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Maternal newborn success pdf

Approximately 1300 questions – all with justification for correct and incorrect answers For 1000 questions plus the 100th question test in book Two, 90-question comprehensive exams encoded according to NCLEX descriptors online in DavisPlus Over 250 alternative format questions types that are distributed throughout text, exam, and both online tests Rationale for correct and incorrect answers Test-tips for selected questions Most questions , written at the application and analysis level - just like the NCLEX exam. Introductory chapter for applying critical thinking to different types of questions. Issues that reflect NCLEX's increased focus on pharmacology and medical administration, management, delegation and patient safety 1 Introduction This book is part of a series published by F. A. Davis Company designed to help student nurses review essential information and take exams, especially in NCLEX-RN exams and exams. The book focuses mainly on childbirth – prenatal, intrapartum, postpartum and newborn – and due to the birth of the child also includes questions about the development of the fetus and newborn. Moreover, because women are pregnant for such a short period of life, because childbearing birth occurs in the context of the family and

because embryonic and fetal development occurs in the context of genetics, the text contains questions on these topics. Other topics, including sexually transmitted diseases, domestic violence, rape and contraception, affect women during childbearing years, which make up about a third of a woman's life, are also included. As a result, this text is an excellent supplement for a number of school medical courses, including parent-child Nursing, Fetal Growth and Development, Basic Genetics, Family Processes, and Women's Health. To get the most out of this book, the student is recommended to read the content related to the different thematic areas and study the material in a logical way. Only if this is done will this book be valuable. Used as an adjunct to fundamental work, this book should be useful for developing the skills needed to successfully conduct exams, such as NCLEX and certification exams, in the relevant content areas. Discussion of the types of questions to be asked in exams, techniques for approaching questions to determine what is asked and how to choose the right answers. HOW TO USE THIS BOOK This book contains 11 chapters and is accompanied by a CD-ROM with two comprehensive reviews. This introductory chapter focuses on the types of issues included in the NCLEX-RN review and on the approach to research and preparation for review. Chapters 2 to 11 focus on the topics related to motherhood, especially the antenatal, intimatum, postpartum and newborn. Each of these chapters contains Questions that test a student's knowledge and practical answers to questions and justification with specific tips on how to approach the answer to the question. The reasons why an answer is correct and why other response options are incorrect are given. They serve as valuable learning tools for the student and help strengthen knowledge. The two comprehensive CD-ROM reviews include questions and answers covering all topics included in the 10 content chapters. The CD-ROM format will provide the test learning device with a practice in answering questions on the computer, valuable help since the NCLEX-RN preview is computer- LEARN MATERIAL The first step before trying to answer questions in this text or exam is to study and study the relevant material. Training does not simply mean reading textbooks and/or attending class. Training is an active process that requires a number of complex skills, including reading, discussing and organising information. 2 MATERNAL AND NEWBORN SUCCESS READ TASKS First you need to read your tasks. And, by far, the best time to read the assigned material is before the class in which the information will be discussed. Then, if students have any questions about what they read, they can ask the professor during class and clarify anything that is confusing. In addition, students will find the discussions much more meaningful when they have a basic understanding of the material. DISCUSS INFORMATION During class, the material should be discussed with students instead of being provided to them. Of course, professors have an obligation to provide stimulating and thought-provoking classes, but students also have an obligation to be prepared to participate in discussions when entering the classroom. Although facts need to be learned, breastfeeding is not an evidence-based profession. The nurse is an applied science. Nurses need to know information, but more importantly, they need to use the information. When the nurse enters the client's room, the client rarely asks the nurse to define a term or recite a fact. Rather, the client presents the nurse with a set of data that the nurse must interpret and act on. In other words, the nurse has to think critically. Therefore, students should discuss customer-based information by asking questions about why, rather than just learning facts by asking questions about what. ORGANIZE INFORMATION When reading and discussing information, nurses should start organizing their knowledge. You can't remember the knowledge of nursing! There is too much information to be saved and, more importantly, memorization negatively affects the ability to use information. Nurses should be able to critically analyse the data to determine priorities and actions. To think critically, nurses must have developed relationships and between the information. There are several steps in the way to organize basic information, including understanding the pathophysiology of the problem; Determination Determination relevant to the specific customer; identification of signs and symptoms; and using the steps of the nursing process: evaluation, diagnosis of nurses, development of a care plan, implementation of this plan and evaluation of results. An example – a woman with a medical diagnosis of placenta previa – is used below and throughout the rest of this chapter to illustrate the use of these interconnected steps to provide a way to organize basic information. Whether learning to explore or use skills in a particular clinical situation, it is often useful to graphically show the links between and between different parts of the information, as is done below. Example: The client has placenta previa. First, the nurse should understand the problem, determine its significance and assess for signs and symptoms. Understand the problem The first action is to understand (do not memorize) the pathophysiology of the problem or problem. (The implied in this example is a prerequisite that the learner already fully understands the normal anatomy and physiology of pregnancy.) The placenta is usually associated with a high vascular site in the decidus of the posterior wall of the uterus. Women who have compromised uterine blood supply - women who are multi-parted, smokers, have diabetes or carry multiple gestations, for example - are at high risk for placenta previa. In this state, the placenta, instead of attaching to the back of the uterine wall, is attached to an area immediately above or adjacent to the internal operating system of the uterus. Determining the importance of pathophysiology The second phase of the process is to determine the importance of pathophysiology. Often the nurse is able to bring out the meaning based on knowledge of normal anatomy and physiology. Since the placenta is a highly vascular organ that delivers oxygen and nutrients to the developing baby, it is essential for the well-being of the fetus. If the cervix is broken or injured, the chorionic lice of the placenta will be destroyed. The mother will lose blood and the oxygen and nutrition of the baby will be critically affected, leading to a life-threatening situation for both the mother and the fetus. CHAPTER 1 INTRODUCTION 3 Predisposing factors: too little intrauterine space / poor blood supply to decidua Placenta is attached to the area immediately above or adjacent to the internal system of the uterus Predisposing factors: too little intrauterine space / poor blood supply to the placenta is attached to the area immediately above or in close proximity to the inner cervix of cervical cervical dilation and/ or placental damage vaginal bleeding and fetal hypoxia Identification of signs and symptoms After extracting the importance of pathophysiology, it is essential to identify signs and symptoms, expected. the mother, nurse would expect to see bleeding with associated changes in haematological signs (haematocrit and Anxiety. Since placental bleeding will be unhindered – that is, the blood will be able to escape easily through the vagina, the nurse will expect that the client will be in little or no pain and that the blood will be bright red. In addition, the nurse will expect the hematological signs of the client to be affected and vital signs to change. However, since women have significantly increased blood volumes during pregnancy, the pulse will rise first, while blood pressure will remain relatively stable. The drop in blood pressure is a late and ominous sign. In addition, the nurse will expect the mother to be concerned about her own and her baby is well-being. In the fetus, if there is significant loss of maternal blood and placental disturbances, the nurse will expect to see adverse changes in heart rate patterns. The late delay of a consequence of a bad morning of blood flow. Predisposing factors: too little intrauterine space / poor blood supply to decidua Placenta attaches to the area immediately above or adjacent to the inner cervix expanding vaginal bleeding and fetal hypoxia Mother: bright red, painless bleeding; pulse; hgb and hct; Bp late sign; Fat anxiety: the late delay observed on an external fetal monitor trace after the problem and the data relating to it are understood, the meaning determined, and the expected signs and symptoms identified, it is time for the student (and nurse) to turn to the breastfeeding process. USE THE NURSING PROCESS The process of breastfeeding is fundamental to nursing practice. In order to provide comprehensive care to their clients, nurses need to understand and use every part of the nursing process – evaluation, diagnosis of nurses, development of a care plan, implementation of this plan and evaluation of results. Nurses collect a variety of information during the stage of evaluation of the breastfeeding process. Some of the information is objective or evidence-based. For example, noting the hematocrit of the client and noting other blood values in the graph are data based on facts that the nurse can use to determine the customer's needs. But in addition, nurses must identify subjective data or information perceived by the client's eyes. The customer's rating for her pain is an excellent example of subjective information. Nurses should be aware of which data should be evaluated, as each customer's situation is unique. In other words, nurses should be able to use the information taught in class and individualise it for each interaction with the customer in order to determine which objective data should be accessible and which questions should be asked by the customer. Once the data have been obtained, the nurse analyses the information as described in above. Formulation of the nursing diagnosis After the nurse has analyzed the data from her assessments, a diagnosis of breastfeeding is made. Nurses are licensed to treat actual or potential health problems. Medical diagnoses are statements about health problems the nurse, in cooperation with the client, has concluded that they are crucial for the well-being of the client. Example (continuation) Based on the above data, the nurse should develop medical diagnoses and prioritize diagnoses, since they relate to the care of a client with placenta previa. Since a woman with placenta previa may or may not begin to bleed, it is essential that the nurse develops two sets of diagnoses: one is aimed at preventing complications, i.e. risk for diagnoses - and one aimed at the worst-case scenario - that is, if the client starts bleeding. The diagnosis of risk to nurses is: • Risk of uneven fluid volume associated with (r/t) hypovolaemia, secondary to excessive blood loss • Risk of impaired foetal gas exchange r/ t reduces blood volume and cardiovascular exposure of the mother • Concern for the mother and for personal and foetal health The worst-case scenario (active bleeding) Diagnosis of breastfeeding are: • Dispositional maternal toxicity is secondary to excessive blood loss • Impaired fetal exchange of gases in the blood and lower blood risk • Maternal health anxiety for personal and foetal health Development of the Care Plan During the planning phase, nurse develops a care plan involving care, expected customer outcomes and interventions necessary to achieve the objectives and results. In other words, the nurse determines what she wants to achieve with regard to each of the medical diagnoses and how he or she expects to achieve these goals. 4 MATERNAL AND NEWBORN SUCCESS A very important part of this process is the development of care priorities. The nurse must determine which diagnoses are most important and therefore which actions are most important. For example, a customer's physical well-being should take precedence over their emotional well-being. In addition, it is important for the nurse to take into account the client's own priorities. And, of course, nurses should take into account the goals and orders of the primary healthcare provider of the client. Example (continuation) The nurse develops a care plan based on the medical diagnoses listed above. Since physical conditions should take precedence, the nurse prioritizes the plan with physical needs. Then the emotional needs of the client will be considered. The care plan for the execution of risky medical diagnoses is shown in box 1-1 and a worst-case scenario plan – active bleeding – is shown in Box 1-2. After the plan is set up, the nurse implements the plan. The plan may include direct care for the client by the nurse and/or care, which are coordinated by the nurse but carried out by other practitioners. It is important to note that if the evaluation data changes during the implementation phase, the nurse must re-analyse the data, change the and change his care again. One very important aspect of all nursing care is that it is Nurses are independent practitioners. They are assigned to provide safe, therapeutic care that has a scientific basis. That's why nurses need to get involved in lifelong learning. It is essential that nurses realize that much of the information in the textbooks is obsolete before the text is even published. In order to provide evidence-based care, nurses must keep their knowledge up to date by accessing information from reliable sources on the internet, in professional journals and at professional conferences. For example, the Plan should be implemented as developed during the planning phase. If the situation needs to change, for example, the woman should begin to bleed spontaneously during a shift, the nurse will immediately review her plan if necessary. In the cited example, the nurse will implement the active care bleeding plan. CHAPTER 1 INTRODUCTION 5 BOX 1-1 Customer care plan with Placenta Previa in Risk Bleeding Bleeding Diagnosis: Risk of unbalanced fluid volume (maternal) associated with (r/t) hypovolemia, secondary to excessive blood loss. Purpose: The client will not bleed throughout the pregnancy. Suggested actions: The nurse will: • Evaluate for vaginal bleeding every shift. • Evaluate for uterine contractions every shift. • Assess the vital signs of each shift. • Evaluate entry and exit during each shift. • Evaluate bowel function every shift. • Do not put anything in the vagina. • Keep the customer in bed as ordered. • Monitor changes in laboratory data as ordered. Lactation diagnosis: Risk for impaired gas exchange (fetal) R/t reduces blood volume and cardiovascular compromise of the mother. Purpose: The fetal heart rate will show average variability and there is no deposition until birth. Suggested actions: The nurse will: • Monitor the fetal heart rate on each shift. • Run stress-free tests as ordered. Lactation diagnosis: Anxiety (maternal) R/t concern for personal and fetal health. Goal: The mother will show minimal anxiety during her pregnancy. Proposed actions: The nurse will: • Provide emotional support. Evaluation The assessment phase is usually defined as the final phase of the nursing process, but can also be classified as another assessment phase. When nurses assess, they reassess customers to determine whether the actions taken during the implementation phase meet the customer's needs. In other words: Have the purposes of nursing been met? If the objectives have not been achieved, the nurse is obliged to develop new actions to achieve the objectives. If any of the objectives have been met, priorities may need to be changed. And so on. As can be seen from this phase, the breastfeeding process continues and is continuously Example (continuation) Throughout the period of care for a nurse, the nurse assesses and reassesses the situation. If necessary, the nurse may report significant changes to the healthcare provider or determine whether a change in medical care is necessary. For example, if the customer starts crying because he is concerned about his baby's health, physiologically, the client is stable, the nurse can concentrate on meeting the emotional needs of the client. The nurse can sit quietly with the customer as she announces her concerns. Conversely, if the customer starts bleeding profusely, the nurse will immediately announce the change to the customer's healthcare provider and implement the active bleeding plan. TYPES OF QUESTIONS There are four integrative processes on which NCLEX-RN issues are based: The breastfeeding process, care, communication and documentation and teaching/training (NCLEX-RN 2007 Test Plan). The examiner must determine which process(s) are assessed in each question. In other words, the test entrepreneur should realize that since breastfeeding is a profession of action, NCLEX-RN issues simulate, in written format, clinical situations. Critical reporting of the test battery is therefore essential. 6 Maternal and newborn SUCCESS BOX 1-2 Patient care plan with placenta Previa Who is bleeding lactation diagnosis: unbalanced fluid volume (maternal) r / t hypovolemia secondary to excessive blood loss. Goal: The client will become hemodynamically stable. Suggested interventions: The nurse will: • Measures vaginal bleeding. • Number of saturated vaginal pads. • Weighing pads — 1 grams 1 ml of blood. • Matte shrinkage monitor model, if available. • Assess vital signs every 15 minutes. • Continuously assess oxygen saturation levels. • Evaluate incoming and performance every hour. • Do not put anything in the vagina. • Keep the customer in bed. • Follow changes in laboratory data as ordered. • Administer intravenous fluids as ordered. • Prepare for an emergency caesarean section as ordered. Lactation diagnosis: Risk for impaired gas exchange (fetal) R/t reduces blood volume and cardiovascular compromise of the mother. Purpose: The fetal heart rate will show average variability and there is no delay in delay. Suggested interventions: Nurse: • Fetal heart rate monitor continuously via an external fetal monitor. Breastfeeding Diagnosis: Anxiety (maternal) R/t concern for personal and fetal health Goal: The mother will exhibit minimal anxiety. Suggested interventions: The nurse will: • Provide clear and calm explanations of all assessments and actions. • Providing emotional support. Most of the questions asked in the NCLEX-RN exam are multiple-opportunity questions. Other types of questions, known as alternative-type questions, include blank replenishment questions, multi-answer questions, drag-and-drop questions, hotspot and chart items, or exposed items. The types of questions and examples for each of them are discussed below. Multiple-choice questions In multiple-answer questions, stems are provided and the tester must choose between four possible answers. Sometimes you will be asked to choose the best answer, sometimes choose the first action to be taken, and the like. There are many ways in which questions can be asked with a choice between several options. The following is an example related to a customer placenta previa. Example: A patient, 36 weeks gestation, is diagnosed with a full placenta previa. The client tells the nurse that he has a bad spine that comes and goes. Which of the following actions should be performed first to the nurse? 1. Give the customer a rub back. 2. Assessment of the vital signs of the client. 3. It's time for the customer to have back pain. 4. Assessment of vaginal bleeding. Answer: 4 The nurse must realize that because backache occurs, this client may be in early labour. And since the enlargement of the cervix can lead to bleeding, the nurse should first be evaluated for placental damage -vaginal bleeding. Questions to fill in the blanks filled in are calculation questions. The test may be asked to calculate the dose of the drug, intravenous (IV) drip rate, minimal urinary power or other factor. Included in the question will be the units that should be in the answer to the test tr. Example: The nurse who cares for a client with placenta previa should determine how much blood the client has lost. The nurse weighs a clean vaginal pad (5 gm) and a saturated client pad (25 gm). How many millilitres of blood has the client lost? ____ mL Answer: 20 ml The test must remove 5 out of 25 to determine that the customer has lost 20 grams of blood. Then, knowing that 1 gm of blood is equal to 1 ml of blood, they do not take a test knowing that the customer has lost 20 ml of blood. Drag and drop questions In drag and drop questions, the test should give four or five possible answers in chronological or rank. Responses can be actions to be taken during nursing procedures, steps in growth and development, and the like. The elements are called drag iplyps questions, as a test tochov will move the items with your computer mouse. Needless to say, in this book, a test toner will simply be asked to write the answers in the correct sequence. Example: The nurse should apply a blood transfusion to a client with the placenta previa, who has lost a significant amount of blood. Please put the following breastfeeding actions in the chronological order in which they should be performed. 1. Stay with the customer for a full 5 minutes and take a full set of vital signs. 2. Compare the customer's name and hospital identification number with the name and packaging number of the product. 3. Check the doctor's order regarding the type of infusion to be administered. 4. Adjust the infusion rate as prescribed. CHAPTER 1 INTRODUCTION 7 Answer: 3, 2, 4, 1 Of the four steps included in the response options, the order must be 3, 2, 4, 1. The nurse must first check a doctor's order to determine exactly what blood product is ordered. Second, the nurse must compare the information about the bag with the customer's name. This should be done with another medical or a doctor. Third, the nurse should start the infusion and adjust the infusion. Finally, the nurse should closely monitor the to be evaluated for all transfusion reactions. At the end of the 5 minutes should take a full set of vital signs. Multiple-answer questions When the test sees the statement Select everything that is applied after a question, he or she should know that the reviewer has included more than one correct answer to the question. Usually five answers are given and the test host must determine which of the five answers is correct. There may be two, three, four or even five correct answers. Example: Nurse takes care of a client, 28 weeks gestation, with placenta previa. Which of the following doctor's orders should you ask about the nurse? Select all applicable. 1. Promoting a blitz. 2. Weigh all vaginal swabs. 3. Evaluate cervical enlargement daily. 4. Conduct a stress-free test every morning. 5. Colace 100 mg PO three times a day Response: 1 and 3 are correct. Since the placenta can be injured, vaginal examinations should not be performed; therefore, the nurse must question the #3 assess cervical enlargement daily. Also, since bleeding may occur, patients with placenta previa are allowed only minimal activity; therefore would not be encouraged. Hotspot elements at the hotspot require the test current to identify a photo, graphic or other image, the correct answer to the question. For example, a test entrepreneur may be asked to put X in place of p wave on an electrocardiogram tape. Example: Below is a diagram of the uterus. Insert X where a full placenta previa will be attached. Answer: The test should be carried out X on the inner axis of the cervix. 8 Maternal and newborn success scheme/Exhibits Some questions may include a diagram or exhibition. The test state is required to interpret the data, identify the location of the data or perform a calculation based on the information given in the chart/statement. Example: While caring for a client who had an emergency caesarean section due to active bleeding associated with full placenta previa, the nurse emptied the Ffley catheter three times during an eight-hour shift. How much milliliter of urine was canceled during the shift? Answer: 250 mL (60 + 90 + 100 = 250) CHAPTER1 INTRODUCTION 9 Urine output for 8-hour shift 7 h. 8am 60 mL 9am 10am 90 mL 12 mL 12pm 12 p.m. 14.00 1.3 m. 100 mL TOTAL HOW TO APPROACH EXAM QUESTIONS There are several techniques that the test learner should use when considering questions. • Imagine that the study is a clinical experience – First of all, they need to address critical thinking issues as if they were in a clinical setting and the situation was developing on the ground. Almost all critical thinking issues are clinically focused. If a test tonic claims to be in a clinical situation, the importance of the answer becomes obvious. In addition, the test entrepreneur is likely to prepare for the study with more This does not mean that students are commit to doing well with exams, but rather that they often treat exams differently than they do in clinical situations. This is a rare nurse who goes to clinical, has not had enough sleep to care for her clients, and yet students often enter the exam room only after 2 or 3 hours of sleep. The student needs the same critical thinking ability that sleep provides when on an exam as a nurse needs a clinical unit. It is important that those taking the test are well rested before all exams. • Read the stem carefully before reading the answers – As discussed above, there are a number of different types of questions for the NCLEX-RN exam, and most faculties include alternative questions in their class exams as well. This is a huge disadvantage of exams in the classroom. A test entrepreneur standing in a customer's room is much less likely to interpret the situation when confronting a customer than when reading an exam question. • Consider possible answers – after a clear understanding of the stem of the question, but before reading the possible answers, the test should consider possible correct answers to the question. It's important for the test to realize that test writers only include acceptable response options. The purpose of the test writer is to determine whether the dough entrepreneur knows and understands the material. Therefore, the test host must have an idea of what the correct answer is before he starts to read the possible answers. • Read the answers – Only after you clearly understand what is being asked and after you develop an idea of what the right answer might be, should you read the answers to the test. The answer that is closest to the content of the test taker guess should be the answer that is chosen, and the test-taker should not second guess himself or himself. The first impression is almost always the right answer. Only if a test entrepreneur knows that he or she mis reads the question should the answer be changed. • Read the rationale for each question – this book provides a justification for each response. The student should take full advantage of this function. Read why the correct answer is correct. The justification may be based on content, interpretation of information or on a number of other grounds. Understanding why the answer to a question is correct is likely to shift to other questions with similar rationalities. Then read why the wrong answers are wrong. Again, the justification may be based on a number of different factors. Understanding why the answers are wrong can also be transferred to other questions. • Finally, read all the test admission tips –Some of the tips refer directly to test-taking skills, while others include invaluable information about test admission. If the host of the use this text as set out in well prepared to be successful when taking an exam in any or all of the content areas presented. And as a result, it must be fully prepared to function as a registered professional nurse in many areas of motherhood and women's health. Maternal and newborn success, course review applying critical thinking testing skills as an e-book

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