetal: physiology of fertilization (for example: conception, implantation, embryonic and fetal development, placental development and function, fetal circulation).

B. **Management of patient care: apply the nursing process to make nursing judgments, substantiated with evidence, to provide safe, quality patient care during the antepartum period.**

1. Assessment: collection of comprehensive patient-centered data to be used as the basis for identifying patient needs.

a. Conduct a patient-centered health history to include baseline data relevant to the woman's health and identify health promotion strategies that will be used at every prenatal visit (for example: consider maternal age, developmental level, obstetric history [gravida, para, type of previous births, any complications following previous births]; life style choices, high risk behaviors, patient preferences, values, personal needs, ask about subjective symptoms, nutritional status, past illnesses, family history [family structure and function, history of past illnesses, history of family illnesses]; genetics and/or ethnicity as risk factors for additional health disorders; intimate partner violence; allergies, past obstetrical history noting any issues with previous pregnancies or deliveries; screen for the risk of teratogen exposure; any concerns a woman has about her pregnancy; availability of support systems; newborn feeding choice, past surgery; history of depression).

b. Conduct a maternal assessment related to the antepartum period (for example: date of last menstrual period, estimated date of delivery, was the pregnancy intended, determine if discomfort with the pregnancy, danger signs with pregnancy [bleeding, abdominal pain, visual disturbances]; current nutrition, exercise, lifestyle choices that may increase teratogenic exposure and/or potential harm, medication and herbal therapy, gynecologic history [menstrual history, perineal and breast self-examination]; reproductive planning, sexual history, stress incontinence, baseline data [pre-pregnancy body mass index, fundal height measurement, fetal heart sounds] blood type including Rh, rubella status, pelvic examination [pap smear, human papillomavirus culture, cultures for Chlamydia, gonorrhea, and Group B Streptococcus; pelvic measurements).

c. Assess for presence of potential complications (for example: hyperemesis gravidarum, spontaneous miscarriage, ectopic pregnancy, gestational trophoblastic disease, premature cervical dilatation, disseminated intravascular coagulation (DIC), preterm labor, premature rupture of membranes, gestational hypertension, HELLP syndrome, hydramnios, oligohydramnios, postterm pregnancy).

d. Assess the patient's and significant other's readiness for teaching and learning (for example: determine barriers to learning, learning preferences, verify patient's understanding of the antepartum period along with the diagnostic tests and procedures used in conjunction with these).

e. Review laboratory and other diagnostic data. Recognize critical values and when to collaborate with appropriate members of the health care team (for example: consider typical testing for all pregnancies such as human chorionic gonadotropin (hCG), genetic screening for commonly inherited diseases, serologic test for syphilis, maternal serum α-fetoprotein (MSAFP) and pregnancy associated plasma protein A, serum antibody titers, glucose screening, consider additional diagnostic testing necessary based on maternal factors and assessing fetal well being, indirect Coombs test, liver enzymes, amniocentesis, chorionic-villi sampling, amniotic fluid index, biophysical profile, non stress test (NST), contraction stress test (CST), lecithin/sphingomyelin [L/S ratio]).

2. Diagnosis: Identification and prioritization of patient problems, labeled as nursing diagnoses, based on analysis of comprehensive assessment.

   a. Nursing diagnoses are derived from the nursing assessment data; nursing diagnoses are revised as new and/or additional assessment data becomes available; nursing diagnoses are prioritized based on assessment data.

   b. Analyze and synthesize data for patterns and cues to identify nursing diagnoses using NANDA-I classification system (for example: Decisional conflict; Deficient knowledge; Risk for injury; Disturbed body image; Anxiety; Risk for ineffective sexuality pattern; Disturbed sleep pattern; Risk for deficient fluid volume; Imbalanced nutrition: less than body requirements; Risk for infection).

   c. Set priorities based on patient and family assessments and needs using theories and/or guidelines (for example: Maslow's hierarchy of needs).

3. Outcome Identification and Planning: Identification of expected outcomes and development of a patient-centered plan of care reflecting nursing interventions that integrate standards of care, protocols, ethics, laws, and regulations.

   a. Create a patient-centered plan to address patient problems; use technology when available and appropriate. Include interventions related to restoration of health, health promotion and maintenance, as well as those directed at palliative care and end of life (for example: variations based on developmental level, culture, religion, and personal preferences/values, patient's medical history influence on antepartum care, consider additional care necessary for those with risk for hypertension due to genetics/ethnicity).

   b. Establish expected outcomes and include a time frame for achievement of the outcome (for example: the patient will state her decision regarding continuation of the pregnancy by 9 weeks gestation; the patient will list three healthy foods to include in her nutritional intake by second antenatal appointment; the patient will keep all of her prenatal appointments; the patient's temperature will be less than 100.4 degrees F/38 degrees C during pregnancy; Fetal heart rate will remain between 110 to 160 beats per minute during pregnancy; the patient will describe safe sexual positions to use during pregnancy).

c. Use established nursing standards, protocols, and evidence-based findings to move the patient towards the expected outcomes (for example: ANA Standards of Professional Nursing Practice, State Nurse Practice Acts, Association of Women's Health, Obstetric, and Neonatal Nurses [AWHONN] Position Statements.

d. Integrate ethical and legal standards (for example: practice in accordance with ANA Code of Ethics, maintain confidentiality, ensure informed consent is obtained, if indicated; recognize ethical dilemmas and advocate for patient preferences regarding abortion, adoption, and adolescent pregnancy; use appropriate interpreters to enhance patient communication and understanding).

4. Implementation: implement the patient plan of care by performing or delegating the interventions that were previously planned. This includes providing care, directing care, collaborating with other members of the health care team, and patient teaching.

   a. Establish a collaborative relationship with the patient and her support system and assist the patient and/or the patient's significant others to cope with the antepartum period (for example: use therapeutic communication skills, assess the patient's use of coping mechanisms, provide culturally competent care, support patient and family when referring to community health agencies, establish reasonable expectations with the patient, help woman voice any concerns about the changes happening to her body to prevent stress or a positive bonding experience, assist with identifying external factors interfering with a safe pregnancy life style that require modification such as the artist who uses lead based paint).

   b. Promote, maintain, or restore the patient's physiological and psychosocial functioning (for example: monitor physiologic changes of the antepartal period; monitor for any potential complications of the antepartal period, help the woman achieve a healthy pregnancy lifestyle [education, screen for danger signs that might reveal a complication is beginning]).

   c. Administer prescribed medications and intravenous therapy (for example: identify contraindications for medication administration including allergies and teratogenic effects of medications, assess pertinent data prior to administration such as lab results, medication reconciliation of any medications taken due to a preexisting condition, modifications in current and new medications related to the patient's pregnancy and gestation, calculate dosage for medication administration, calculate drip rates for intravenous for magnesium sulfate, administer terbutaline sulfate, monitor patient's response to administration of medications such as therapeutic, adverse, side effects, use an infusion pump to administer total parenteral nutrition and high alert medications such as magnesium sulfate, have calcium gluconate available if needed, document administered medications in the Electronic Medical Record [EMR]).

   d. Educate patient and family about the antepartum period and a safe pregnancy lifestyle. Consider health literacy of patient/family when providing education including educational materials. Incorporate medication regimens, procedures, treatments, and diagnostic tests. Include information on how therapy for a preexisting condition may need to be modified to adjust to pregnancy. Consider cultural considerations related to

antepartum period (for example: health promotion during pregnancy, fetal development [milestones, awareness of teratogens]; medications for fetal development [folic acid and prenatal vitamins]; managing minor changes associated with each trimester of pregnancy [pharmacologic and non-pharmacologic]; nutrition [relationship to fetal health; components of healthy nutrition for the pregnant woman; foods to avoid or limit; women with unique nutritional needs: adolescent; women planning to breastfeed; overweight; underweight; woman who has had bariatric surgery; woman with multiple pregnancy]).

e. Promote continuity of care (for example: conduct patient/family education, act as a patient advocate, recognize RN leadership role, identify the need for referrals [nutrition if patient has hyperemesis gravidarum or lactose intolerance, pharmacy for medication reconciliation of any medication being taken for a preexisting condition] and follow through with obtaining required orders, collaborate with members of the inter-professional health care team, discharge planning [working with case manager to identify home care needs such as a patient with a PICC line for hyperemesis gravidarum]; identify community resources with patient such as support groups, shelters, clinics, childbirth education classes, breastfeeding classes, sibling classes).

f. Assign, supervise, and communicate patient care needs to members of the nursing care team: RN, LPN/LVN, unlicensed assistive personnel [UAP] (for example: use the principles of delegation to make decisions regarding assignments for a patient or for a group of patients; communicate changes in a patient(s) condition without delay; evaluate effectiveness of patient care provided by other members of the health care team, determine if the unlicensed assistive personnel measured the intake and output of the patient with hyperemesis gravidarum, determine whether the unlicensed assistive personnel reported patient's condition as instructed, use standardized tools for hand-off communication (Situation, Background, Assessment and Recommendation [SBAR]).

5. Evaluation – evaluation of the plan of care. Determine whether the expected patient outcomes were achieved.

   a. Evaluate patient response to attainment of the expected outcomes (for example: the patient was able to list three healthy foods to include in her nutritional intake, the patient kept all of her prenatal appointments, the patient's temperature remained less than 100.4 degrees F/38 degrees C during pregnancy, the fetal heart rate remained between 110 to 160 beats per minute during pregnancy, the patient described safe sexual positions to use during pregnancy).

b. Revise the patient's plan of care based on new or additional patient data (for example: increase the frequency of assessment for the patient who has bleeding during pregnancy, perform strict intake and output on the patient who vomits following any intake, provide more information to the patient with a preexisting condition who does not make changes in her medication regime as directed by her health care provider, reassign members of the health care team when there is a change in the patient's condition).

c. Consider areas for quality improvement (for example: use evidence based findings to improve performance such as QSEN competencies, evaluate the process for addressing errors and actions taken to prevent future errors, evaluate the adequacy of policies and procedures, campaign by AWHONN to encourage pregnant women to stay pregnant until 40 weeks of gestation).

TEST YOUR KNOWLEDGE

Which members of the interprofessional team would be appropriate to include when managing a complication of pregnancy, such as preterm labor, a positive Maternal serum alpha fetoprotein, gestational diabetes, history of depression? (Professional Identity)

Which nursing diagnoses might be appropriate when planning care for each of the conditions listed above? (Nursing Judgment)

What topics would you include when planning education for a woman in the first trimester; second trimester or third trimester? (Nursing Judgment)

III. Intrapartal Care

20 PERCENT OF EXAM

In this section you are responsible for studying:

- Intrapartum care of the mother
- Intrapartum assessment of fetal well being
- Potential sudden third trimester placenta complications
- Potential complications to the mother during Intrapartum
- Potential complications to the fetus during Intrapartum
- The application of the nursing process (section B) to the patient and family during the intrapartum period (Section A)

REQUIRED READINGS:

Burchum, J. R., & Rosenthal, L.D. (2019). *Lehne's pharmacology for nursing care* (10th ed.)

Chapter 47: Drugs for Hypertension (Sections on "Drugs for Hypertensive Disorders of Pregnancy")

Chapter 64: Drugs That Affect Uterine Function (Beginning of chapter until section on "Drugs for Postpartum Hemorrhage")

Ladwig, G., Ackley, B., & Makic, M. B. F. (2020). *Mosby's guide to nursing diagnosis* (6th ed.)

Use Mosby's Guide to Nursing Diagnosis 6th edition to review the nursing diagnoses specific to the content covered in this content area.

Silbert-Flagg, J., & Pillitteri, A. (2018). *Maternal and child health nursing: Care of the childbearing and childrearing family* (8th ed.)

Chapter 15: Nursing Care of a Family During Labor and Birth

Chapter 16: The Nursing Role in Providing Comfort During Labor and Birth

Chapter 21: Nursing Care of a Family Experiencing a Sudden Pregnancy Complication (sections on placenta previa and premature separation of the placenta)

Chapter 23: Nursing Care of a Family Experiencing a Complication of Labor or Birth

Chapter 24: Nursing Care of a Family During a Surgical Intervention for Birth

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A. Concepts related to intrapartal care

1. Maternal
    a. The labor process (for example: signs and symptoms, uterine contractions [true versus false labor], cervical changes, rupture of amniotic membrane, stages and phases of labor).
    b. Maternal responses to labor (for example: physiological [cardiovascular, hematopoietic, respiratory, urinary, musculoskeletal, and neurologic systems]; psychological [for example: pain, fatigue, fear]).
    c. Cesarean birth (for example: elective, scheduled, emergent, vaginal birth after cesarean [VBAC]).
    d. Potential complications or collaborative problems (for example: dysfunctional labor such as ineffective uterine force, prolonged and/or arrest of labor progress, prolapsed cord, precipitate labor, uterine rupture, uterine inversion, amniotic fluid embolism, placenta accreta, third trimester placenta complications).
    e. Treatment modalities
        1) Induction and/or augmentation of labor (for example: indications, Bishop Score).
        2) Procedures associated with vaginal births (for example: amniotomy, episiotomy, instrument assisted vaginal birth, external cephalic version).
        3) Non Pharmacologic labor support (for example: variations in labor and birthing positions, complementary and/or alternative therapies such as focused breathing and muscle relaxation, aroma therapy, hydrotherapy, massage).
        4) Pharmacologic labor support (for example: analgesics, antiemetics, anesthesia [general vs. regional], oxytocics, prostaglandins, tocolytics, magnesium sulfate nitrous oxide).
2. Fetal
    a. The labor process (for example: position and presentation of the fetus, cardinal movements of labor, engagement, station).
    b. Fetal responses to labor (for example: neurologic, cardiovascular, respiratory, integumentary systems).
    c. Potential complications or collaborative problems (for example: umbilical cord prolapse, fetal malpresentation, shoulder dystocia, cephalopelvic disproportion [CPD]).

B. Management of patient care: apply the nursing process to make nursing judgments, substantiated with evidence, to provide safe, quality patient care to the maternal/fetal dyad during the intrapartum period.

1. Assessment: collection of comprehensive patient-centered data to be used as the basis for identifying maternal/fetal needs.

a. Conduct a patient-centered antenatal health history including maternal response to the pregnancy (for example: consider age, developmental level, multiple gestation, gravida, parity, estimated date of birth, previous birth experience, cultural preferences, presence of support system, and child birth preparation, plan and expectations, use of recreational, herbal supplements and prescription drugs, morbid obesity).

b. Conduct a maternal/fetal assessment (for example: uterine contractions [start of regular contractions, duration, frequency and strength], bloody show, rupture of amniotic membranes, level of pain, phase of labor, Leopold maneuvers, cervical dilation, station, engagement, fetal heart rate pattern [baseline, variability, periodic changes]).

c. Assess for presence of potential complication (for example: unfavorable changes in fetal heart rate/pattern, hypertonic or hypotonic uterine contractions, prolonged second stage of labor, hemorrhage, maternal fever, sudden sharp abdominal pain, maternal dyspnea, precipitate labor, anomalies of the placenta and/or umbilical cord).

    1) Assess the patient and her support person for readiness for teaching and learning (for example: identify barriers to learning, learning preferences, verify understanding of the labor/birth process and anticipated procedures & comfort measures).

    2) Review laboratory and other diagnostic data. Recognize critical values and when to collaborate with appropriate members of the health care team (for example: maternal blood type and Rh sensitivity, outcome of sexually transmitted infections [STIs], Group B Streptococcus screenings, lecithin/sphingomyelin(L/S) ratio, urinalysis, CBC, liver enzymes, platelet count, serum glucose levels, estimated gestational age of neonate, review of electronic fetal heart rate monitoring).

2. Diagnosis: identification and prioritization of patient problems labeled as nursing diagnoses and based on analysis of comprehensive assessment.

    a. Nursing diagnoses are derived from the nursing assessment data; nursing diagnoses are revised as new and/or additional assessment data becomes available; nursing diagnoses are prioritized based on assessment data.

    b. Analyze and synthesize data for maternal/fetal dyad patterns and cues to identify nursing diagnoses using NANDA-I classification system (for example: Anxiety, Fear, Acute Pain, Powerlessness, Risk for Injury, Risk for Fluid Volume Deficit, Deficient Knowledge, Risk for Infection, Ineffective Breathing Pattern).

    c. Set priorities based on patient assessment and needs of the maternal/fetal dyad, using theories and/or guidelines (for example: Maslow's hierarchy of needs).

3. Outcome Identification and Planning: identification of expected outcomes and development of a patient-centered plan of care reflecting nursing interventions that integrate standards of care, protocols, ethics, laws, and regulations.

a. In collaboration with the patient or patient's family, create a patient-centered plan of care to address the identified patient problems. Use technology when available and appropriate, such as electronic fetal monitoring. Include interventions related to health promotion and maintenance, physiological adaptation, reduction of risk potential as well as those directed at basic care and comfort (for example: provide non pharmacological comfort measures during labor, perform continuous fetal heart rate monitoring, monitor hourly urinary output).

b. Establish patient-centered expected outcomes that include a time frame for achievement of the outcome (for example: the patient will verbalize that the level of pain during a contraction is manageable during the active phase of labor, the fetus will maintain a fetal heart rate with moderate variability during the intrapartum period).

c. Use established nursing standards, protocols, and evidenced-based findings to move the patient toward the achievement of the expected outcome (for example: ANA standards of Professional Nursing Practice; Association of Women's Health, Obstetric, and Neonatal Nurses [AWHONN]; Quality & Safety Education Nurses [QSEN]; standards for delegating nursing care to unlicensed assistive personnel).

d. Integrate ethical and legal standards (for example: practice in accordance with ANA Code of Ethics; practice within legal scope of practice; practice in compliance with AWHONN position statements.

4. Implementation: implement the patient plan of care by performing or delegating the nursing interventions that were previously planned. This includes providing care and collaborating with other members of the health care team.

    a. Establish a collaborative relationship with the patient by assisting her to cope and maintain comfort throughout the intrapartum period and recognize variations based on presence or absence of support person(s) (for example: use therapeutic communication skills; provide culturally competent care; discuss whether components of birth plan are realistic and safe for maternal/fetal dyad).

    b. Promote, maintain, or restore the patient's physiologic and psychosocial changes during the intrapartum period.

        1) Maternal (for example: encourage ambulation and position changes that promote fetal descent; monitor uterine contractions and cervical change; assess maternal physical and emotional responses to labor; assess vital signs and level of pain, assess uterine tone with and without a contraction, promote patient comfort through non pharmacological and/or pharmacological support, consider how the RN will respond to dysfunctional labor patterns, provide pre-operative and intra-operative care when a Cesarean birth is necessary).

        2) Fetus (for example: assess fetal responses to labor, episodic or continuous external fetal heart rate monitoring, internal fetal heart rate monitoring, consider how the RN will respond to non-reassuring fetal heart rate patterns).

c. Administer prescribed medications and intravenous therapy (for example: monitor maternal/fetal dyad reaction to prescribed medication administered, accurately calculate drug dosage, accurately calculate and regulate IV therapy administration via an infusion control device, be aware of high alert medications such as IV magnesium sulfate or oxytocin, titrate dose of intravenous oxytocin based on maternal contraction pattern according to physician's orders, have calcium gluconate available if needed).

d. Educate patient and support person about what to expect during the intrapartum period. Consider health literacy of patient/support person when providing educational materials. Incorporate medication regimens, procedures, treatments, and diagnostic tests. Include information on how therapy for a preexisting condition may need to be modified to adjust to the labor and birth process. Consider cultural preferences related to intrapartum care (for example: pros and cons of the various pharmacological and non pharmacological pain relief measures, external fetal monitoring versus internal fetal monitoring, pre operative education when a Cesarean birth is necessary, maternal position changes to promote maternal fetal circulation and/or fetal descent, IV access and insertion of Foley catheter).

e. Promote continuity of care (for example: provide education; act as a patient advocate; recognize RN leadership role, identify the need for spiritual support, consider the laboring patient with no support person, consider the laboring patient with a plan for open adoption of her newborn).

f. Collaborate with nursing and interprofessional teams and communicate maternal/fetal dyad care needs to members of the nursing care team including the RN, neonatal care unit, respiratory therapy, anesthesia (for example: assess maternal and fetal wellbeing during administration of an epidural by the anesthesia care provider, alert neonatal nursing staff of impending birth of preterm infant, alert respiratory therapist of a newborn requiring neonatal resuscitation).

5. Evaluation: evaluation of the plan of care. Determine whether the expected patient outcomes were achieved.

   a. Evaluate patient response to achievement of the expected outcome (for example: mother stated that the pain during her contraction was not manageable using patterned breathing techniques; fetus maintained moderate FHR variability during intrapartum).

   b. Revise the patient's plan of care based on new or additional patient data (for example: introduce alternate pain relief measure, such as hydrotherapy, when patient states pain not manageable during contractions, change from episodic assessment of fetal heart rate to continuous electronic FHR monitoring when collected data shows a non-reassuring fetal heart rate).

   c. Consider areas for quality improvement (for example: use evidence-based findings to improve performance, such as QSEN competencies, evaluate the process for addressing errors and actions taken to prevent future errors, review adequacy of policy regarding the manner in which a birth plan is shared with nursing staff, incorporate recommendations from AWHONN Position Statements).

TEST YOUR KNOWLEDGE

What is your viewpoint on written birth plans? (Patient-Centered Care)

Does an expectant mother have the right to refuse electronic fetal monitoring during labor? What alternative are available? (Professional Identity)

What are the risks and benefits of pharmacologic pain relief in labor? (Nursing Judgment)

IV. Postpartal Care

20 PERCENT OF EXAM

In this section you are responsible for studying:

- Postpartum care of the mother
- Postpartum care of the newborn
- Potential complications to the mother in the postpartum period
- Potential complications to the newborn in the postpartum period
- The application the nursing process (Section B) to the patient and family during the postpartal period (Section A).

REQUIRED READINGS:

Burchum, J. R., & Rosenthal, L.D. (2019). *Lehne's pharmacology for nursing care* (10th ed.)

Chapter 64: Drugs That Affect Uterine Function (Section on "Drugs for Postpartum Hemorrhage")

Chapter 107: Additional Noteworthy Drugs (Sections on Drugs for Neonatal Respiratory Distress Syndrome)

Ladwig, G., Ackley, B., & Makic, M. B. F. (2020). *Mosby's guide to nursing diagnosis* (6th ed.)

Use Mosby's Guide to Nursing Diagnosis 6th edition to review the nursing diagnoses specific to the content covered in this content area.

Silbert-Flagg, J., & Pillitteri, A. (2018). *Maternal and child health nursing: Care of the childbearing and childrearing family* (8th ed.)

Chapter 17: Nursing Care of a Postpartal Family

Chapter 18: Nursing Care of a Family With a Newborn

Chapter 19: Nutritional Needs of a Newborn

Chapter 24: Nursing Care of a Family During a Surgical Intervention for Birth (Sections on "Postpartal Care Measures" through end of chapter)

Chapter 25: Nursing Care of a Family Experiencing a Postpartum Complication

Chapter 26: Nursing Care of a Family With a High-Risk Newborn

Chapter 48: Nursing Care of a Family when a Child has an Endocrine or a Metabolic Disorder (Sections on "Metabolic Disorders Inborn Errors of Metabolism")

WEB-BASED AND PROFESSIONAL JOURNAL RESOURCES

Click this link to access web-based and professional journal resources through the Excelsior College Library.

Articles found in the Excelsior College Library will require you to sign in to your MyExcelsior account.

A. Concepts related to postpartal care

1. Maternal
   a. Physiologic changes (for example: uterine involution, breast changes, body system changes).
   b. Psychosocial changes (for example: behavioral adjustment: phases of puerperium, role changes, attachment).
   c. Complications or collaborative problems (for example: hemorrhage, lacerations, mastitis, puerperal infections, thrombophlebitis, urinary system disorders, cardiovascular system disorders, psychologic disorders).
   d. Treatment modalities (for example: oxytoxics, prostaglandins, antibiotics, anticoagulants, anticonvulsants, blood transfusions).
2. Newborn
   a. Transition to extrauterine life (for example: body system adaptations, thermoregulation).
   b. Nutritional needs of the newborn (for example: breastfeeding vs. formula feeding).

c. Complications or collaborative problems (for example: preterm birth, large for gestational age, small for gestational age, respiratory distress syndrome, transient tachypnea of the newborn, hemolytic disease of the newborn, hypothermia, hypoglycemia, Group B Streptococcus, neonatal abstinence syndrome, fetal alcohol spectrum disorder, sudden infant death syndrome [SIDS]).

B. Management of patient care: apply the nursing process to make nursing judgments, substantiated with evidence, to provide safe, quality patient care during the postpartal period.

1. Assessment: collection of comprehensive patient-centered data to be used as the basis for identifying patient needs.

a. Conduct a patient-centered health history including patient's response to care delivery (for example: consider age, developmental level, life style choices, high risk behaviors, patient preferences, values, personal needs, ask about subjective symptoms, nutritional status, past illnesses, family history, allergies, current and past obstetrical history [noting any issues with previous pregnancies or deliveries, parity, multiple gestation, prolonged labor, rupture of membranes]; availability of support systems, newborn feeding choice, history of depression).

b. Conduct maternal and newborn assessment related to the postpartum period (for example: consider necessary assessments related to type of delivery [vaginal vs. cesarean birth]; mother's reaction to baby at birth [excited, disappointed, talkative]; mother's ability to begin infant and self-care [wants to change diaper or depends on caregiver to provide for care of the newborn]; maternal newborn bonding [interaction with newborn - does mother hold and talk to infant?]).

1) Mother: (for example: uterus assessment, lochia characteristics, perineum, breasts, voiding following delivery, vital signs, cesarean birth, if applicable).

2) Newborn: (for example) vital signs, number of cord vessels, Apgar score, pulse oximetry, cardiopulmonary status [consider differences associated with vaginal births and cesarean births]; thermoregulation, full body systems, newborn measurements, periods of alertness, gestational age assessment).

c. Assess for presence of potential complications:

1) Mother: (for example: post partum hemorrhage, puerperal infections, disseminated intravascular coagulation[DIC], thrombophlebitis, mastitis, urinary system disorders, gestational hypertension, emotional and psychological complications).

2) Newborn: (for example: difficulty maintaining temperature, respiratory distress syndrome, transient tachypnea of the newborn, meconium aspiration syndrome, hemolytic disease in the newborn, Group B Streptococcal infection, opthalmia neonatorum, hypoglycemia, neonatal abstinence syndrome, newborn with fetal alcohol exposure).

d. Assess the patient's and significant other's readiness for teaching and learning (for example: determine barriers to learning, learning preferences, health literacy, verify patient's understanding of the postpartum period along with the diagnostic tests and procedures [metabolic screening tests]; self-care, newborn care, and breast feeding).

e. Review laboratory and other diagnostic data. Recognize critical values and when to collaborate with appropriate members of the health care team.

1) Mother (for example: confirm typical antepartum results and alert health care provider if unavailable or not completed [blood type, Rh status, Group B Streptococcus status, rubella titer, complete blood count [CBC], coagulation, if indicated, consider additional diagnostic tests that may be indicated (for example: culture results, doppler ultrasound, contrast venograph, clean catch urine specimen, arterial blood gases, plasma glucose levels).

2) Newborn (for example: hearing screening, metabolic screening tests, consider additional diagnostic tests that may be indicated such as bilirubin level, chest x-ray, GBS blood culture, Coombs Test, glucose screening).

2. Diagnosis: identification and prioritization of patient problems, labeled as nursing diagnoses, based on analysis of comprehensive assessment.

a. Nursing diagnoses are derived from the nursing assessment data; nursing diagnoses are revised as new and/or additional assessment data becomes available; nursing diagnoses are prioritized based on assessment data.

b. Analyze and synthesize data for patterns and cues to identify nursing diagnoses using NANDA-I classification system (for example: Deficient Fluid Volume, Risk for Infection, Disturbed Sleep Pattern, Imbalanced Nutrition: Less Than Body Requirements, Acute Pain, Risk for Impaired Parenting, Anxiety, Ineffective Breastfeeding, Risk For Ineffective Airway Clearance, Impaired Gas Exchange, Neonatal Jaundice, Ineffective Thermoregulation).

c. Set priorities based on assessments and needs of the patient and family using theories and/or guidelines (for example: Maslow's hierarchy of needs).

3. Outcome Identification and Planning: identification of expected outcomes and development of a patient-centered plan of care reflecting nursing interventions that integrate standards of care, protocols, ethics, laws, and regulations.

a. Create a patient-centered plan to address patient problems, use technology when available and appropriate, include interventions related to restoration of health, health promotion, and maintenance, as well as those directed at palliative care and end of life (for example: variations based on developmental level, culture, and personal preferences/ values, patient's medical history, influence on postpartum care, consider how maternal health and lifestyle affects health of the newborn [smoking]).

b. Establish expected outcomes and include a time frame for achievement of the outcome (for example: the patient will have lochia flow of less than one saturated peri pad per hour within 24 hours of birth, the patient's oral temperature will be 100.4 degrees F/38 degrees C or lower during the postpartum period, the breastfeeding mother verbalizes reason for increasing daily caloric intake before discharge, the patient will voice two positive characteristics of the newborn by the second day of life, the newborn will have clear breath sounds 1 hour following birth, the newborn will have an axillary temperature of 98.6 degrees F/37 degreee C one hour after birth, the newborn's cord will be dry and free of erythema one day following birth).

c. Use established nursing standards, protocols, and evidence-based findings to move the patient towards the expected outcomes (for example: ANA Standards of Professional Nursing Practice; State Nurse Practice Acts, The UNICEF/WHO Global Criteria for the Baby-Friendly Hospital Initiative, Association of Women's Health, Obstetric, and Neonatal Nurses [AWHONN] Position Statements.

d. Integrate ethical and legal standards (for example: practice in accordance with ANA Code of Ethics, maintain confidentiality; ensure informed consent is obtained when indicated, recognize ethical dilemmas and advocate for patient wishes[tubal ligation, breastfeeding in public places, circumcision, adoption]; use appropriate interpreters to enhance patient communication and understanding, nurses' role in legal mandates, mother who may refuse mandated treatments [Vitamin K injection for newborn]).

4. Implementation: implementation of the patient plan of care by performing or delegating the interventions that were previously planned. This includes providing care, directing care, collaborating with other members of the health care team, and patient teaching. Encourage mother baby care to promote bonding.

   a. Establish a collaborative relationship with the patient and her support system and assist the patient and/or the patient's significant others to cope with the postpartum period (for example: interventions needed to enhance family functioning, bonding, and increasing the woman's self-esteem; assess the family's movement through the phases of the puerperium and the development of bonding and positive family relationships; bereavement care following infant death; modify nursing care to demonstrate respect of cultural diversity, support patient and family when referring to community health agencies, establish reasonable expectations with the patient, Identify external factors interfering with the patient's recovery-stressors, for example the inability to work, ability to afford medications and maintain the therapeutic regime, increase in family size and change in family relationships and roles).

b. Promote, maintain, or restore the patient's physiological and/or psychosocial functioning during the postpartal period.

   1) Mother (for example: monitor physiologic changes of the postpartal period [monitor uterus, lochia, perineum, breasts, elimination, peripheral circulation, emotional status]; promote optimal health of the mother [caloric and fluid intake requirements and foods to avoid when breast feeding, avoidance of fatigue]; provide post–operative care for a woman following cesarean birth, provide pain/comfort management, monitor for any postpartum complications).

   2) Newborn (for example: monitor the newborn's transition to extrauterine life, encourage skin to skin contact, perform newborn identification and incorporate measures to provide a safe environment [reduce risk of infant abduction, place newborn on back to sleep, provide information on car seat safety]; provide circumcision care, if indicated, provide pain/comfort management, monitor phototherapy, if indicated, monitor for any newborn complications, perform neonatal resuscitation, if indicated).

c. Administer prescribed medications and intravenous therapy (for example: identify contraindications for medication administration including allergies and the use of medications in relation to breast feeding [antibiotics, pain medications]; assess pertinent data prior to administration such as lab results, modifications related to the patient's age, calculate dosage for medication administration, be aware of high alert medications (IV oxytocin, magnesium sulfate), administer medications for mother [carboprost tromethamine (Hemabate), methylergonovine maleate (Methergine), Misoprostol (Cytotec); Rubella vaccine (if needed), Rho (D) Immune Globulin (when indicated)]; calculate drip rates for intravenous infusions for oxytocin, magnesium sulfate, calculate drug dosages for newborn according to body weight, administer medications to newborn [Vitamin K, Hepatitis B vaccination, Erythromycin ophthalmic ointment]; assist with administration of surfactant, monitor patient's response to administration of medications such as therapeutic, adverse, side effects, assess and monitor intravenous therapy and maintenance of insertion site for peripheral lines, use an infusion pump to administer oxytocin and magnesium sulfate to mother, use an infusion pump to administer IV medications to newborn [antibiotics]; document administered medications in the electronic medical record [EMR]).

d. Educate patient about self–and newborn–care to prepare the patient and family for discharge. Consider health literacy of patient/family when providing education including educational materials. Incorporate medication regimens, procedures, treatments, and diagnostic tests (for example: education for infant feeding, limitations [heavy lifting, importance of rest, exercise]; personal hygiene [tub baths vs. showers]; resumption of sexual activity, contraception, returning to work, infant care [cord care, circumcision care]; car seat safety, shaken baby information, place newborn on back to sleep [SIDS], when to call the health care provider for herself and the newborn).

e. Promote continuity of care (for example: conduct patient/family education, act as a patient advocate, recognize RN leadership role, identify the need for referrals [registered dietician referral based on metabolic screening results, audiology referral based on newborn hearing screening results, lactation consultant for breast feeding mother]; follow through with obtaining required orders, collaborate with members of the inter-professional health care team, woman and family with unique postpartal care needs [child is born with illness or physical challenge, newborn has died, adoption]; consider spiritual care, discharge planning [working with case manager to identify home care needs [assistance with wound care following cesarean birth, referral to Women, Infants and Children (WIC) for nutritional support for low income women and children]; identify community resources with patient such as support groups [breastfeeding support, postpartum depression]; shelters, clinics, assess whether parents/caregivers require follow up care for newborn or self at home).

f. Assign, supervise, and communicate patient care needs to members of the nursing care team: RN, LPN/LVN, unlicensed assistive personnel [UAP] (for example: use the principles of delegation to make decisions regarding assignments for a patient or for a group of patients, communicate changes in a patient's condition without delay, evaluate effectiveness of patient care provided by other members of the health care team [did the unlicensed/assistive personnel weigh the diapers for output if needed, determine whether the unlicensed assistive personnel reported patient's condition as instructed]).

5. Evaluation: evaluation of the plan of care. Determine whether the expected patient outcomes were achieved.

   a. Evaluate patient response to achievement of the expected outcome(s) (for example: the newborn's respiratory rate remained between 30-60 breaths per minute, the newborn voided within the first 24 hours following birth, the mother saturated less than 1 peri pad per hour, the mother's abdominal incision remained without redness and drainage, the newborn was able to "latch on" correctly, the mother was able to correctly demonstrate a newborn bath).

   b. Revise the patient's plan of care based on new or additional patient data (for example: increase the frequency of assessment for the patient who has a boggy fundus and/or increased vaginal flow, increase frequency of assessment for the newborn who has retractions, collaborate with lactation consultant when the mother experiences difficulty with breast feeding, reassign members of the health care team when there is a change in the patient's condition).

   c. Consider areas for quality improvement (for example: use evidence based findings to improve performance such as QSEN competencies, evaluate the process for addressing errors and actions taken to prevent future errors, explore whether policies to promote infant bonding are successful, perform drills to improve the readiness for and response to postpartum hemorrhage).

TEST YOUR KNOWLEDGE

What is the Baby-Friendly Hospital Initiative and how does it relate to the Healthy People 2020 goal of increasing exclusive breastfeeding? (Spirit of Inquiry)

How would you educate yourself to provide culturally sensitive care to the mother-baby dyad? (Patient-Centered Care)

How would you evaluate the effectiveness of education for the family who is being discharged home with a normal newborn? (Nursing Judgment)

V. Congenital Anomalies, Genetic Disorders, and Developmental Challenges

20 PERCENT OF EXAM

In this section you are responsible for studying:

- Genetic assessment and counseling
- Nursing care of the child with:
  - a congenital cardiovascular disorder.
  - a physical or developmental challenge.
  - respiratory disorders.
  - hematologic disorders.
  - gastrointestinal disorders.
  - renal or urinary tract disorders.
  - musculoskeletal disorders.
- The application of the nursing process (Section B) to the patient care associated with health disorders identified in this content area (Section A).

REQUIRED READINGS:

Ladwig, G., Ackley, B., & Makic, M. B. F. (2010). *Mosby's guide to nursing diagnosis* (6th ed.)

Use Mosby's Guide to Nursing Diagnosis 6th edition to review the nursing diagnoses specific to the content covered in this content area.

Silbert-Flagg, J., & Pillitteri, A. (2018). *Maternal and child health nursing: Care of the childbearing and childrearing family* (8th ed.)

Chapter 8: The Nursing Role in Genetic Assessment and Counseling

Chapter 27: Nursing Care of the Child Born With a Physical or Developmental Challenge

Chapter 36: Nursing Care of a Family With an Ill Child (Beginning of chapter until section on "Discharge Planning")

Chapter 40: Nursing Care of a Family When a Child Has a Respiratory Disorder (beginning of chapter until section on "Laboratory Tests," section on "Choanal Atresia," "Bronchopulmonary dysplasia" and sections on "Cystic Fibrosis")

Chapter 41: Nursing Care of a Family When a Child Has a Cardiovascular Disorder (beginning of chapter until section on "Diagnostic Tests," sections on "Congenital Heart Disorders" until section on "Cardiac Surgery")

Chapter 44: Nursing Care of a Family When a Child Has a Hematologic Disorder (sections on "Hemophilias")

Chapter 45: Nursing Care of a Family When a Child Has a Gastrointestinal Disorder (beginning of chapter until section on "Diarrhea," sections on "Pyloric Stenosis," sections on "Obstruction of the Bile Ducts", sections on "Intussusception" through sections on "Necrotizing Enterocolitis," Sections on "Hirschsprung Disease")

Chapter 46: Nursing Care of a Family When a Child Has a Renal or Urinary Tract Disorder (sections on "Structural Abnormalities of the Urinary Tract")

Chapter 49: Nursing Care of a Family When a Child Has a Neurologic Disorder (beginning of chapter until section on "Diagnostic Testing," Sections on "Cerebral Palsy," and sections on "Group B Streptococcal Infection")

Chapter 51: Nursing Care of a Family When a Child Has a Musculoskeletal Disorder (sections on "The Muscular Dystrophies")

WEB-BASED AND PROFESSIONAL JOURNAL RESOURCES

Click this link to access web-based and professional journal resources through the Excelsior College Library.

Articles found in the Excelsior College Library will require you to sign in to your MyExcelsior account.

A. Concepts related to genetic disorders, congenital anomalies, and developmental challenges

1. Genetic disorders

a. Nature of inheritance and terminology associated with inheritance (for example: genes, chromosomes, autosomal, dominant, recessive, X-linked, Y-linked, translocation).

b. Selected genetic diseases (for example: muscular dystrophy, cystic fibrosis, hemophilia A, Turner syndrome, Down syndrome [Trisomy 21], phenylketonuria [PKU]).

2. Congenital anomalies: Systemic specific disorders (for example: heart disorders, neurologic disorders [cerebral palsy, meningitis from Group B Streptococcal infection]; respiratory [choanal atresia, bronchopulmonary dysplasia, gastrointestinal [pyloric stenosis, intussusception, necrotizing enterocolitis]; renal or urinary tract [exstrophy of the bladder, hypospadias, epispadias]).

a. Physical and/or developmental challenges. Systemic specific disorders (for example: skeletal system [absent or malformed extremities, torticollis, talipes disorders, developmental hip dysplasia]; gastrointestinal system [cleft lip, cleft palate, Pierre Robin syndrome, esophageal atresia, tracheoesophageal fistula, abdominal wall defects, meconium plug syndrome, diaphragmatic hernia, imperforate anus]; nervous system [hydrocephalus, neural tube defects]).

b. Complications or collaborative problems (for example: pneumonia, congestive heart failure, infection, dehydration).

c. Treatment modalities (for example: surgery, casting, physical therapy, medications).

B. Management of patient care: apply the nursing process to make nursing judgments, substantiated with evidence, to provide safe, quality patient care across the life span.

1. Assessment: collection of comprehensive patient-centered data to be used as the basis for identifying patient needs.

a. Conduct a patient-centered health history including the patient's and family's response to the health issue (for example: gestational age at time of delivery, pattern of inheritance in family, consider whether patient meets developmental level for chronologic age, patient preferences, values of the family, personal needs of the family, subjective symptoms, nutritional status, past illnesses, family history, allergies, availability of support systems, consider what is meant by the caretaker's description of the signs and symptoms [differentiate between "spitting up" and projectile vomiting]).

b. Conduct focused assessment related to signs and symptoms of health issue. Consider that assessment findings vary depending on the body system disorder (for example: cardiovascular, neurological disorders, respiratory, hematologic, gastrointestinal, nutritional status [issues with newborn feeding, inability to suck, cleft palate, cleft lip]; genitourinary, musculoskeletal, characteristics associated with genetic disorders [simian crease for Down syndrome, absence of secondary sex characteristics for Turner syndrome]).

c. Assess for presence of potential complications (for example: dehydration, congestive heart failure, meningitis from Group B Streptococcus, disuse syndrome from spasticity of muscle groups, nutrition issues, pneumonia).

d. Assess the family's readiness for teaching and learning (for example: determine barriers to learning, learning preferences, verify patient's/family's understanding of the disease along with the diagnostic tests and procedures used in conjunction with the disease, assess change in family dynamics as a result of child with a health issue).

e. Review laboratory and other diagnostic data. Recognize critical values and when to collaborate with appropriate members of the health care team (for example: echocardiogram and chest x-ray; sweat chloride test, pulse oximetry, pulmonary function test, stool analysis, liver enzymes, partial thromboplastin time (PTT); occult blood in stool).

2. Diagnosis: identification and prioritization of patient problems, labeled as nursing diagnoses, based on analysis of comprehensive assessment.

   a. Nursing diagnoses are derived from the nursing assessment data; nursing diagnoses are revised as new and/or additional assessment data becomes available; nursing diagnoses are prioritized based assessment data.

   b. Analyze and synthesize data for patterns and cues to identify nursing diagnoses using NANDA-I classification system (for example: Risk for Imbalanced Nutrition: Less than Body Requirements, Ineffective Airway Clearance, Deficient Knowledge (parents), Risk for Compromised Family Coping, Acute Pain, Ineffective Peripheral Tissue Perfusion, Risk for Delayed Development, Decreased Cardiac Output, Impaired Physical Mobility).

   c. Set priorities based on patient and family assessments and needs using theories and/or guidelines (for example: Maslow's hierarchy of needs).

3. Outcome Identification and Planning: identification of expected outcomes and development of a patient-centered plan of care reflecting nursing interventions that integrate standards of care, protocols, ethics, laws, and regulations.

   a. Create a patient-centered plan to address patient problems, use technology when available and appropriate. Include interventions related to restoration of health, health promotion, and maintenance, as well as those directed at palliative care and end of life (for example: variations based on developmental level, culture, religion and personal preferences/values, patient's medical history influence on disorder).

   b. Establish expected outcomes and include a time frame for achievement of the outcome (for example: the patient will score a 2 or less on FACES Pain Scale during hospitalization, the patient will have clear breath sounds in upper and lower lobes bilaterally following chest physiotherapy, the patient will maintain a 10 percent or higher weight on growth chart for 3 months, the parent will demonstrate passive range of motion exercises on child by end of teaching session).

   c. Use established nursing standards, protocols, and evidence-based findings to move the patient towards the expected outcomes (for example: ANA Standards of Professional Nursing Practice, State Nurse Practice Acts, Centers for Disease Control and Prevention [CDC] guidelines for hand hygiene, Joint Commission National Patient Safety Goals to improve the safety of using medications).

d. Integrate ethical and legal standards (for example: practice in accordance with ANA Code of Ethics, maintain confidentiality, recognize ethical dilemmas and advocate for patient/family wishes, use appropriate interpreters to enhance patient communication and understanding recognize variations in family structure when identifying primary caregiver of child, identify who has legal authority to sign medical permission, make informed decisions related to genetic testing).

4. Implementation: implementation of the patient plan of care by performing or delegating the interventions that were previously planned. This includes providing care, directing care, collaborating with other members of the health care team, and patient teaching.

   a. Establish a collaborative relationship with the patient and family and assist in coping with the health issue (for example: use therapeutic communication skills, assess coping mechanisms, explore cultural beliefs related to cause of child's disorder [myths such as evil eye and eating certain foods], provide culturally competent care, support patient and family when referring to community health agencies, establish reasonable expectations with the patient and family, identify external factors interfering with the patient's recovery-stressors [parent's inability to work, ability to afford medications, maintaining the therapeutic regime, child is cared for by a caregiver from an older generation]).

   b. Promote, maintain, or restore the patient's physiological and psychosocial functioning (for example: have the child perform activities of daily living to maximum ability, establish a rest schedule for the child with a cardiac anomaly without compromising growth and development for the child, perform chest physiotherapy for the child with cystic fibrosis).

   c. Administer prescribed medications and parenteral therapy (for example: identify contraindications for medication administration including allergies, assess pertinent data prior to administration such as lab results, modifications related to the patient's age [use of prefilled syringes specifically designed for pediatric population]; calculate dosage for safe medication administration, calculate drip rates for intravenous medications, calculate drug dosages for children according to body weight, administer water miscible vitamin supplements, diuretics, digoxin, anticonvulsants, synthetic pancreatic enzymes, blood products, monitor patient's response to administration of medications such as therapeutic, adverse, side effects, assess and monitor intravenous insertion therapy and maintenance of insertion site for peripheral and central lines, use an infusion pump to administer medications, document administered medications in the electronic medical record [EMR]).

d. Educate patient and family about management of the health issue. Consider health literacy of patient/family when providing education including educational materials. Incorporate medication regimens, procedures, treatments, and diagnostic tests (for example: educate family on how to maintain a safe home environment, dietary modifications that may be needed [PKU], correct positioning of the child related to the condition [hydrocephalus, neural tube defect]; how to take medications safely at home [digoxin, pancrelipase]; how to use adaptive equipment that may be used with the patient to maintain activities of daily living, how to feed a newborn with a cleft lip and/or cleft palate).

e. Promote continuity of care (for example: conduct patient/family education, act as a patient advocate, recognize RN leadership role, identify the need for referrals [occupational therapy, physical therapy, speech therapy, registered dietician]; follow through with obtaining required orders, collaborate with members of the interprofessional health care team, discharge planning [working with case manager to identify home care needs]; identify community resources with patient such as support groups, shelters, clinics, assess whether parents/caregivers require follow up care for child at home).

f. Assign, supervise, and communicate patient care needs to members of the nursing care team: RN, LPN/LVN, unlicensed assistive personnel [UAP] (for example: use the principles of delegation to make decisions regarding assignments for a patient or for a group of patients, communicate changes in a patient(s) condition without delay, evaluate effectiveness of patient care provided by other members of the health care team, determine whether adaptive devices were applied correctly and consistently, determine whether the unlicensed assistive personnel reported patient's condition as instructed]).

5. Evaluation: evaluation of the plan of care. Determine whether the expected patient outcomes were achieved.

   a. Evaluate patient response to achievement of the expected outcomes (for example: the patient's breath sounds are clear in the upper and lower lobes bilaterally following chest physiotherapy, the patient maintained a 10 percent or higher weight on growth chart for the last 3 months, the parent demonstrates passive range of motion exercises correctly on the child following the teaching session).

   b. Revise the patient's plan of care based on new or additional patient data (for example: increase the frequency of intake and output assessment for the child who is vomiting and losing weight, consult with physical therapy to work with the family of a child who has a new brace for increased mobility, reassign members of the health care team when there is a change in the patient's condition).

c. Consider areas for quality improvement (for example: use evidence-based findings to improve performance such as QSEN competencies, evaluate the process for addressing errors and actions taken to prevent future errors, evaluate adequacy of policies regarding antibiotics for meningitis).

TEST YOUR KNOWLEDGE

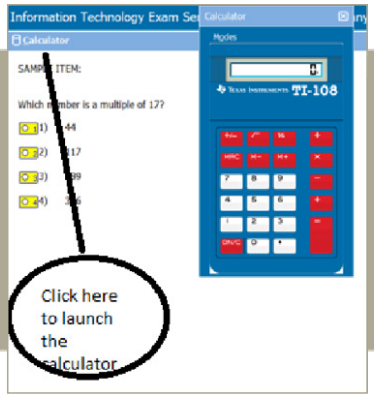
Discuss the differences in the members of the interprofessional team when planning care for a family with a child with a congenital heart disorder and a family with a child with cerebral palsy. Consider how the needs will change as the child becomes older. (Professional Identity)

How would you instruct a caregiver to give oral medication to a newborn? What safety measures must be included? (Nursing Judgment)

How would you include the cultural norms of the family in planning care for a child with a developmental challenge? (Patient-Centered Care)

Sample Questions

The questions that follow illustrate those typically found on this examination. The answer rationales can be found on pages 44–48 of this guide. The statement "Select all that apply" in a question indicates that there are multiple answers, and you must choose them all to get the question right. Such questions are appearing in all state licensure exams and selected Excelsior College Examinations, as well. During your exam, a basic 8-function calculator will be available on your computer.



A WORD ON CALCULATION QUESTIONS IN EXCELSIOR COLLEGE EXAMINATIONS

Calculation questions for medication dosages will call for either a whole number response or a response rounded to one or two decimal places, with a leading zero (0.X) required for values less than 1.

Each calculation question will indicate whether the response needs to be a whole number or a number with one or two decimal places. If a student enters a value that is not of the right type (for example, a whole number when the question asks for one decimal place), an error message will pop up to prompt the student to enter the right type of response.

1. Which question would the RN ask the patient who reports difficulty achieving and sustaining an erection?
   1) "Have you been getting too much exercise?"
   2) "What is your cholesterol level?"
   3) "Have you been checked for diseases such as diabetes?"
   4) "Do you understand the normal sexual response cycle?"

2. Which diagnostic test provides a definitive diagnosis for a female patient who presents with symptoms of gonorrhea?
   1) Rapid plasma reagin (RPR)
   2) Darkfield examination of exudate
   3) Pap smear
   4) Culture of cervical discharge

3. Which intervention is the priority for the RN to take when admitting a female client who is a rape victim?
   1) Refer client to Rape Support Group
   2) Establish a safe environment
   3) Administer ordered antibiotics
   4) Take pictures for evidence

4. Which intervention is a priority for a patient following a total abdominal hysterectomy who stopped taking oral contraceptives two weeks ago and smokes?
    1) Apply compression stockings on the patient as soon as possible.
    2) Encourage drinking at least 2,000 mL of water a day.
    3) Allow rest periods for as long as possible.
    4) Monitor vital signs more frequently.

5. Which statement by the patient indicates to the RN that the patient understands the definition of endometriosis?
    1) "My uterus and underlying muscle tissue are infected."
    2) "The lining of my uterus and fallopian tubes have shrunk."
    3) "Multiple fibroid tumors have developed in my uterus and cervix."
    4) "Tissue similar to uterine tissue is outside my uterus in my pelvis."

6. Which are probable signs of pregnancy? Select all that apply.
    1) Breast tingling
    2) Changes in cervix
    3) Morning sickness
    4) Braxton-Hicks contractions
    5) Auscultation of fetal heartbeat
    6) Fatigue

7. An RN performs an assessment on a patient diagnosed with placenta previa. Which of these assessment findings would the RN expect to find? Select all that apply.
    1) Uterine rigidity
    2) Uterine tenderness
    3) Severe abdominal pain
    4) Bright red vaginal bleeding
    5) Soft, relaxed, non-tender uterus

8. Which information would the RN include to a couple seeking guidance to improve their potential of becoming pregnant?
    1) The couple should use vaginal lubricants.
    2) The couple should engage in coitus daily.
    3) The woman should refrain from douching.
    4) The woman should be on top during intercourse.

9. Which assessment finding indicates to the RN that delivery is imminent for the patient who is in the second stage of labor?
    1) The patient pushes with each contraction.
    2) The fundus rises above the umbilicus.
    3) The fetal head is crowning.
    4) The cervix is dilated completely.

10. The RN is caring for the patient in labor and interprets the fetal monitor tracing to have moderate variability. Which action should the RN perform first?
    1) Provide labor support.
    2) Place the woman on her left side.
    3) Administer oxygen as ordered.
    4) Call the physician immediately.

11. Which physical finding necessitates further testing in a primigravida being evaluated during her third trimester of pregnancy?
    1) Quickening
    2) Braxton-Hicks contractions
    3) Fetal heart rate of 186 beats/min
    4) Consistent increase in fundal height

12. Which neonatal system is affected when kernicterus results from untreated hyperbilirubinemia?
    1) Cardiovascular
    2) Gastrointestinal
    3) Nervous
    4) Respiratory

13. Which factor can cause a neonate to develop hemorrhagic disease?
    1) Genetic predisposition
    2) Immune system disorder
    3) Hemolysis of red blood cells
    4) Absence of intestinal flora

14. A newly delivered Asian mother chooses to delay breast-feeding until after she goes home. What cultural belief is the barrier to the mother initiating breast-feeding earlier?
    1) Colostrum is considered unclean.
    2) Breast-feeding is only done in the home.
    3) Early initiation of breast-feeding will lead to overfeeding.
    4) Breast-feeding is most effective with familial support.

15. Which assessment finding on a one-day-old infant would the RN need to report to the physician immediately?
    1) Blood in the diaper
    2) Intercostal retractions
    3) Positive Babinski reflex
    4) Dark blue area on the buttocks

16. Which nursing intervention would facilitate breast-feeding for a postpartum woman with breast engorgement?
    1) Teach the patient to apply warm packs to each breast prior to feeding.
    2) Allow the patient to substitute formula until the engorgement subsides.
    3) Provide the patient with a nipple shield and instructions for its use.
    4) Instruct the patient to roll each nipple between her thumb and forefinger.

17. While performing a postpartum assessment on a woman who delivered vaginally two hours ago, the RN assesses a firm uterus at the umbilicus with heavy lochial flow. Which is the most appropriate intervention to perform?
    1) Massage the fundus.
    2) Instruct the patient to void, and then reassess.
    3) Notify the physician.
    4) Perform the assessment again in one hour.

18. Which information in an infant's health history is most consistent with a diagnosis of Hirschsprung's disease?
    1) Fatty stools
    2) Chronic constipation
    3) Projectile vomiting
    4) Frequent respiratory infections

19. Which assessment finding in the neonate with meningomyelocele would the RN report to the physician?
    1) Neurological deficit
    2) Meconium stool
    3) Vomiting following feeding
    4) Acrocyanosis

20. Which lunch choice by the parents of a two-year-old child indicates to the RN that they are maintaining their child on a low-phenylalanine diet?
    1) Chicken salad
    2) Fruit salad
    3) Egg salad sandwich
    4) Peanut butter and jelly sandwich

Sample Questions:
Connecting Rationales to the Learning Outcomes

End of Program Student Learning Outcomes (EPSLO)

EPSLO1. Use a caring holistic approach to provide and advocate for safe quality care for patients and families in an environment that values the uniqueness, dignity, and diversity of patients. *(Patient-Centered Care)*

EPSLO2. Apply the nursing process to make nursing judgments, substantiated with evidence to provide safe, quality patient care across the lifespan. *(Nursing Judgment)*

EPSLO3. Use principles of management and delegation to implement plans of care with members of the intra-professional team to achieve safe, quality patient outcomes. *(Nursing Judgment)*

EPSLO4. Demonstrate the standards of professional nursing practice and core values within an ethical and legal framework. *(Professional Identity)*

EPSLO5. Apply principles of leadership and inter-professional collaboration to improve patient outcomes. *(Professional Identity)*

EPSLO6. Use evidence-based findings and information technology to improve the quality of care for patients. *(Spirit of Inquiry)*

Course Level Student Learning Outcomes (SLO)

Upon successful completion, you will be expected to demonstrate the ability to:

SLO1. Demonstrate caring and cultural sensitivity when providing patient-centered care. *(Patient-Centered Care)*

SLO2. Interpret functional health, developmental stages, and illness management to formulate plans of care for patients with pain, discomfort, sensory impairment, chronic illness, and end-of-life needs. *(Nursing Judgment)*

SLO4. Apply ethical and legal principles of professional nursing practice to the care of individuals with pain, discomfort, sensory impairment, chronic illness, or end-of-life needs. *(Professional Identity)*

SLO5. Use principles of interprofessional collaboration to improve patient outcomes in a variety of health care settings. *(Professional Identity)*

SLO6. Identify the use of evidence-based findings and technology related to the nursing skills and competencies to provide safe, quality, patient care in a variety of health care settings. *(Spirit of Inquiry)*

***correct answer**

1. (IB1)

1) Fatigue is a psychogenic cause of erectile dysfunction but level of exercise itself is neither an organic nor a psychogenic cause.

2) Elevated cholesterol level is a documented risk for coronary artery disease, but not for erectile dysfunction.

*3) **Endocrine diseases such as diabetes, pituitary tumors, and hypo- and hyperthyroidism are among the organic causes of erectile dysfunction.**

4) Erectile dysfunction is unrelated to understanding of the normal sexual response cycle.

This question relates to EPSLO #2 and SLO #2.

2. (IB1)

1) Rapid plasma reagin (RPR) is a serological test most often used for prenatal screening for syphilis.

2) Darkfield examination of serous exudate from a moist lesion is done to check for the presence of T. pallidum, the causative organism of syphilis.

3) The Pap test, as used in gynecology, is primarily a screening test for cancer of the cervix. It can detect infection, but is not organism specific.

*4) **The preferred method for diagnosing gonorrhea in women is by means of a cervical culture.**

This question relates to EPSLO #2 and SLO #2.

3. (IB4)

1) The client should have the referral, but it is not a priority at present

*2) **Safety is a basic physiologic need according to Maslow's hierarchy of needs and must be addressed before all other interventions take place.**

3) Collecting evidence is important, but should be performed by a specially trained nurse

4) Antibiotics will be ordered, but is not the priority at this time.

This question relates to EPSLO #1 and SLO #1.

4. (IB4)

*1) **General postoperative care following abdominal surgery includes the use of elastic pressure stockings, leg exercises, and early ambulation to prevent deep vein thrombosis.**

2) IV fluid replacement is standard for up to 24 hours after surgery or until the patient is stable and tolerating oral fluids. Following general anesthesia, nausea and vomiting is common; therefore, large amounts of oral fluids would be contraindicated.

3) Early ambulation and turning and positioning every two hours should be encouraged to prevent cardiopulmonary complications.

4) The protocol for assessing vital signs is followed unless the patient becomes hemodynamically unstable or complications arise.

This question relates to EPSLO #2 and SLO #2.

5. (IB5)

1) Endometriosis is not an infective condition; endometritis is an infection.

2) Endometriosis is hormone dependent, active as long as the ovaries are active. Atrophy in the reproductive system occurs when hormone production declines.

3) Endometriosis is characterized by multiple cystic nodules lined with endometrial tissue, not by fibrotic tumors.

*4) **Endometriosis is a condition in which endometrial tissue, which undergoes proliferative and secretory changes in response to estrogen and progesterone, is found in locations outside the uterus.**

This question relates to EPSLO #2 and SLO #2.

*correct answer

6. (IIB1)

1) This is a presumptive sign that may or may not occur with pregnancy.

*2) **This is a probable sign of pregnancy that may be caused by pelvic congestion.**

3) This is a presumptive sign that may or may not occur with pregnancy.

*4) **This is a probable sign of pregnancy that can also be associated with uterine fibroids.** (This question tests concepts related to Student Learning Outcome #2 - Nursing Judgment)

5) This is an positive sign of pregnancy that can be confirmed by the health care provider.

6) This is a presumptive sign that may or may not occur with pregnancy.

This question relates to EPSLO #2 and SLO #2.

7. (IIB1)

1) Rigidity is often present in placenta abruption.

2) Tenderness is present in placental abruption.

3) Abruptio placenta always involves severe abdominal pain.

*4) **Bright red vaginal bleeding is a classic sign of placenta previa, especially in the second or third trimester of pregnancy.**

*5) **It is expected to have a soft, relaxed, non-tender uterus with placenta previa.**

This question relates to EPSLO #2 and SLO #2.

8. (IIB4)

1) The use of vaginal lubricants may interfere with fertility by changing the pH of the vagina.

2) Although frequent intercourse may stimulate sperm production, men need sperm recovery time after ejaculation to maintain an adequate sperm count.

*3) **The use of douches or intravaginal medications or sprays could interfere with vaginal pH.**

4) The male-superior position is the best position for coitus to achieve conception because it places sperm closest to the cervical opening.

This question relates to EPSLO #1 and SLO #1.

9. (IIIB1)

1) Pushing with each contraction is not a sign that labor is imminent. The patient may feel pressure and have the urge to push before complete cervical dilatation.

2) The fundus does not rise further above the umbilicus as labor progresses.

*3) **Crowning is a sign of imminent delivery. Crowning indicates that the fetal head is maintaining the perineal opening and is no longer forced back upwards by the pelvic floor muscles.**

4) The second stage of labor begins when the cervix is dilated completely.

This question relates to EPSLO #2 and SLO #2.

10. (IIIB4)

*1) **Because the variability is moderate (6 to 25 beats per minute), the RN can conclude that the baby is tolerating labor well and continued labor support is indicated.**

2) Because the variability is moderate, there is no need to change the patient's position.

3) Because the variability is moderate, there is no need to administer oxygen to the patient.

4) Because the variability is moderate, there is no need to notify the physician.

This question relates to EPSLO #2 and SLO #2.

11. (IIIB4)

1) Quickening or awareness of fetal movement occurs during week 17 to 20.

2) Intermittent uterine contractions are common.

*3) **Normal range of fetal heart rate is 110-160 beats/min and slows with fetal growth. Marked tachycardia is a rate greater than 180 beats/min.**

4) Fundal height should increase as infant grows.

This question relates to EPSLO #2 and SLO #2.

*correct answer

12. (IVB1)

1) Hyperbilirubinemia has no direct effect on the cardiovascular system.
2) Hyperbilirubinemia has no direct effect on the gastrointestinal system.
*3) **Untreated hyperbilirubinemia is toxic to the brain and will result in permanent neurological sequelae.**
4) Hyperbilirubinemia has no direct effect on the respiratory system.

This question relates to EPSLO #2 and SLO #2.

13. (IVB1)

1) Genetic predisposition is not a factor in neonatal hemorrhagic disease.
2) Immune system disorder is not a factor in neonatal hemorrhagic disease.
3) Hemolysis of red blood cells causes hyperbilirubinemia, not hemorrhagic disease.
*4) **Hemorrhagic disease of the newborn results from a deficiency of vitamin K-dependent clotting factors. Vitamin K is produced in the bowel by means of bacterial flora that are initially low in the newborn. Vitamin K is administered to newborns shortly after delivery to prevent hemorrhagic disease.**

This question relates to EPSLO #2 and SLO #2.

14. (IVB1)

*1) **Some Asians, Latinas, Eastern Europeans, and Native Americans may delay breast feeding because they believe colostrum is bad or unclean.**
2) While many women may prefer to breast-feed at home, this is not a cultural consideration or barrier to breast-feeding.
3) There is no evidence that early breast feeding can lead to overfeeding.
4) While support and assistance by the extended family may be beneficial, it is not always desired or available to the new mother and baby.

This question relates to EPSLO #1 and SLO #1.

15. (IVB4)

1) Pseudomenses is a normal finding in a one-day old female infant.
*2) **Retractions (in-drawing of tissues between the ribs, below the rib cage, or above the sternum and clavicles) is a sign of respiratory distress.**
3) A positive Babinski reflex can be elicited in some normal babies until they are two years old.
4) Mongolian spots are areas of gray, dark blue, or purple and are most commonly located on the back and buttocks. Mongolian spots are seen most commonly in infants whose ethnic backgrounds include the Mediterranean area, Latin America, Asia, or Africa.

This question relates to EPSLO #5 and SLO #5.

16. (IVB4)

*1) **Engorgement is a result of insufficient emptying of the breast and areola due to poor sucking or infrequent or inadequate nursing. If engorgement causes problems with breast-feeding, the patient should be taught to apply warm packs to both breasts before feeding.**
2) Substituting formula is not appropriate because engorgement will become worse with inadequate or infrequent sucking.
3) Use of nipple shields will not help the infant latch on to an engorged breast.
4) Rolling the nipple between two fingers is done to make a flat or inverted nipple more prominent.

This question relates to EPSLO #2 and SLO #2.

*correct answer

17. (IVB4)

1) The uterus is already contracted. Providing massage will not decrease the lochia flow.
2) The uterus is at the umbilicus and unlikely to have been displaced by a full bladder.
*3) **The bleeding is heavier than normal. The patient may be bleeding from another area in the birth canal and the primary care provider should be notified.**
4) The cause of the increased bleeding needs to be identified and the patient requires immediate attention.

This question relates to EPSLO #5 and SLO #5.

18. (VB1)

1) With Hirschsprung's disease, the stool is not greasy, but ribbonlike and watery. Greasy stools are associated with celiac disease.
*2) **With Hirschsprung's disease, the muscle of the bowel lacks nerve innervation, which leads to absence of peristalsis and results in chronic constipation.**
3) Projectile vomiting is not a clinical manifestation of Hirschsprung's disease.
4) Hirschsprung's disease is a megacolon disorder and does not affect the respiratory system.

This question relates to EPSLO #2 and SLO #2.

19. (VB1)

*1) **Meningomyelocele involves herniation of the spinal cord with sensory and motor dysfunction corresponding to the level of the spinal anomaly.**
2) Meconium stool is the first stool of the newborn and is usually passed within 24 hours after birth.
3) There is no vomiting associated with meningomyelocele.
4) Acrocyanosis is a common assessment finding in the neonate and is not associated with meningomyelocele.

This question relates to EPSLO #2 and SLO #2.

20. (VB4)

1) Chicken salad is not low in phenylalanine.
*2) **Fruit salad has no protein; therefore, it has no phenylalanine.**
3) An egg salad sandwich has a high level of phenylalanine.
4) Peanut butter has a high level of phenylalanine.

This question relates to EPSLO #2 and SLO #2.