Chapter 37. Nursing Care of Patients With Disorders of the Urinary System

Multiple Choice
Identify the choice that best completes the statement or answers the question.

____ 1. A female patient with a history of diabetes mellitus presents at the health care provider's (HCP) office with chills, a high fever, and flank pain. The nurse notes that a collected urine specimen appears cloudy. Which condition does the nurse expect?
1. Diabetic related sepsis
2. Infection from hepatitis
3. Urethritis and bladder infection
4. Complicated pyelonephritis

____ 2. The nurse is collecting data from a male patient who reports hematuria and bladder cramping. The patient's history indicates a 20-year history of smoking and long-term employment in a tool factory. Which specific test does the nurse expect the HCP to order?
1. Complete blood count
2. Urine test for telomerase
3. Urinalysis for bladder infection
4. Urine culture for presence of bacteria

____ 3. The nurse is providing postoperative care for a patient with a newly formed ileal conduit for a diagnosis of cancer. Which factor regarding the patient's surgery does the nurse identify as incorrect?
1. The nurse can expect the urine to contain mucus.
2. Urine will drain continuously from the reservoir.
3. Bladder continence will develop after healing.
4. The surgery includes the formation of an ileostomy.

____ 4. The nurse is providing care for a patient admitted with severe flank pain identified as renal colic. Urinalysis is positive for microscopic hematuria. Which nursing intervention is most important for the nurse to implement?
1. Administer prescribed narcotic medication.
2. Maintain IV fluids and encourage oral fluids.
3. Promote assisted ambulation as tolerated.
4. Strain urinary output and observe for stones.

____ 5. The nurse is preparing a patient for a cystectomy and the creation of a continent urinary diversion. For which reason does the nurse identify creation of this type of diversion?
1. Convenience for the patient
2. Extensive bladder destruction exists
3. Prevention of skin breakdown
4. Failed previous incontinent diversion

____ 6. The nurse is providing care for older adult clients in an extended care facility. Which patient will the nurse monitor most closely for symptoms of urosepsis?
1. The patient with continuous urinary incontinence

2. The patient who is unable to obtain fluids independently
3. The patient who has an indwelling catheter for a urinary tract infection (UTI)
4. The patient who has surgery for placement of an ileostomy

____ 7. The nurse is providing care for a patient who is diagnosed with urinary obstruction from a blockage of the urethra. An emergency surgery is scheduled. The nurse is aware of which complication occurring without resolution of the condition?
1. Bilateral hydronephrosis
2. Urinary bladder rupture
3. Irreparable kidney damage
4. Dilation of the ureters

____ 8. The nurse is providing support for a client who just finished a hemodialysis session. Which patient symptom is considered to be a complication of hemodialysis?
1. Headache from a drop-in blood pressure
2. Increased clotting time from dialysate
3. Cardiac arrhythmias and angina from fluid loss
4. High energy level related to loss of toxins

____ 9. The nurse is reinforcing teaching about the most serious side effect of peritoneal dialysis with a patient scheduled for the first treatment. Which side effect stated by the patient indicates correct understanding?
1. Peritonitis
2. Paralytic ileus
3. Respiratory distress
4. Cramps in the abdomen

____ 10. The nurse is providing care for a patient with glomerulonephritis. Which form of kidney injury should the nurse realize has occurred with this patient?
1. Prerenal
2. Postrenal
3. Intrarenal
4. Suprabladder

____ 11. A 19-year-old patient reports flank pain and scanty urination. The nurse notices periorbital edema, and the urinalysis reveals white blood cells, red blood cells, albumin, and casts. Which question will provide important information for the nurse to include in data collection?
1. “Have you noticed changes in your vision?”
2. “Have you ever had unprotected sex?”
3. “Have you had any gastrointestinal problems lately?”
4. “Have you had any type of strep infection recently?”

____ 12. The nurse is providing care for a patient scheduled for surgery for the formation of an orthotopic bladder substitution. Which patient teaching is important for the nurse to review during the patient’s recovery?
1. How to monitor the stoma
2. How to prevent skin injury
3. How to perform catheterization

4. How to apply an ostomy appliance

____ 13. Which patient will the nurse consider to be at greatest risk for cancer of the kidney?
1. A 30-year-old male who smokes a pack a day and is treated for hypertension
2. A 46-year-old female who is obese and works full time as an x-ray technician
3. A 55-year-old female who has undergone dialysis for 6 years for renal disease
4. A 50-year-old male with a 20-year history of smoking and works in a chemical laboratory

____ 14. The nurse is collecting data on a patient admitted for symptoms of renal insufficiency. Which factor will cause the nurse to suspect prerenal injury?
1. A family history of polycystic kidney disease (PKD)
2. Medications for chronic joint pain and hypertension
3. Laboratory results indicating a high level of an aminoglycoside
4. A tumor obstruction diagnosed as being present in the right ureter

____ 15. The nurse is planning care for a patient diagnosed with chronic renal failure. The nurse notes that the patient's output is 620 mL for the last 24 hours. The patient has periorbital edema and crackles in all lung fields upon auscultation. Which intervention is most important for the nurse to implement during care of this patient?
1. Administer oxygen therapy.
2. Measure abdominal girth.
3. Obtain daily weights.
4. Maintain fluid restrictions.

____ 16. The nurse is visiting a patient who performs peritoneal dialysis at home. The nurse is evaluating the patient's technique and environment. Which situation is least likely to cause the nurse concern?
1. The patient has several pets who roam around the house.
2. The patient verbally expresses symptoms to report to the HCP.
3. The patient uses clean technique when instilling the dialysate.
4. The patient voices the reasons for limiting dietary protein intake.

____ 17. The nurse is providing care for a patient who is scheduled for the formation of access for hemodialysis. Which important action does the nurse take with this patient?
1. Refrains from drawing blood or placing IV lines in the nondominate arm
2. Prepares the patient for permanent placement of a central venous catheter
3. Instructs the patient about the need for showering with antimicrobial soap
4. Reviews the type of underclothing that will be worn to protect the access

Multiple Response
Identify one or more choices that best complete the statement or answer the question.

____ 18. The nurse is reinforcing teaching provided to a patient with a history of calcium oxalate kidney stones. The nurse recognizes that teaching has been effective if the patient avoids which foods? (Select all that apply.)
1. Bread
2. Cocoa
3. Lettuce

4. Spinach
5. Instant coffee

____ 19. The nurse is reinforcing teaching provided to a patient about caring for a new arteriovenous (AV) fistula in the left arm for dialysis. Which patient statements indicate correct understanding? (Select all that apply.)
1. "Do not sleep on my arm."
2. "Keep my arm elevated at all times."
3. "Keep a firm bandage on my arm."
4. "Wear loose clothing on my left arm."
5. "Avoid carrying heavy things with my left arm."

____ 20. The nurse is preparing to reinforce teaching to a patient newly diagnosed with PKD. Which information does the nurse include? (Select all that apply.)
1. Typically, first signs of the disease appear during late childhood.
2. Grape-like cysts will replace normal, functioning structures.
3. Initial symptoms are dull heaviness in the flank area and hematuria.
4. Patients are at risk for brain aneurysms and diverticulosis in the colon.
5. Disease is likely to require additional treatment for hypertension and UTIs.

Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Answer Section

MULTIPLE CHOICE

1. ANS: 4
   Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
   Objective: Explain the predisposing causes, symptoms, laboratory abnormalities, and treatment of urinary tract infections.
   Page: 742
   Heading: Urinary Tract Infections
   Integrated Process: Clinical Problem-Solving Process (Nursing Process)
   Client Need: Physiological Integrity—Physiological Adaptation
   Cognitive Level: Analysis (Analyzing)
   Concept: Elimination
   Difficulty: Moderate

	Feedback
1	The patient's symptoms support a diagnosis involving the urinary tract. Diabetic related sepsis is too broad of a term to apply to the patient's manifestations.
2	There is no information in the question to support the presence of infection from hepatitis.
3	The symptoms presented indicate an involvement of upper urinary tract rather than the urethra and bladder.
4	The patient is exhibiting the symptoms of complicated pyelonephritis, which includes a high fever, flank pain, and existing diabetes mellitus.

   PTS: 1 CON: Elimination

2. ANS: 2
   Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
   Objective: List risk factors and signs and symptoms of cancer of the bladder.
   Page: 747
   Heading: Cancer of the Bladder
   Integrated Process: Clinical Problem-Solving Process (Nursing Process)
   Client Need: Physiological Integrity—Physiological Adaptation
   Cognitive Level: Analysis (Analyzing)
   Concept: Cellular Regulation
   Difficulty: Difficult

	Feedback
1	Routinely, the HCP may order a complete blood count.
2	A urine test for the presence of the enzyme telomerase is 90 percent accurate for the diagnosis of early or late bladder cancer. Given the patient's symptoms and history, this is the most specific test that the HCP can order.
3	The patient does not exhibit the symptoms of a bladder infection. Urine for

	cytology can be obtained to determine the presence of cancer cells.
4	A urine culture can be done because the symptoms of a bladder infection can be similar to the symptoms of bladder cancer. However, this is not the most specific test.

PTS: 1 CON: Cellular Regulation

3. ANS: 3
Chapter: Nursing Care of Patients With Disorders of the Urinary System
Objective: Discuss nursing care for a patient with an ileal conduit or continent reservoir.
Page: 751
Heading: Incontinent Urinary Diversion
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)
Concept: Cellular Regulation
Difficulty: Moderate

	Feedback
1	The nurse will expect mucus in the patient's urine because the diversionary pouch is created from part of the bowel, which is mucus producing.
2	With an ileal conduit, the urine will drain continuously from the reservoir.
3	Bladder continence is never obtained with an ileal conduit, the reservoir continuously drains from the stoma into a collection bag.
4	The surgery for an ileal conduit always includes the formation of an ileostomy through which the urine is drained.

PTS: 1 CON: Cellular Regulation

4. ANS: 4
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Explain the predisposing causes, symptoms, treatment, and teaching for kidney stones.
Page: 747
Heading: Renal Calculi (Urolithiasis)
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Moderate

	Feedback
1	The patient with severe flank pain described as renal colic is frequently prescribed narcotic medication for pain control. However, this is not the most important intervention.
2	The nurse is aware that an increase in fluids will assist in flushing the kidney stone through the urinary system. However, this is not the most important intervention.
3	Ambulation can be effective in moving a renal stone through the urinary system.

	If the patient is in extreme pain or medicated with a narcotic, assistance is warranted.
4	The most important intervention for the nurse to implement involves straining all urinary output for the collection of any passed stones. The stones are then sent to the laboratory where the type can be identified and appropriate treatment implemented.

PTS: 1 CON: Elimination

5. ANS: 1
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Discuss nursing care for a patient with an ileal conduit or continent reservoir.
Pages: 751–752
Heading: Continent Urinary Diversion
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Applying (Application)
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	Continent urinary diversion, of either a Kock or Indiana pouch, is created for the convenience of the patient. An incontinent diversion requires the formation of a stoma and constant use of a collection pouch as opposed to intermittent catheterization through a valve opening.
2	If the bladder is destroyed by disease, either a continent or incontinent diversion can be considered.
3	The possibility of skin breakdown is more likely with an incontinent diversion; however, this reason alone is not a determination for formation of a continent diversion.
4	The failure of an incontinent urinary diversion is not necessarily a reason to form a continent urinary diversion.

PTS: 1 CON: Patient-Centered Care

6. ANS: 3
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Explain the predisposing causes, symptoms, laboratory abnormalities, and treatment of urinary tract infections.
Page: 742
Heading: Types of Urinary Tract Infections
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback

1	Continuous incontinence places the patient at risk for skin breakdown and not for urosepsis.
2	The patient who is unable to independently obtain fluids is at risk for dehydration or for a UTI.
3	The patient with an indwelling urinary catheter is at high risk for urosepsis; the possibility is increased by an already existing UTI.
4	The patient who had surgery for the placement of an ileostomy may be at risk for urosepsis; however, the patient with an indwelling catheter and a UTI is at greatest risk.

PTS: 1 CON: Patient-Centered Care

7. ANS: 3
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Explain the pathophysiology and nursing care for diabetic nephropathy, nephrosclerosis, hydronephrosis, and glomerulonephritis.
Page: 744
Heading: Hydronephrosis
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Moderate

	Feedback
1	Bilateral hydronephrosis will occur from a blocked urethra when the urine backs up to the kidneys. The condition is reversible with surgical resolution of the blockage.
2	With a blockage of the urethra, urine will back up into the bladder, but the bladder is not at risk for rupture. The urine will continue to back up past the bladder.
3	Irreparable damage to the kidneys can occur with the formation of hydronephrosis. Within hours, the blood vessels and renal tubules can be extensively damaged. Both kidneys are at risk with a urethral blockage.
4	With blockage of the urethra, it is possible for the urine to back up to the point of dilating the ureters. However, this condition is reversible with resolution of the blockage.

PTS: 1 CON: Elimination

8. ANS: 3
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Plan nursing care for patients on hemodialysis.
Page: 766
Heading: Hemodialysis
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)

Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	The patient is likely to experience low blood pressure causing weakness, dizziness, and nausea.
2	The patient is likely to experience increased clotting time related to the use of heparin to prevent blood clotting during dialysis.
3	Cardiac arrhythmias and angina can occur after dialysis because of a sudden fluid drop.
4	After dialysis, the patient is more likely to feel weak and fatigued, and possibly unable to even eat.

PTS: 1 CON: Patient-Centered Care

9. ANS: 1
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Planning care for patients on peritoneal dialysis.
Page: 766
Heading: Peritoneal Dialysis
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	A major complication of peritoneal dialysis is peritonitis, which can be life threatening. The major cause of peritonitis is poor technique when connecting the bag of dialyzing solution to the peritoneal catheter.
2	Paralytic ileus and respiratory distress are not associated with peritoneal dialysis.
3	Paralytic ileus and respiratory distress are not associated with peritoneal dialysis.
4	Abdominal cramps can occur with this type of dialysis; however, they are not the most serious side effect of this treatment.

PTS: 1 CON: Patient-Centered Care

10. ANS: 3
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Explain the pathophysiology and nursing care for diabetic nephropathy, nephrosclerosis, hydronephrosis, and glomerulonephritis.
Page: 755
Heading: Intrarenal Injury
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)

Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	This patient's kidney injury is not caused by a pre- or postrenal injury.
2	This patient's kidney injury is not caused by a pre- or postrenal injury.
3	Intrarenal kidney injury occurs when there is damage to the nephrons inside the kidney. Causes are ischemia, reduced blood flow, toxins, infectious processes leading to glomerulonephritis, trauma to the kidney, allergic reactions to radiograph dyes, and severe muscle injury.
4	Suprabladder is not a type of kidney injury.

PTS: 1 CON: Patient-Centered Care

11. ANS: 4
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Explain the pathophysiology and nursing care for diabetic nephropathy, nephrosclerosis, hydronephrosis, and glomerulonephritis.
Page: 741
Heading: Acute Poststreptococcal Glomerulonephritis
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Moderate

	Feedback
1	Asking about blurred vision, sexual activity, and gastrointestinal problems will not provide important information regarding the patient's condition.
2	Asking about blurred vision, sexual activity, and gastrointestinal problems will not provide important information regarding the patient's condition.
3	Asking about blurred vision, sexual activity, and gastrointestinal problems will not provide important information regarding the patient's condition.
4	The patient has symptoms of glomerulonephritis, which can be caused by a variety of factors, but is most commonly associated with a beta-hemolytic streptococcus infection following a streptococcal infection of the throat or skin.

PTS: 1 CON: Elimination

12. ANS: 3
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Discuss nursing care for a patient with an ileal conduit or continent reservoir.
Page: 770
Heading: Orthotopic Bladder Substitution
Integrated Process: Teaching/Learning
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Application (Applying)
Concept: Patient-Centered Care

Difficulty: Moderate

	Feedback
1	The patient who has orthotopic bladder substitution does not have a stoma. A "new" bladder is surgically formed and both the ureters and urethra are implanted.
2	The patient who has orthotopic bladder substitution is not prone to skin breakdown even though incontinence is sometimes a problem.
3	The patient who has orthotopic bladder substitution may need to perform intermittent catheterization as needed. The nurse needs to review this procedure during the recovery period.
4	The patient who has orthotopic bladder substitution will not need to wear an appliance. The patient will be able to urinate through the urethra normally.

PTS: 1 CON: Patient-Centered Care

13. ANS: 4
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: List risk factors and signs and symptoms of cancer of the kidneys.
Page: 750
Heading: Cancer of the Kidney
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integration—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Cellular Regulation
Difficulty: Difficult

	Feedback
1	Men are more likely to develop cancer of the kidney, but rarely under the age of 45; smoking is a high risk for the disease; and hypertension can be caused by multiple conditions. This patient has two possible risks, smoking and gender.
2	This client has three risks for kidney cancer: age, obesity, and radiation exposure.
3	This client has two risks for kidney cancer: age and long-term kidney dialysis.
4	This client has four risks for kidney cancer: gender, age, smoking history, and chemical exposure.

PTS: 1 CON: Cellular Regulation

14. ANS: 2
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Plan nursing care for a patient with an acute kidney injury.
Page: 730
Heading: Prerenal Injury
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Elimination

Difficulty: Difficult

	Feedback
1	The patient may or may not have PKD; however, the condition is an intrarenal injury.
2	Medications such as NSAIDs for joint pain and cyclooxygenase-2 inhibitors for hypertension can cause prerenal injury by impairing the autoregulatory responses of the kidney by blocking prostaglandin, which is needed for renal perfusion.
3	An aminoglycoside is an antibiotic that is cleared by the kidneys and is nephrotoxic. However, nephrotoxicity from any cause is an intrarenal injury.
4	Any obstruction to the outflow of urine is considered to be a postrenal injury.

PTS: 1 CON: Elimination

15. ANS: 3
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Plan nursing care for patients with chronic kidney disease.
Page: 753
Heading: Nursing Care for the Patient With Chronic Kidney Disease
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Moderate

	Feedback
1	The patient may or may not need oxygen therapy; this intervention requires a prescription by the HCP.
2	Measurement of abdominal girth provides information about ascites. Patients with renal failure may not initially exhibit abdominal ascites. There is a better nursing intervention.
3	Patients with acute or chronic renal failure must be weighed daily at the same time, on the same scale, wearing the same type of clothing. Any weight gain of 2 pounds or more indicates fluid retention. This is the most important nursing intervention.
4	Fluids may or may not need to be restricted; this intervention requires a prescription by the HCP.

PTS: 1 CON: Elimination

16. ANS: 2
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Plan nursing care for patients on peritoneal dialysis.
Page: 765
Heading: Peritoneal Dialysis
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential

Cognitive Level: Analysis (Analyzing)
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	The patient on peritoneal dialysis needs to perform the procedure in a clean environment. The nurse needs to be concerned about the cleanliness with several pets roaming around in the house.
2	It is important that the patient understands the symptoms that need to be reported to the HCP. The symptoms of infection or peritonitis must have immediate treatment. This is the nurse's least concern.
3	The patient must use sterile technique when attaching and instilling the dialysate to prevent the introduction of pathogens or microbes into the abdominal cavity. Clean technique is a matter of concern.
4	The nurse is concerned if the patient limits dietary protein intake. The patient on peritoneal dialysis loses proteins through the peritoneal membrane. Increased protein is needed. This is a matter of concern for the nurse.

PTS: 1 CON: Patient-Centered Care

17. ANS: 1
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Discuss nursing care for a vascular access site.
Page: 763
Heading: Vascular Access
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Patient-Centered Care
Difficulty: Moderate

	Feedback
1	The patient will have an arteriovenous (AV) fistula formed; placement is in the nondominate arm. Therefore, all needle sticks and blood pressures should be avoided in this arm to prevent damage to the veins.
2	A central venous catheter may be placed temporarily until the AV fistula is healed and developed. Long use of a central catheter should be avoided due to the risk for infection.
3	There is no need for the patient to shower with antimicrobial soap before or after the establishment of an AV fistula.
4	The AV fistula is most commonly placed on the patient's arm. Tight clothing on the arm needs to be avoided, but there are no restrictions about under clothing.

PTS: 1 CON: Patient-Centered Care

MULTIPLE RESPONSE

18. ANS: 2, 4, 5
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Plan nursing care for a patient with acute kidney injury.
Page: 744
Heading: Urological Obstructions
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Difficult

	Feedback
1.	Bread does not need to be restricted on a low-oxalate diet.
2.	A low-oxalate diet restricts foods such as beets, rhubarb, spinach, cocoa, and instant coffee.
3.	Lettuce does not need to be restricted on a low-oxalate diet.
4.	A low-oxalate diet restricts foods such as beets, rhubarb, spinach, cocoa, and instant coffee.
5.	A low-oxalate diet restricts foods such as beets, rhubarb, spinach, cocoa, and instant coffee.

PTS: 1 CON: Elimination

19. ANS: 1, 4, 5
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Discuss nursing care for a vascular access site.
Page: 764
Heading: Vascular Access
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Reduction of Risk Potential
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Difficult

	Feedback
1.	The fistula must be protected from anything causing pressure or restriction of blood flow. The patient should not sleep on the left arm.
2.	The left arm does not need to be elevated at all times.
3.	A firm bandage does not need to be on the left arm.
4.	The fistula must be protected by anything causing pressure or restriction of blood flow. Loose clothing should be worn on the left arm.
5.	The fistula must be protected by anything causing pressure or restriction of blood flow. Heavy objects should not be carried with the left arm.

PTS: 1 CON: Elimination

20. ANS: 2, 3, 4, 5
Chapter: Chapter 37. Nursing Care of Patients With Disorders of the Urinary System
Objective: Plan nursing care for patients with chronic kidney disease.
Page: 760
Heading: Polycystic Kidney Disease
Integrated Process: Clinical Problem-Solving Process (Nursing Process)
Client Need: Physiological Integrity—Physiological Adaptation
Cognitive Level: Analysis (Analyzing)
Concept: Elimination
Difficulty: Difficult

	Feedback
1.	The first signs of PKD occur in adulthood.
2.	Grape-like structures do replace normal, functioning kidney structures. The cysts contain serous fluid, blood, or urine.
3.	The initial symptoms will include a dull heaviness in the flank or lumbar region, accompanied by hematuria.
4.	Persons with inherited PKD are at risk for brain aneurysms and diverticulosis in the colon.
5.	Persons diagnosed with PKD are likely to have hypertension and UTIs that require treatment.

PTS: 1 CON: Elimination