1. The nurse is caring for the following clients on a medical unit. Which client should the nurse assess first?
   1. The client with acute glomerulonephritis who has oliguria and periorbital edema.
   2. The client with benign prostatic hypertrophy who has blood oozing from the intravenous site.
   3. The client with renal calculi who is complaining of flank pain rated as a 5 on a scale of 1 to 10.
   4. The client with nephrotic syndrome who has proteinuria and hypoalbuminemia.

2. The nurse is inserting an indwelling catheter into a male elderly client. Which intervention should the nurse implement first?
   1. Ask the client if he has any prostate problems.
   2. Determine if the client has any betadine allergies.
   3. Lubricate the end of the indwelling catheter.
   4. Ensure urine is obtained in the indwelling catheter.

3. The nurse is preparing to administer intravenous narcotic medication to the client who has renal calculi and is complaining of pain rated as 8 on 1 to 10 pain scale. The client's vital signs are stable. Which intervention should the nurse implement first?
   1. Clamp the IV tubing proximal to the port of medication administration.
   2. Administer the narcotic medication slowly over 2 minutes.
   3. Check the medication administration record (MAR) against the hospital identification band.
   4. Determine if the client’s intravenous site is patent.

4. The nurse is administering medications to clients on a surgical unit. Which medication should the nurse administer first?
   1. The narcotic analgesic morphine IV infusion to the client who is 8 hours postoperative and is complaining of pain, rating it as a 7 on a 1 to 10 pain scale.
   2. The aminoglycoside antibiotic vancomycin intravenous piggyback (IVPB) to the client with an infected abdominal wound.
   3. The proton-pump inhibitor pantoprazole (Protonix) IVPB to the client who is at risk for developing a stress ulcer.
   4. The loop-diuretic furosemide (Lasix) intravenous push (IVP) to the client who has undergone surgical debridement of the right lower limb.
5. The nurse and unlicensed assistive personnel (UAP) are caring for clients on a surgical unit. Which action by the UAP warrants immediate intervention?
1. The UAP empties the indwelling catheter bag for the client with transurethral resection of the prostate (TURP).
2. The UAP assists a client who received an IV narcotic analgesic 30 minutes ago to ambulate in the hall.
3. The UAP provides apple juice to the client with a nephrectomy who has just been advanced to a clear liquid diet.
4. The UAP applies moisture barrier cream to the elderly client with urinary incontinence who has an excoriated perianal area.

6. The charge nurse is making shift assignments to the surgical staff, which consists of two nurses, two licensed practical nurses (LPNs), and two unlicensed assistive personnel (UAP). Which assignment would be most appropriate for the charge nurse to make?
1. Instruct the nurse to administer all PRN medications.
2. Instruct the UAP to clean the recently vacated room.
3. Assign the LPN to change the client’s ileal conduit bag.
4. Request the LPN to complete the admission for a new client.

7. The charge nurse is making assignments in the day surgery center. Which client should be assigned to the most experienced nurse?
1. The 24-year-old client who had a circumcision and is being prepared for discharge.
2. The client scheduled for a cystectomy who is crying and upset about the surgery.
3. The client diagnosed with kidney cancer who is receiving two units of blood.
4. The client who has end-stage renal disease and had an arteriovenous fistula created.

8. The nurse is completing the admission assessment on the client scheduled for cystectomy with creation of an ileal conduit. The client tells the nurse, “I am taking saw palmetto for my enlarged prostate.” Which intervention should the nurse implement first?
1. Notify the client’s HCP to write an order for the herbal supplement.
2. Ask the client why he is taking an herb for his enlarged prostate.
3. Consult with the pharmacist to determine any potential drug interactions.
4. Look up saw palmetto in the Physicians’ Desk Reference (PDR).

9. The client scheduled for a D&C is upset because the HCP told her she has syphilis. The client asks the nurse, “This is so embarrassing. Do you have to tell anyone about this?” Which statement is the nurse’s best response?
1. “This must be reported to the Public Health Department and your sexual partners.”
2. “According to the Health Insurance Portability and Accountability Act (HIPAA), I cannot report this to anyone without your permission.”
3. “You really should tell your sexual partners, so they can be treated for syphilis.”
4. “I realize you are embarrassed. Would you like to talk about the situation?”

10. The nurse is caring for clients on the renal unit. Which task is most appropriate for the nurse to delegate to the unlicensed assistive personnel (UAP)?
1. Instruct the UAP to calculate the clients’ urinary intake and output.
2. Request the UAP to double-check a unit of blood that is being administered.
3. Tell the UAP to change the surgical dressing on the client with a kidney transplant.
4. Ask the UAP to transfer the client from the renal unit to the intensive care unit.
11. The nurse is caring for clients on a renal unit and making assignments for the day shift. Which client should the nurse assess first?
   1. The client diagnosed with interstitial cystitis who has urinary urgency and pain in the bladder.
   2. The client with acute post–streptococcal glomerulonephritis who has hematuria with a smoky appearance.
   3. The client diagnosed with Goodpasture syndrome who has pallor, anemia, and renal failure.
   4. The client diagnosed with nephrolithiasis who has hematuria and is complaining of pain, rating it as a 9 on 1 to a 10 pain scale.

12. Which action by the licensed practical nurse (LPN) requires intervention by the critical care charge nurse?
   1. The LPN has the trough drawn after hanging the aminoglycoside.
   2. The LPN changes out a “sharps” container that is over the fill line.
   3. The LPN asks another nurse to observe wastage of a narcotic.
   4. The LPN inserts an indwelling urinary catheter into the client.

13. The unlicensed assistive personnel (UAP) reports to the nurse the client’s urine output has bright red blood. Which intervention should the nurse implement first?
   1. Instruct the UAP to take a urine specimen to the laboratory.
   2. Document the findings in the client’s nursing notes.
   3. Assess the client’s urine specimen and complete a renal assessment.
   4. Ask the UAP to take the client’s vital signs.

14. The charge nurse is making client assignments. Which client should the nurse assign to the graduate nurse who has just finished orientation?
   1. The client with a cystectomy who had a creation of an ileal conduit.
   2. The client on continuous hemodialysis who is awaiting a kidney transplant.
   3. The client with renal trauma secondary to a motor vehicle accident.
   4. The client who has had abdominal surgery and whose wound has eviscerated.

15. The charge nurse on the renal unit is notified of a bus accident with multiple injuries and clients are being brought to the emergency department (ED). The hospital is implementing the disaster policy. Which action should the nurse take first?
   1. Determine which clients could be discharged home immediately.
   2. Call any off-duty nurses to notify them to come in to work.
   3. Assess the staffing to determine which staff could be sent to ED.
   4. Request all visitors to leave the hospital as soon as possible.

16. The 18-year-old client diagnosed with renal trauma is admitted to the critical care unit after a serious motor vehicle accident resulting from driving under the influence. The mother comes to the unit and starts yelling at her son about “driving drunk.” Which action should the nurse implement?
   1. Allow the mother to continue talking to her son.
   2. Notify the hospital security to remove the mother.
   3. Escort the mother to a private area and talk to her.
   4. Tell the mother if she wants to stay, she must be quiet.

17. The nurse is caring for an 84-year-old male client diagnosed with benign prostatic hypertrophy. The client has undergone a transurethral resection of the prostate (TURP) and is complaining of bladder spasms. Which intervention should the nurse implement first?
   1. Administer an antispasmodic medication for bladder spasms.
   2. Calculate the client’s urinary output.
   3. Palpate the client’s abdomen for bladder distention.
   4. Assess the client’s three-way urinary catheter for patency.
18. The nurse is caring for clients on a surgical unit. Which client should the nurse assess first after shift report?
   1. The client diagnosed with polycystic kidney disease who has a B/P 170/100.
   2. The client diagnosed with bladder cancer who has gross painless hematuria.
   3. The client diagnosed with renal calculi who thinks he passed a stone.
   4. The client with acute pyelonephritis who has nausea/vomiting and is dehydrated.

19. The 78-year-old client with Alport syndrome asks the clinic nurse, “What should I do so I won’t get sick this winter?” Which priority statement is the nurse’s best response?
   1. “You should not be around any crowds during the winter months.”
   2. “It is recommended you get a flu vaccine yearly.”
   3. “You need to eat three well-balanced meals a day.”
   4. “Dress warmly when it is less than 40 degrees Fahrenheit outside.”

20. The elderly female client tells the nurse, “I have vaginal dryness and it hurts when my husband and I make love.” Which priority intervention should the nurse discuss with the client?
   1. Tell the client to discuss hormone replacement therapy with her HCP.
   2. Encourage the client to refrain from having sexual intercourse.
   3. Recommend the client use a vaginal lubricant prior to intercourse.
   4. Explain to the client that vaginal dryness is not uncommon in the elderly.

21. The elderly female client diagnosed with osteoporosis is prescribed the bisphosphonate medication alendronate (Fosamax). Which intervention is priority when administering this medication?
   1. Administer the medication first thing in the morning.
   2. Ask the client whether she has a history of peptic ulcer disease.
   3. Encourage the client to walk for at least 30 minutes.
   4. Have the client remain upright for 30 minutes after administering the medication.

22. Which nursing task should the nurse on the renal unit assign to the licensed practical nurse (LPN)?
   1. Insert an indwelling urinary catheter before surgery.
   2. Turn and reposition the client every 2 hours.
   3. Measure and record the urine in the bedside commode.
   4. Feed the client who choked on food during the last meal.

23. The nurse on a medical unit has just received the evening shift report. Which client should the nurse assess first?
   1. The client with renal vein thrombosis who has a heparin drip infusion and a PTT of 92.
   2. The client on peritoneal dialysis who has a clear dialysate draining from the abdomen.
   3. The client on hemodialysis whose right upper arm fistula has an audible bruit.
   4. The client diagnosed with cystitis who is complaining of burning on urination.

24. The nurse is preparing to administer medications. Which medication should the nurse administer first?
   1. Digoxin (Lanoxin), a cardiac glycoside, due at 0900.
   2. Furosemide (Lasix), a loop diuretic, due at 0800.
   3. Propoxyphene (Darvon), an analgesic, due in 2 hours.
   4. Acetaminophen (Tylenol), an analgesic, due in 5 minutes.

25. Which intervention should the nurse implement first when assisting a client with a flaccid bladder to urinate?
   1. Perform the Credé’s maneuver on the client.
   2. Perform intermittent catheterization on the client.
   3. Place the client on the bedside commode.
   4. Request the client to drink a full glass of water.
26. The nurse is caring for clients in a family practice clinic. Which client should the nurse assess first?
1. The male client with chronic pyelonephritis who has costovertebral tenderness.
2. The female client who is having burning and pain on urination.
3. The female client with urethritis who reports dysuria, urgency, and frequent urination.
4. The male client who has hesitancy, terminal dribbling, and intermittency.

27. The nurse and unlicensed assistive personnel (UAP) are working in a family practice clinic. Which task should the nurse delegate to the UAP?
1. Give the client sample medications for a urinary tract infection (UTI).
2. Show the client how to use a self-monitoring blood glucometer.
3. Answer the telephone triage line and take messages from clients.
4. Take the vital signs of a client scheduled for a physical examination.

28. Which task is most appropriate for the nurse on the renal unit to delegate to the unlicensed assistive personnel (UAP)?
1. Escort the client with acute polynephritis to the radiology department for a CT scan.
2. Obtain a sterile urine specimen for the client to rule out (R/O) a urinary tract infection.
3. Hang the bag of D5W for the client diagnosed with post-streptococcal glomerulonephritis.
4. Provide discharge instructions for the client diagnosed for nephrotic syndrome.

29. Which task should the employee health nurse delegate to the unlicensed assistive personnel (UAP)?
1. Request the UAP read the PPD result administered to the client 72 hours ago.
2. Ask the UAP to obtain a urine specimen for the client having a urine drug screening.
3. Tell the UAP to apply an ice pack to the client who slipped and has a sprained right ankle.
4. Instruct the UAP to complete the incident report for the nurse who had a “dirty needle stick.”

30. The nurse manager in the medical-surgical outpatient clinic is making assignments. Which task is most appropriate to delegate/assign to the UAP/LPN?
1. Ask the LPN to administer the flu vaccine to the client.
2. Tell the UAP to call the pharmacist to refill a prescription.
3. Request the LPN to obtain the height and weight of the client.
4. Instruct the UAP to empty the trashcans in the clients’ rooms.

31. Which behavior warrants intervention by the clinical manager in the medical-surgical outpatient clinic?
1. The UAP is discussing a client’s condition in the waiting room.
2. The LPN is talking to a client over the phone about laboratory tests.
3. The RN is triaging phone messages during his or her lunch break.
4. The UAP is taking vital signs for the client being placed in a room.

32. The UAP in the school nurse’s office is listening to a female student who is pregnant and scared to tell her parents. Which action should the school nurse implement?
1. Tell the UAP she cannot talk to the female student.
2. Call the student’s parents and tell them their daughter is pregnant.
3. Do not take any action and allow the UAP to listen to the student.
4. Ask the UAP to leave and continue to talk to the student.
33. The nurse observes an LPN discussing an intravenous pyelogram, a diagnostic test, with a client in the waiting room of the outpatient clinic. Which action should the nurse implement?
   1. Praise the LPN for talking to the client about the diagnostic test.
   2. Tell the LPN the nurse needs to talk to her in the office area.
   3. Go to the waiting room and tell the LPN not to discuss this there.
   4. Inform the HCP that the LPN was talking to the client in the waiting room.

34. The charge nurse in a large outpatient clinic notices the staff members are arguing and irritable with one other and the atmosphere has been very tense for the past week. Which action should the charge nurse take?
   1. Wait for another week to see whether the situation resolves itself.
   2. Write a memo telling all staff members to stop arguing.
   3. Schedule a meeting with the staff to discuss the situation.
   4. Tell the staff to stop arguing or they will be terminated.

35. The employee health nurse is obtaining a urine specimen for a pre-employment drug screen. Which action should the nurse implement first?
   1. Obtain informed consent for the procedure.
   2. Maintain the chain of custody for the specimen.
   3. Allow the client to go to any bathroom in the clinic.
   4. Take and record the client’s tympanic temperature.

36. The client comes to the clinic reporting pain and burning on urination. Which action should the nurse implement first?
   1. Assess and document the client’s vital signs.
   2. Determine whether the client has seen any blood in the urine.
   3. Request the client give a midstream urine specimen.
   4. Ask the client whether she wipes front to back after a bowel movement.

37. The nurse is working at the emergency health clinic in a disaster shelter. Which intervention is priority when initially assessing the client?
   1. Find out how long the client will be in the shelter.
   2. Determine whether the client has his or her routine medications.
   3. Document the client’s health history in writing.
   4. Assess the client’s vital signs, height, and weight.

38. The HCP orders an intravenous pyelogram for the 27-year-old male client diagnosed with R/O renal calculi. The client is diagnosed with schizophrenia and is delusional. Which action should the clinic nurse implement?
   1. Ask the client whether he is allergic to yeast.
   2. Request the client to sign a permit for the procedure.
   3. Obtain informed consent from the client’s significant other.
   4. Discuss the local hospital’s day surgery procedure with the client.

39. The home health (HH) aide tells the home health nurse one of the older male clients is taking an herbal supplement, saw palmetto, every day. Which statement is the nurse’s best response?
   1. “Herbal supplements are dangerous and I will talk to the client.”
   2. “Saw palmetto is used to treat benign prostatic hypertrophy. Let him take it.”
   3. “I will notify the client’s healthcare provider as soon as possible.”
   4. “Many clients use herbal supplements. He has a right to take it.”

40. The home health (HH) aide caring for the client who is postoperative kidney transplant asks the home health nurse, “Why is the physical therapist coming to visit the client?” Which statement is the home health nurse’s best response?
   1. “The physical therapist will evaluate the client’s swallowing difficulty.”
   2. “The physical therapist will assist the client with fine motor coordination.”
   3. “The physical therapist will assist with caregiver concerns and making referrals.”
   4. “The physical therapist will work with the client on strengthening and endurance.”
41. The home health (HH) nurse is admitting a female client diagnosed with end-stage renal disease who refuses to be placed on hemodialysis. The client is ready to die, but verbalizes having so many regrets in her life. Which intervention would be most appropriate for the nurse?
1. Contact the agency chaplain to come talk to the client.
2. Call her church pastor and discuss the client’s concerns.
3. Ask the client whether or not she would like to pray with the nurse.
4. Determine whether or not the client has an advance directive.

42. The nurse is preparing to perform a dressing change on a female client who has end-stage renal disease. The nurse notes the client’s husband is silently holding the client’s hand and praying. Which action should the nurse implement first?
1. Continue to prepare for the dressing change in the room.
2. Call the chaplain to help the client and spouse pray.
3. Quietly leave the room and come back later for the dressing change.
4. Ask the husband whether or not he would like the nurse to join in the prayer.

43. The unit manager on the renal unit is evaluating the staff nurse. Which data should be included in the nurse’s yearly evaluation?
1. The fact that the nurse clocked in late to work twice in the last year.
2. The complaint stating the nurse did not answer a call light during a code.
3. The number of times the nurse switched shifts with another nurse.
4. The appropriateness of the nurse’s written documentation in the charts.

44. The hospice nurse is providing follow-up care with the family member of a client who died with chronic renal disease. Which intervention is priority?
1. Attend the client’s funeral service or visitation.
2. Check on the family 1 to 2 months after the death of the client.
3. Make sure the arrangements are what the client wanted.
4. Help the family member dispose of the client’s belongings as soon as possible.

45. The nurse is attempting to start an intravenous (IV) line in an elderly client who is dehydrated. After two unsuccessful attempts, which intervention should the nurse implement?
1. Keep trying to get a patent IV access.
2. Ask the HCP to order oral fluid replacement.
3. Ask a second nurse to attempt to start the IV.
4. Place cold packs on the client’s arms for comfort.

46. The client diagnosed with chronic kidney disease (CKD), and who has a left forearm graft, is assigned to the nurse and unlicensed assistive personnel (UAP). Which action by the UAP requires immediate intervention by the nurse?
1. The UAP avoids using soap while bathing the client.
2. The UAP takes the BP on the client’s left arm.
3. The UAP tells the client she should not eat chips.
4. The UAP measures a scant amount of urine in the BSC.
47. The nurse is on the day shift in a long-term care facility. Which medication should the nurse question administering to the 85-year-old client with chronic pyelonephritis and heart failure?

1. Lanoxin.
2. Lasix.
4. Dulcolax.

48. The elderly patient diagnosed with heart failure is scheduled to receive a unit of packed red blood cells (PRBCs). The PRBCs are prepared in 350 mL of solution. At what rate should the nurse set the pump? ____________

49. Which interventions should the nurse delegate to the unlicensed assistive personnel (UAP) when caring for the client who is 2 days postoperative open surgery of the kidney? Select all that apply.
1. Explain the procedure for using the patient-controlled analgesia (PCA) pump.
2. Check the client’s flank surgical dressing for drainage.
3. Take and record the client’s vital signs and pulse oximeter reading.
4. Empty the client’s indwelling catheter bag at the end of the shift.
5. Assist the client to ambulate in the hallway three to four times a day.

50. The client with open surgery of the kidney has an AP 118 and B/P 88/58. Which intervention should the nurse implement first?
1. Obtain the client’s pulse oximeter reading.
2. Check the client’s last hemoglobin and hematocrit.
3. Notify the client’s surgeon immediately.
4. Monitor the client’s urine output.

51. The 88-year-old female client is complaining of urinary frequency and dribbling. Which nursing interventions should be implemented? Rank in order of performance.
1. Have the unlicensed assistive personnel (UAP) make “potty” rounds on the client every 2 hours.
2. Give the client perineal pads to place inside her underwear.
3. Place an absorbent pad on the client’s bed.
4. Put a bedside commode at the client’s bedside.
5. Instruct the client in providing a clean-catch urine specimen.
52. The nurse in the dialysis center is initiating the morning dialysis run. Which client should the nurse assess first?
   1. The client who has a hemoglobin of 9.0 mg/dL and hematocrit of 26%.
   2. The client who does not have a palpable thrill or auscultated bruit.
   3. The client who is reporting a 3.6 kg weight gain and is refusing dialysis.
   4. The client on peritoneal dialysis who is complaining of a hard, rigid abdomen.

53. The male client with chronic kidney disease has received the initial dose of erythropoietin, a biological response modifier, 1 week ago. Which data warrants the nurse to notify the healthcare provider?
   1. The client’s pulse oximeter reading of 95%.
   2. The client has a platelet count of 155,000.
   3. The client has a blood pressure reading of 184/102.
   4. The client has a tympanic temperature of 99.8°F.

54. The nurse is developing a nursing care plan for the client diagnosed with chronic kidney disease. Which nursing problem should be addressed first?
   1. Self-care deficit.
   2. Knowledge deficit.
   3. Chronic pain.
   4. Excess fluid volume.

55. The client with chronic kidney disease is placed on a fluid restriction of 1,500 milliliters per day. On the 7 a.m. to 7 p.m. shift the client drank an 8-ounce cup of coffee, 8 ounces of juice, 16 ounces of tea, and 8 ounces of water with medications. What amount of fluid can the 7 p.m. to 7 a.m. nurse give to the client?

56. The client receiving dialysis is complaining of being dizzy and light-headed. Which priority intervention should the nurse implement?
   1. Place the client in the reverse Trendelenburg position.
   2. Decrease the volume of blood being removed from the client.
   3. Bolus the client 300 mL of 0.9% saline solution.
   4. Notify the healthcare provider as soon as possible.

57. The client is NPO and is receiving total parenteral nutrition (TPN) via a subclavian line. Which precautions should the nurse implement? Select all that apply.
   1. Place the client’s TPN on a gravity intravenous line.
   2. Monitor the client’s blood glucose every 24 hours.
   3. Weigh the client daily, first thing in the morning.
   4. Change the client’s IV tubing with every TPN bag administered.
   5. Monitor the client’s intake and output every shift.

58. The client has received IV solutions for 3 days through a 20-gauge IV catheter placed in the left cephalic vein. On morning rounds the nurse notes the IV site is tender to palpation, it is edematous, and a red streak has formed. Which interventions should the nurse implement? Rank in priority order.
   1. Start a new IV in the right hand.
   2. Discontinue the intravenous line.
   3. Complete an incident record.
   4. Place a warm washcloth over the site.
   5. Document the situation in the client’s chart.

59. The nurse and unlicensed assistive personnel (UAP) are caring for a group of clients. Which nursing intervention should the nurse perform?
   1. Measure the client’s output from the indwelling catheter.
   2. Record the client’s intake and output on the I&O sheet.
   3. Instruct the client on appropriate fluid restrictions.
   4. Provide water for a client diagnosed with acute polynephritis.
60. The nurse emptied 2,340 mL from the drainage bag of a continuous irrigation of a client who had a transurethral resection of the prostate (TURP). The amount of irrigation in the hanging bag was 3,000 mL at the beginning of the shift. There was 1,550 mL left in the bag 8 hours later. What is the correct urine output at the end of the 8 hours? 

61. Which nursing diagnosis is priority for the client who has undergone a transurethral resection of the prostate (TURP)?
1. Potential for sexual dysfunction.
2. Potential for altered urinary elimination.
3. Potential for infection.
4. Potential for hemorrhage.

62. The client is 1 day postoperative transurethral resection of the prostate (TURP). Which action by the unlicensed assistive personnel (UAP) warrants intervention by the nurse?
1. The UAP increased the client’s irrigation fluid to clear clots from the tubing.
2. The UAP elevated the client’s scrotum on a towel roll for support.
3. The UAP emptied the client’s indwelling urinary catheter bag.
4. The UAP brought ice water to the client’s bedside.

63. The male client diagnosed with renal calculi is admitted to the medical unit. Which intervention should the nurse implement first?
1. Request the client to urinate in a urinal.
2. Assess the client’s pain.
3. Increase the client’s oral fluid intake.
4. Strain the client’s urine.

64. The female client with renal calculi is scheduled for a STAT kidney, ureter, bladder (KUB). Which statement by the client warrants intervention by the nurse?
1. “I am allergic to shell fish and iodine.”
2. “I just had my lunch tray and ate all of it.”
3. “I have not had my period for 3 months.”
4. “I am having pain in my lower back.”

65. The client diagnosed with renal calculi is scheduled for a 24-hour urine specimen collection. Which interventions should the nurse implement? Select all that apply.
1. Keep the client NPO during the time the urine is being collected.
2. Instruct the client to urinate, and include this urine when starting collection.
3. Place client’s urine in an appropriate specimen container for 24 hours.
4. Insert an indwelling catheter in client after having the client empty the bladder.
5. Post signs on the client’s door alerting staff to save all of the client’s urine output.

66. The client diagnosed with renal calculi is 1 hour post-procedure lithotripsy. Which task is most appropriate for the nurse to delegate to the unlicensed assistive personnel (UAP)?
1. Tell the UAP to check the amount, color, and consistency of the client’s urine output.
2. Request the UAP to transcribe the client’s healthcare provider’s orders.
3. Instruct the UAP to strain the client’s urine and place any sediment in a sterile container.
4. Ask the UAP to take the client’s post-procedural vital signs.

67. The client had surgery to remove a kidney stone. Which of the following laboratory assessment data warrants intervention by the nurse?
1. A serum potassium level of 5.2 mEq/L.
2. A urinalysis showing blood in the urine.
3. A creatinine level of 1.2 mg/100 mL.
4. A white blood cell count of 9,500 mm/dL.
68. Which intervention should the nurse implement first for the client diagnosed with urinary incontinence?
   1. Palpate the bladder after an incontinent episode.
   2. Administer oxybutynin, an anticholinergic agent.
   3. Ensure the client does not sit or lie in the urine.
   4. Instruct the client to go to the bathroom every 2 hours.

69. The nurse is caring for an elderly female client who has an indwelling catheter. Which data warrants notifying the healthcare provider?
   1. The client’s vital signs are T 98, AP 90, RR 16, B/P 142/88.
   2. The client has had a change in her mental status.
   3. The client’s urine is cloudy with sediment.
   4. The client has no discomfort or pain.

70. The nurse is observing the unlicensed assistive personnel (UAP) provide care to a client with an indwelling catheter. Which action by the UAP warrants immediate intervention by the nurse?
   1. The UAP does not secure the tubing to the client’s leg with tape.
   2. The UAP wears gloves when providing catheter care to the client.
   3. The UAP positions the collection bag on the side of the client’s bed.
   4. The UAP cares for the client’s catheter after washing his or her hands.
Ms. Brenda is the clinical manager on a 20-bed renal unit. Today, Ms. Brenda is the charge nurse for the 7p-7a shift because the regular charge nurse is on emergency family leave. The staff for the shift includes two RNs (Mr. Ray and Ms. Mary), one LPN (Ms. Cindy), and two unlicensed assistive personnel (UAPs) (Ms. Debbie and Ms. Paula).

1. Ms. Mary, RN, and Ms. Debbie, the UAP, are caring for clients on the unit. Which nursing task would be most appropriate for Ms. Mary to delegate to Ms. Debbie?
   1. Assist the radiology technician with a portable chest x-ray.
   2. Evaluate the client’s 8-hour intake and output.
   3. Perform an in and out catheterization for a sterile urine specimen.
   4. Administer a cation-exchange resin enema.

2. Mr. Ray is preparing to perform hemodialysis on the client diagnosed with end-stage renal disease. Which data warrants immediate intervention from Mr. Ray?
   1. A hemoglobin of 9.8 mg/dL and hematocrit of 30%.
   2. Inability to palpate thrill or auscultate a bruit.
   3. Complaints of being exhausted and unable to sleep.
   4. No urine output in the past 12 hours.

3. The client who is 1 day postoperative cystectomy has a nasogastric tube (NGT) in place and an IV running at 150 mL/hr via an IV pump. Which data should Ms. Mary report to the healthcare provider?
   1. The client’s peripheral intravenous access is infiltrated.
   2. The client has hypoactive bowel sounds.
   3. The client has crackles bilaterally in the lower lobes.
   4. The client has 2+ bilateral pedal pulses.

4. The elderly client is diagnosed with chronic glomerulonephritis. Which lab value indicates the condition has gotten worse?
   1. The BUN is 18 mg/dL.
   2. The creatinine level is 1.0 mg/dL.
   3. The glomerular filtration rate is 60 mL/minute.
   4. The 24-hour creatinine clearance is 120 mL/minute.

5. Ms. Debbie emptied 3,000 mL from the drainage bag of a continuous bladder irrigation (CBI) of a client who had a transurethral resection of the prostate (TURP). The amount of irrigation in the bag hanging was 4,000 mL at the beginning of the shift. There was 2,000 mL left in the bag at 0700. What is the corrected urine output for the shift? ___________

6. The client returned from surgery after having a TURP and has a P 96, R 20, B/P 110/70 and light pink urine draining in the indwelling urinary bag. Which interventions should Mr. Ray implement? Select all that apply.
   1. Assess the urine in the continuous irrigation drainage bag.
   2. Increase the irrigation fluid in the continuous irrigation catheter.
   3. Lower the head of the bed while raising the foot of the bed.
   4. Contact the surgeon to give an update in the client’s condition.
   5. Monitor the client’s postoperative hematocrit and hemoglobin.

7. The client diagnosed with renal calculi is admitted to the unit. Which intervention should Ms. Mary implement first?
   1. Complete the admission assessment documentation.
   2. Assess the client’s pain and rule out complications.
   3. Increase the client’s oral fluid intake.
   4. Transcribe the client’s healthcare provider’s orders.
8. The client diagnosed with renal calculi is scheduled for lithotripsy. Which post-procedure nursing task is most appropriate to delegate to Ms. Debbie, the UAP?
   1. Assess the amount, color, and consistency of urine output.
   2. Teach the client about care of the indwelling urinary catheter.
   3. Instruct Ms. Debbie to strain the client’s urine.
   4. Maintain the client on strict bed rest.

9. Ms. Brenda is making rounds on clients. Which client should Ms. Brenda assess first?
   1. The client with end-stage renal disease on hemodialysis who has a palpable thrill.
   2. The client with acute glomerulonephritis who has hematuria and proteinuria.
   3. The client with bladder cancer who has painless urination with bright red urine.
   4. The client with an ileal conduit who has not had any drainage in the drainage bag.

10. Ms. Mary, the RN, and Ms. Cindy, the LPN, are caring for clients. Which intervention should Ms. Mary assign Ms. Cindy?
    1. Teach the client the home care of the suprapubic catheter.
    2. Monitor of the post-op client with a WBC of 22,000 mm/dL.
    3. Administer antineoplastic medications to the client with bladder cancer.
    4. Administer a narcotic analgesic to the client with renal calculi.
The correct answer number and rationale for why it is the correct answer are given in **boldface type**. Rationales for why the other possible answer options are incorrect also are given, but they are not in boldface type.

1. 1. The nurse would expect the client with acute glomerulonephritis to have oliguria and periorbital edema. Acute glomerulonephritis is a disorder of the glomeruli (glomerulonephritis), or small blood vessels in the kidneys.

2. **The nurse would not expect the client with BPH to have oozing blood from the intravenous site.** This may indicate disseminated intravascular coagulation (DIC), which is a potentially life-threatening complication and requires immediate intervention.

3. The nurse would expect the client with renal calculi to have pain, but a level 5 pain indicates the pain is under control; therefore, this client does not need to be seen first.

4. The nurse would expect the client with nephrotic syndrome to have proteinuria (protein in the urine) and hypoalbuminemia (decreased protein in the blood). Nephrotic syndrome is a nonspecific disorder in which the kidneys are damaged, causing them to leak large amounts of protein into the urine.

**MAKING NURSING DECISIONS:** The nurse must determine which sign/symptom is not expected for the disease process. If the sign/symptom is not expected, or if it is an emergency situation, the nurse should assess the client first. This type of question is determining if the nurse is knowledgeable of signs/symptoms of a variety of disease processes.

2. 1. This is an appropriate question, but even clients with prostate problems can have an indwelling catheter inserted carefully.

2. **Betadine is included in the indwelling catheter kit; so another form of cleaning agent must be used when inserting the catheter. Therefore, this is the first intervention.**

3. This is appropriate, but not the first intervention.

4. **Urine should be obtained in the catheter, but it is not the first intervention.**

**MAKING NURSING DECISIONS:** When the question asks, “Which intervention should be implemented first?” it means all the options are things a nurse could implement, but only one should be implemented first. The nurse should use the nursing process and remember: If the client is in distress, do not assess; if the client is not in distress, the nurse should assess.

3. 1. The nurse should clamp the tubing to ensure the medication goes directly into the client and not retrograde up the tubing, but it is not the first administration.

2. The medication should be administered over 2 minutes, but it is not the first intervention.

3. The nurse should always ensure the medication is being administered to the correct client, but the nurse should first make sure the route of administration is safe.

4. **Ensuring the site is patent is the first intervention because even if it is the correct client, the medication should not be administered if the IV site is infiltrated.**

**MAKING NURSING DECISIONS:** When the question asks, “Which intervention should be implemented first?” it means all the options are things a nurse could implement, but only one should be implemented first. The nurse should use the nursing process and remember: If the client is in distress, do not assess; if the client is not in distress, the nurse should assess.

4. 1. The client who is in pain is priority. None of the other clients have a life-threatening condition. Pain is considered the fifth vital sign.

2. Routine antibiotics are not priority over a client who has postoperative pain.

3. Risk for a stress ulcer is a potential, not an actual, problem, and proton-pump inhibitors
are administered routinely to help prevent stress ulcers.

4. The loop diuretic is a routine medication prescribed for a medical comorbid condition, not for surgical debridement.

5. 1. The unlicensed assistive personnel (UAP) can empty an indwelling catheter drainage bag because this does not require judgment.

   2. The client who received a narcotic analgesic 30 minutes ago is at risk for falling because of the effects of the medication; therefore, the UAP should not ambulate this client. The nurse should intervene.

   3. The UAP can provide juice to the client, and apple juice is part of the client’s liquid diet.

   4. Moisture barrier cream is not a medication; therefore, the UAP can apply such creams to an intact perianal area.

6. 1. The LPN can administer routine as well as some PRN medications; assigning the nurse to administer all PRN medications is not appropriate.

   2. The housekeeping department, not the UAP, is assigned to clean recently vacated rooms.

   3. It is within an LPN’s scope of practice to change an ileal conduit drainage bag; therefore, this would be the most appropriate assignment for the LPN.

   4. The nurse would be the most appropriate staff member to complete the admission assessment.

MAKING NURSING DECISIONS: When the nurse is making a decision about prioritizing medication administration, client comfort takes priority over regularly scheduled medications.

MAKING NURSING DECISIONS: The nurse cannot delegate assessment, evaluation, teaching, administration of medications, or an unstable client to an unlicensed assistive personnel (UAP).

7. 1. The most experienced nurse should be assigned to the client who requires teaching prior to being discharged. Postoperative complications can occur, so the client must be knowledgeable of when to call the healthcare provider and how to take care of the surgical site.

   2. A less experienced nurse can talk to the client who is crying and upset. The most experienced nurse should care for a client who requires more knowledge.

   3. A less experienced nurse can administer and monitor blood transfusion to the client.

   4. Although the creation of an arteriovenous fistula requires assessment and teaching on the part of the most experienced nurse, this client is not being discharged home at this time.

MAKING NURSING DECISIONS: The nurse must determine which client is the most unstable or requires extensive teaching. This client requires the most experienced nurse, thus making this type of question an “except” question. Three clients are either stable or have non–life-threatening conditions.

8. 1. If the HCP deems that the client can continue to take the herbal supplement, then an order must be written; however, this is not the first intervention.

   2. The nurse could ask for clarification of the reason he is taking the herbal supplement, but this is not the first intervention. Many clients use herbal supplements for a variety of healthcare needs.

   3. According to the NSCN NCLEX-RN® test plan, collaboration with interdisciplinary team members is part of the management of care. The nurse should first consult with the pharmacist to determine whether the client is taking any medications that could interact with the saw palmetto.

   4. The PDR is available to research medications, not herbal supplements.
MAKING NURSING DECISIONS: The nurse must be knowledgeable of interventions when administering medications to clients undergoing surgery, such as, the client should not receive any PO medications, the client should not receive any medications that could increase bleeding, or if the client is taking any complementary alternative medications, such as herbs.

9. 1. HIPAA does not apply in some situations, including the reporting of sexually transmitted diseases to the Public Health Department. The Public Health Department will attempt to notify any sexual partners the client reports.
   2. This is a false statement. HIPAA does not apply in certain situations, and the nurse must be knowledgeable of HIPAA guidelines.
   3. The client should notify her sexual partners so they can be treated; however, in response to the client asking, “Does anyone have to know?” the nurse’s best response is to provide facts.
   4. This is a therapeutic response aimed at encouraging the client to verbalize feelings, but the nurse should provide factual information in this situation.

MAKING NURSING DECISIONS: There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy for these questions; the nurse must be knowledgeable of management issues. The Health Insurance Portability and Accountability Act (HIPAA) passed into law in 1996 to standardize exchange of information between healthcare providers and to ensure patient record confidentiality.

10. 1. The unlicensed assistive personnel (UAP) can calculate intake and output for clients. The UAP cannot evaluate the numbers to determine if the treatment is effective, but the UAP can obtain the numbers.
    2. Two nurses must double-check a unit of blood prior to infusing the blood; therefore, this task cannot be delegated.
    3. The surgeon or the nurse must change the surgical dressing for a kidney transplant.

This task cannot be delegated to personnel with a lower level of expertise.

4. The UAP cannot transfer the unstable client from the renal unit to the intensive care unit.

MAKING NURSING DECISIONS: An RN cannot delegate assessment, teaching, evaluation, medications, or an unstable client to a UAP. Tasks that cannot be delegated are nursing interventions requiring nursing judgment.

11. 1. Interstitial cystitis is a chronic, painful inflammatory disease of the bladder characterized by urgency/frequency and pain in the bladder and/or pelvis. Since the signs/symptoms are expected, the nurse would not assess this client first.
    2. The clinical manifestations of acute post-streptococcal glomerulonephritis are varied, including generalized body edema, hypertension, oliguria, hematuria with a smoky or rusty appearance, and proteinuria. Since the signs/symptoms are expected, the nurse would not assess this client first.
    3. Goodpasture syndrome is a rare autoimmune disease seen primarily in young male smokers characterized by hematuria, weakness, pallor, anemia, and renal failure. Since the signs/symptoms are expected, the nurse would not assess this client first.
    4. Nephrolithiasis, kidney stones, is characterized by pain and hematuria, but the nurse must assess the pain to determine whether a complication has occurred or it is the expected routine pain. Pain is the common priority of these four clients.

MAKING NURSING DECISIONS: The nurse can use Maslow’s Hierarchy of Needs to determine which client to assess first. Pain is a physiological need.

12. 1. The trough should be drawn before the aminoglycoside, vancomycin, antibiotic is hung. This requires intervention by the critical care charge nurse.
    2. The LPN should change out a “sharps” container that is full; if not changed, then this constitutes an OSHA violation.
3. The LPN must have a narcotic wastage observed by another nurse.
4. The LPN can insert an indwelling urinary catheter in their scope of practice.


MAKING NURSING DECISIONS: The nurse must know the scope of practice for the LPN. The nurse must know the correct procedure for administering medications to the client and OSHA standards.

13. 1. The unlicensed assistive personnel (UAP) can take a specimen to the lab, but this is not the first intervention.
2. The findings should be documented in the nurse’s notes, but it is not the first intervention.
3. The nurse must first assess the UAP’s findings and the client before taking any further action.
4. The UAP can take the client’s vital signs, but it is not the first intervention for the nurse.


MAKING NURSING DECISIONS: A rule of thumb when answering test questions is this: If anyone gives the nurse information about a client, the nurse’s first intervention is to assess the client. The nurse should always make decisions based on his or her assessment of the client.

14. 1. Although cystectomy is a major surgical procedure, it has a predictable course, and no complications were identified. After removing the bladder, the client must have an ileal conduit. This is expected with this type of surgery, and the new graduate nurse could be assigned of this client.
2. A client on continuous hemodialysis would require a nurse trained in this area of nursing; therefore, this client should be assigned to a more experienced nurse.
3. Renal trauma is unpredictable and requires continuous assessment. A more experienced nurse should be assigned to this client.
4. An eviscerated wound indicates the client’s incision has opened and the bowels are out of the abdomen. This client is critically ill and should not be assigned to an inexperienced nurse.


MAKING NURSING DECISIONS: When the test taker is deciding which client should be assigned to a new graduate, the most stable client should be assigned to the least experienced nurse.

15. 1. The charge nurse should have as many beds as possible available for any clients who must be transferred to the unit. The charge nurse should send a nurse to ED and then assess the bed situation.
2. This may need to be done, but it is not the first intervention, and the charge nurse could assign this to a staff member who is not providing direct client care.
3. Most disaster policies require one nurse to be sent immediately from each area; therefore, this intervention should be implemented first. The charge nurse must determine which staff nurse would be most helpful in the ED without compromising the staffing in the ICU.
4. The charge nurse should not request anyone leave the hospital. This is not typical protocol for a disaster.


MAKING NURSING DECISIONS: The nurse must be knowledgeable of emergency preparedness. Employees receive this information in employee orientation and are responsible for implementing procedures correctly. The NCSBN NCLEX-RN® blueprint includes questions on safe and effective care environment.

16. 1. The nurse must diffuse the situation and remove the mother from the client’s room because a seriously ill client does not need to be yelled at.
2. Hospital security does not need to be called unless the mother refuses to leave the client’s room in the critical care unit.
3. The nurse should remove the mother from the room and allow her to ventilate her feelings about the accident her son sustained while he was under the influence.
4. The nurse should remove the mother because she is upset and let her ventilate. Telling the mother she must be quiet is
Condescending, and when someone is upset, telling the person to be quiet is not helpful.

**Content – Medical/Surgical: Category of Health**

**Alteration – Genitourinary: Integrated Processes –**

**Nursing Process: Implementation: Client Needs –**

**Psychosocial Integrity: Cognitive Level – Application**

**MAKING NURSING DECISIONS:** The NCLEX-RN® blueprint includes Therapeutic Community as a subcategory in Psychosocial Integrity. The nurse should allow clients and family to ventilate feelings.

17. 1. The nurse may need to administer an antispasmodic medication, but not before assessment of the client. Bladder spasms in a client who has had a TURP are usually caused by clots remaining in the bladder. A three-way indwelling catheter that is working properly will flush the clots from the bladder.

2. The nurse should calculate the client’s urine output, but that is not the first intervention and will not address the client’s pain.

3. The nurse could palpate the client’s bladder for distention, but this will not help decrease the client’s pain.

4. The three-way indwelling catheter is placed during surgery to keep blood clots from remaining in the bladder and causing bladder spasms and increasing bleeding. The nurse should first assess the drainage system to make sure that it has not become obstructed with a clot.

**Content – Medical/Surgical: Category of Health**

**Alteration – Genitourinary: Integrated Processes –**

**Nursing Process: Assessment: Client Needs –**

**Physiological Integrity: Reduction of Risk Potential: Cognitive Level – Application**

**MAKING NURSING DECISIONS:** The test taker must read all the options to determine whether an option contains a life-threatening situation. If an option contains information that is expected or within normal limits, that client does not have priority.

19. 1. Avoiding crowds may help the elderly client avoid getting a cold or the flu, but it is not the important intervention to help prevent getting sick during the winter months.

2. The yearly flu shot is the best way to help prevent getting sick during the winter months, since the flu can cause serious illness, and even death, in the elderly. Alport syndrome is also known as chronic hereditary nephritis.

3. Eating a well-balanced diet is helpful, but it will not ensure the elderly do not get sick during the winter months.

4. Dressing appropriately in the winter months is appropriate, but the flu vaccine provides the elderly with added immunity.

**Content – Medical/Surgical: Category of Health**

**Alteration – Genitourinary: Integrated Processes –**

**Nursing Process: Implementation: Client Needs –**

**Physiological Integrity: Physiological Adaptation: Cognitive Level – Application**

**MAKING NURSING DECISIONS:** The test taker should use a systematic guide when deciding on a priority intervention. The nursing process is an excellent tool for the test taker to use in this question. Assessment is the first step of the nursing process.

18. 1. The client with polycystic kidney disease, the most common life-threatening genetic disease in the world, is expected to have hypertension along with hematuria and a feeling of heaviness in the back, side, or abdomen. The nurse should not assess this client first since the clinical manifestations are expected.

2. The client with polycystic kidney disease is painless gross hematuria; therefore, the nurse would not assess this client first.

3. The nurse should check to determine whether the client has passed a stone, but this is a desired outcome and could wait until the client with an emergency has been assessed and appropriate interventions initiated.

4. The client with acute pyelonephritis, an inflammation of the renal parenchyma and collecting system, is not expected to get dehydrated; therefore, this client should be assessed first.

**Content – Medical/Surgical: Category of Health**

**Alteration – Genitourinary: Integrated Processes –**

**Nursing Process: Assessment: Client Needs –**

**Psychosocial Integrity: Reduction of Risk Potential: Cognitive Level – Analysis**

**MAKING NURSING DECISIONS:** The nurse must be able to teach health promotion to clients. Immunizations are priority for children and the elderly.

20. 1. Hormone replacement therapy may be needed, but not due to vaginal dryness. The client should discuss this with her HCP, but it does not address the client’s statement.

2. Many elderly are sexually active and sexual activity should be encouraged by the nurse, not discouraged.

3. Vaginal lubricant will help with the vaginal dryness and help decrease pain during sexual intercourse.

4. Vaginal dryness is common in the elderly, but the nurse should discuss ways to address the dryness, not explain that it is normal.
MAKING NURSING DECISIONS: When the question asks for the priority intervention, it means one or more of the options could be something a nurse might discuss with the client. The test taker should select the option that answers the client's statement directly.

21. 1. Fosamax should be administered in the morning on an empty stomach to increase absorption, but it is not priority over the client’s sitting up for 30 minutes. The client should remain upright for at least 30 minutes to prevent regurgitation into the esophagus and esophageal erosion.

2. The client with peptic ulcer disease may be more a risk for esophageal erosion, but the HCP should have assessed this prior to prescribing this medication for the client.

3. The client with osteoporosis should be encouraged to walk to increase bone density, but this is not pertinent when administering the medication.

4. Fosamax should be administered on an empty stomach with a full glass of water to promote absorption of the medication. The client should remain upright for at least 30 minutes to prevent regurgitation into the esophagus and esophageal erosion.

MAKING NURSING DECISIONS: The nurse must be aware of interventions that must be implemented when administering medications. The nurse must know which interventions will help prevent untoward complications when administering medications.

22. 1. The LPN is qualified to perform a sterile procedure, such as inserting an indwelling catheter before surgery. This is an appropriate assignment.

2. Turning and repositioning a client can be delegated to an unlicensed assistive personnel (UAP).

3. Emptying a client’s bedside commode and recording the amount of urine can be delegated to a UAP.

4. The nurse should feed the client who choked during the last meal to assess the client's ability to swallow. This client is unstable and cannot be assigned/delegated.

MAKING NURSING DECISIONS: The nurse cannot delegate or assign assessment, teaching, evaluation, or an unstable client to an LPN. The LPN can transcribe HCP orders, can call HCPs on the phone to obtain orders for a client, and can perform sterile procedures.

23. 1. The therapeutic PTT level should be 1.5 to 2 times the normal PTT of 39 seconds. The therapeutic levels of heparin are 58 and 78. With a PTT of 92, the client is at risk for bleeding, and the heparin drip should be held. The nurse should assess this client first.

2. The client on peritoneal dialysis should have clear dialysate, so this client does not have to be assessed first.

3. The client on hemodialysis should have an audible bruit over the fistula, which indicates the fistula is patent.

4. Cystitis is inflammation of the urinary bladder, and burning on urination is an expected symptom.

MAKING NURSING DECISIONS: The test taker must determine if any of the assessment data are normal or abnormal for the client’s diagnosis. If the data are abnormal, then this client should be seen first.

24. 1. Digoxin can be administered later because it is a routine medication.

2. Lasix can be administered within the 1-hour leeway (30 minutes before and after); it does not need to be administered first.

3. Darvon is not due yet; the nurse should assess the client and determine whether non-pharmacological interventions to relieve pain can be implemented, but this medication cannot be administered for 2 hours.

4. Tylenol is administered for mild-to-moderate pain. By the time the nurse obtains the medication and performs all of the steps to administer a medication correctly, it will be time for the client to receive the Tylenol. This medication should be administered first.

MAKING NURSING DECISIONS: The nurse must be knowledgeable of how and when to administer medications.

25. 1. Credé’s maneuver is a method used for expressing urine by pressing the hand on the bladder, especially a paralyzed bladder. It is a non-invasive procedure and should be implemented first prior to catheterization, which is an invasive procedure.
   2. Intermittent catheterization is an invasive procedure, which may lead to possible infection when done every 3 to 4 hours.
   3. The nurse could place the client on the bedside commode, but this is used for clients with an uninhibited bladder pattern.
   4. Drinking water prior to attempting to urinate will not help the client.


MAKING NURSING DECISIONS: If the nurse was undecided between an invasive or a non-invasive procedure, the nurse should select the non-invasive procedure first.

26. 1. The client with pyelonephritis typically presents with costovertebral tenderness over the affected side; therefore, this is expected and the nurse would not assess this client first.
   2. More than likely, this client has a urinary tract infection, which requires a mid-stream urinalysis. Of these four clients, this client should be seen first to have the test ordered.
   3. The client with urethritis would present with these symptoms; therefore, the clinic nurse would not need to see this client first.
   4. Hesitancy, terminal dribbling, and intermittency are signs/symptoms of benign prostatic hypertrophy, which requires surgery; therefore, this client should not be seen prior to a client with a possible urinary tract infection.


MAKING NURSING DECISIONS: The nurse cannot delegate assessment, evaluation, teaching, administration of medications, or care of an unstable client to a UAP.

28. 1. The unlicensed assistive personnel (UAP) can escort a client who is stable to the radiology department; therefore, this is the most appropriate task to delegate to the UAP.
   2. The UAP cannot obtain a sterile specimen; therefore, this task cannot be delegated.
   3. The UAP cannot hang intravenous bags because they are medications, and medication administration cannot be delegated to a UAP.
   4. Discharge instructions are teaching, and teaching cannot be delegated to a UAP.


MAKING NURSING DECISIONS: An RN cannot delegate assessment, teaching, evaluation, medications, or an unstable client to a UAP. Tasks that cannot be delegated are nursing interventions requiring nursing judgment.

29. 1. The unlicensed assistive personnel (UAP) cannot administer medication or evaluate the effectiveness of medication; therefore, this task cannot be delegated.
   2. This is a legal issue and should not be delegated to the UAP.

MAKING NURSING DECISIONS: When deciding which client to assess first, the test taker should determine whether the signs/symptoms the client is exhibiting are normal for the client situation. After eliminating the expected options, the test taker should determine which situation can be cured, or which is more life threatening.

27. 1. The nurse should not delegate medication administration, including giving the client boxes of sample medications, to an unlicensed assistive personnel (UAP).
   2. Showing the client how to use a glucometer is teaching the client, and the nurse cannot delegate teaching.
   3. Triaging calls requires nursing judgment; this responsibility cannot be delegated to the UAP.
   4. The UAP is trained to take vital signs on a client who is stable. This task could safely be delegated by the nurse.
3. The UAP can apply ice to the right ankle since the client is stable.
4. The nurse should complete the incident report, not the UAP.


**MAKING NURSING DECISIONS:** The nurse is responsible for the actions and behavior of UAPs and LPNs working in the unit. The nurse must correct behavior as needed.

32. 1. The unlicensed assistive personnel (UAP) is a member of the healthcare team and should be able to listen to a student’s concerns.
2. The nurse cannot violate the student’s rights, even in the school nurse setting.
3. The nurse should allow the UAP to continue to talk to the female student, and then the nurse can talk to the student after the UAP and student finish talking.
4. The UAP has established a relationship with the student and should be allowed to talk to the student. If the student had wanted to talk to the school nurse, the student would have done so.


**MAKING NURSING DECISIONS:** The nurse is responsible for the actions and behavior of UAPs in any healthcare setting. The nurse should know when to intervene and when not to intervene.

33. 1. This is a breach of confidentiality. The LPN should not discuss the client’s health problem in the waiting room area where everyone can hear.
2. The nurse should remove the LPN from the situation without embarrassing the LPN. Asking the LPN to come to the office area is the appropriate action for the nurse to take. The LPN’s action is a violation of HIPAA.
3. The nurse should not correct the LPN’s behavior in front of the client. This is embarrassing to both the LPN and the client.
4. The nurse does not have to report this to the HCP. The nurse can talk to the LPN concerning this breach of confidentiality.


**MAKING NURSING DECISIONS:** The nurse is responsible for knowing and complying with local, state, and federal standards of care. The LPN’s discussion of a confidential matter in a public area is a violation of HIPAA.
34. 1. The charge nurse must address this situation because it has been going on for more than a week.
   2. Writing a memo does nothing to discover the cause of the tense atmosphere.
   3. The charge nurse should call a meeting and attempt to determine what is causing the staff’s behavior and the tense atmosphere. The charge nurse could then problem-solve, with the goal being to have a more relaxed atmosphere in which to work.
   4. This is threatening, which is not an appropriate way to resolve a staff problem.

**MAKING NURSING DECISIONS:** In any business, including a healthcare facility, arguing should not occur among staff at any level where the customers—in this case, the clients—can hear it or see it. The nurse should address the situation directly with the staff members.

35. 1. Obtaining a urine sample is not an invasive procedure and does not require informed consent.
   2. The urine specimen must adhere to a chain of custody, so the client cannot dispute the results.
   3. The bathroom for drug testing should not have access to any water via a sink, so that the client cannot dilute the urine specimen.
   4. The tympanic temperature is taken in the client’s ear and is not required for a urine drug sample.

**MAKING NURSING DECISIONS:** There are management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy for these questions. The nurse must be knowledgeable of management issues, and know what must comply with local, state, and federal requirements.

36. 1. Any client seen in the clinic should have the vital signs taken, but given the signs/symptoms of the client, the nurse should first obtain a urinalysis.
   2. The nurse should determine whether there has been blood in the urine, but it is not the nurse’s first intervention. The HCP needs a urinalysis to confirm the probable diagnosis.
   3. The client is verbalizing the classic signs/symptoms of a urinary tract infection, but it must be confirmed with a urinalysis. The nurse should first obtain the specimen so the results will be available by the time the HCP sees the client.
   4. The nurse should always teach the client and asking this question is appropriate, but it is not the clinic nurse’s first intervention.


**MAKING NURSING DECISIONS:** The client’s signs/symptoms often provide the nurse with the most likely problem, and the nurse should confirm the condition with a laboratory test, if possible. Clinic and emergency room nurses obtain tests so the HCP will have the results when seen.

37. 1. The nurse may need to know how long the client will be in the shelter, but this is not priority during the initial assessment of the client.
   2. During a disaster, the priority is to determine whether the client has routine medications that can be taken while in the shelter. If clients have life-sustaining medications, then obtaining the medications becomes priority. Remember, psychiatric medications are life sustaining.
   3. The client’s health history is important, but no matter what the history is, if the client does not have life-sustaining medications, the client will end up in the hospital.
   4. The client should be assessed, but unless the client has a specific complaint in this situation, assessment of vital signs, height, and weight is not priority.


**MAKING NURSING DECISIONS:** The nurse must be knowledgeable of emergency preparedness. This is part of hospital requirements since 9/11. The NCSBN NCLEX-RN® blueprint includes questions on safe and effective care environment.

38. 1. The nurse should ask whether the client is allergic to iodine, such as shellfish.
   2. An incompetent client cannot sign the consent form. Because the client is diagnosed
with schizophrenia, asking him to sign a permit form is not an appropriate intervention.

3. An incompetent client is an individual who is not autonomous and cannot give or withhold consent—for example, individuals who are cognitively impaired, mentally ill, neurologically incapacitated, or under the influence of mind-altering drugs. This client is diagnosed with schizophrenia, a mental illness, and is delusional; therefore, the client’s significant other must sign for the procedure.

4. This procedure is performed in the radiology department, not in a day surgery department.


**MAKING NURSING DECISIONS:** The NCLEX-RN® blueprint includes questions on nursing care that is ruled by legal requirements. The nurse must be knowledgeable of these issues.

39. 1. Some herbal supplements can interact with prescribed medications and become dangerous, but saw palmetto is not one of them.

2. **Saw palmetto is recommended by many urologists and used to treat BPH; therefore, this is the most appropriate statement.**

3. The nurse should notify the client’s HCP, but the best response is to support the client’s use of saw palmetto for BPH.

4. This is a true statement, but the nurse should address the client taking the saw palmetto, not make a general statement.


**MAKING NURSING DECISIONS:** The NCLEX-RN® tests complementary alternative medicine (CAM), so the nurse must be familiar with the common herbs used to treat disease processes.

40. 1. This is the role of the speech therapist, a member of the home care team.

2. This is the role of the occupational therapist, a member of the home care team.

3. This is the role of the social worker, a member of the home care team.

4. **This is the role of the physical therapist, a member of the home care team.**


**MAKING NURSING DECISIONS:** The home health (HH) nurse must know the roles of the members of the home care team. The HH nurse must be able to make appropriate referrals.

41. 1. The NCSBN NCLEX-RN® test blueprint includes referrals, under Management of Care. The client is in spiritual distress, and the chaplain is the member of the team who addresses spiritual needs.

2. The nurse should not discuss the client’s concerns with the client’s pastor. The nurse should contact the agency chaplain, and then, if needed, the agency chaplain could talk to the client’s pastor.

3. This is crossing professional boundaries. The nurse should not impose his or her religious beliefs on the client. If the client asks the nurse to pray, then the nurse could—but the nurse should not ask the client to pray.

4. The client is verbalizing thoughts about dying, not asking questions about living wills. This would not be an appropriate intervention.


**MAKING NURSING DECISIONS:** The test taker must be knowledgeable of the roles of all members of the multidisciplinary healthcare team.

42. 1. This is a private moment between the client and spouse; the nurse should not impose on the situation.

2. The client and spouse did not ask for help; the nurse should not assume that help is needed.

3. **This is a private moment and should be respected by the nurse. The nurse should allow the client and spouse quiet time together.**

4. This is a private moment between the client and spouse; the nurse should not impose on the situation.


**MAKING NURSING DECISIONS:** The nurse must be aware of spiritual needs and help to support the client’s needs whenever possible.

43. 1. Clocking in late twice in a year’s time is not a pattern of behavior.
2. The nurse involved in a code would not be able to leave the code to answer a call light.
3. The nurse has covered him- or herself, or may be changing to cover someone else. This action is assuming responsibility for the client care on the unit and does not require a mention in the evaluation, unless the nurse is changing at the request of management.
4. The nurse’s care is being evaluated, including the nurse’s documentation. The completeness of documentation should be included in the evaluation.

**MAKING NURSING DECISIONS:** There will be management questions on the NCLEX-RN®. In many instances, there is no test-taking strategy for these questions; the nurse must be knowledgeable of management issues.

44. 1. This is a nice gesture, but the priority is to provide support when the family and friends have returned to their own lives.
2. The family and friends will have returned to their own lives 1 to 2 months after a family member has died. This is when the next of kin needs support from the hospice nurse. Hospice will follow up with the significant other for up to 13 months.
3. This is the family’s responsibility, not that of the hospice nurse.
4. This is not the nurse’s responsibility and should be discouraged for a short period of time. In the immediate grieving period, the significant other may get rid of possessions that later he or she may wish had been kept.

**MAKING NURSING DECISIONS:** The test taker must be knowledgeable of the roles of all members of the multidisciplinary healthcare team. This knowledge will be tested on the NCLEX-RN® exam.

45. 1. The nurse should not continue to attempt IV access if there is another nurse available who may be able to insert the IV line successfully.
2. The client needs IV replacement at this time.
3. After two attempts, the nurse should arrange for a second nurse to attempt the placement.
4. Cold packs would cause the circulatory system to contract and make it more difficult to start an IV line. Hot packs dilate the blood vessels.

**Content – Medical/Surgical: Category of Health Alteration – Genitourinary: Integrated Processes – Nursing Process: Implementation: Client Needs – Safe and Effective Care Environment: Management of Care:**

**Cognitive Level – Application**

**MAKING NURSING DECISIONS:** The nurse must be able to perform skills safely. The nurse should not continue to inflict pain on the client after attempting invasive procedures more than twice.

46. 1. The unlicensed assistive personnel (UAP) should not use soap when bathing a client diagnosed with CKD. Soap is drying and the client diagnosed with CKD has altered skin integrity.
2. The nurse should stop the UAP from using the arm with the graft. Pressure on the graft could occlude the graft.
3. The UAP can tell the client not to eat contraband food. This is not teaching.
4. This is an appropriate action for the UAP; the nurse would not need to intervene.

**Content – Medical/Surgical: Category of Health Alteration – Genitourinary: Integrated Processes – Nursing Process: Assessment: Client Needs – Safe and Effective Care Environment: Safety and Infection Control:**

**Cognitive Level – Analysis**

**MAKING NURSING DECISIONS:** “Delegation” means that the nurse is responsible for the UAP’s actions and performance. The nurse must correct the UAP’s performance to ensure the client is cared for safely, in the hospital or the home.

47. 1. Lanoxin is frequently ordered for elderly patients with a history of heart failure. The nurse should take an apical heart rate and hold the medication if the apical pulse is less than 60. This is a maintenance dose of the medication.
2. Lasix is a diuretic frequently prescribed for patients with a history of heart failure. The nurse should determine if the patient is having muscle cramping, which is a sign of potassium deficiency. The nurse would not question administering this medication without an indication of potassium deficiency.
3. K Dur is potassium, which is given to prevent potassium depletion when administering a diuretic.
4. Dulcolax is a stimulant laxative. Overuse of stimulant laxatives can cause laxative dependency and colon obstruction. The nurse should contact the HCP and...
arrange for a bulk laxative if the client requires a daily laxative.


MAKING NURSING DECISIONS: This is an alternate type of question included in the NCLEX-RN® blueprint. The test taker must be able to read a medication administration record (MAR), be knowledgeable of medications, and be able to make an appropriate decision as to the nurse’s most appropriate intervention.

48. Answer: 88 mL per hour (350 divided by 4 hours = 87.5 mL per hour)
The client is diagnosed with heart failure, which indicates the client is at high risk for fluid volume overload when administering any type of fluids. Blood must be administered within 4 hours.


MAKING NURSING DECISIONS: The NCLEX-RN® blueprint includes dosage calculations under Pharmacological and Parenteral Therapies. This category is included under Physiological Integrity, which promotes physical health and wellness by providing care and comfort, reducing client risk potential, and managing health alterations.

49. 3, 4, and 5 are correct.

1. Teaching is the responsibility of the nurse and cannot be delegated to an unlicensed assistive personnel (UAP).
2. The word “check” indicates a step in the assessment process, and the nurse cannot delegate assessing to a UAP.
3. The client is 2 days postoperative and vital signs should be stable so the UAP can take vital signs. The nurse must make sure the UAP knows when to immediately notify him/her of vital signs not within the guidelines the nurse provides to the UAP.
4. This action does not require judging, assessing, teaching, or evaluating on the part of the UAP. This task can be delegated to the UAP.
5. A client who is 2 days postoperative should be ambulating frequently. The UAP can perform this task.


MAKING NURSING DECISIONS: This is an alternate type of question included in the NCLEX-RN®. The nurse must be able to select all of the options that answer the question correctly. There are no partially correct answers.

50. 1. The nurse could obtain the client’s pulse oximeter reading, but this client is hemorrhaging and the surgeon should be notified immediately.
2. Checking the client’s last H&H could be done, but this client’s AP and B/P are indicating hemorrhaging; therefore, the first intervention is to notify the client’s surgeon.
3. The client’s apical pulse (AP) and blood pressure (B/P) indicate the client is hemorrhaging; therefore, the nurse should first notify the client’s surgeon.
4. The nurse could monitor the client’s urine output, but it will not help the client’s hemorrhaging; therefore, this is not the nurse’s first intervention.


MAKING NURSING DECISIONS: The test taker needs to read all of the options carefully before choosing the option that says, “Notify the HCP.” If any of the options will provide information the HCP needs to know in order to make a decision, the test taker should choose that option. If, however, the HCP does not need any additional information to make a decision and the nurse suspects the condition is serious or life threatening, the priority intervention is to call the HCP.

51. Correct Answer: 4, 5, 2, 3, 1

4. Safety should be the primary concern of the nurse. A bedside commode will provide the client with an option that is easier to get to than walking to the bathroom and prevent the client from slipping on urine that may be dribbled.
5. The nurse needs to obtain a urine culture, so antibiotic therapy can be initiated.

2. This will help the client stay dry and not soil his or her clothes, as well as allowing some independence in ambulation in the room and hallways.
3. This will protect the bed and the client from soiling.

1. Providing frequent assistance with toileting will prevent the client from having incontinence.

**Making Nursing Decisions:** This is an alternate type of question included in the NCLEX-RN® blueprint. The nurse must be able to implement interventions in the correct order.

52. These laboratory findings are low, but would not require a blood transfusion. These laboratory findings are often expected in a client who is anemic secondary to chronic kidney disease.

2. This client’s dialysis access is compromised and should be assessed, but this is not life threatening.

3. This client should be seen, but not prior to a potentially life-threatening situation.

4. The client on peritoneal dialysis who has a hard, rigid abdomen has a potentially life-threatening complication; this client should be assessed first and then sent to the hospital.

**Making Nursing Decisions:** The test taker must determine if any of the assessment data are normal or abnormal for the client’s diagnosis. If the data are abnormal, then this client should be seen first. If the data are normal, then a client with a psychosocial problem is the client the nurse should assess first.

53. This pulse oximeter reading is above 93%; therefore, this information does not warrant notifying the healthcare provider.

2. The client’s platelet count is within normal limits; therefore, this information does not warrant notifying the healthcare provider.

3. Excess fluid volume is priority because the stress placed on the heart and vessels, which could lead to heart failure, pulmonary edema, and death.

**Making Nursing Decisions:** The NCLEX-RN® integrates the nursing process throughout the Client Needs categories and subcategories. The nursing process is a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation, and evaluation. The nurse will be responsible for identifying a nursing diagnosis for clients.

55. **Answer: 300 mL.** The nurse must add up how many milliliters of fluid the client drank on the 7 a.m. to 7 p.m. shift, then subtract that number from 1,500 mL to determine how much fluid the client can receive on the 7 p.m. to 7 a.m. shift. One ounce is equal to 30 mL. The client drank 26 ounces (8 + 8 + 16 + 8) of fluid, or 1,200 mL (40 × 30) of fluid. Therefore, the client can have 300 mL (1,500 – 1,200) of fluid on the 7 p.m. to 7 a.m. shift.

**Making Nursing Decisions:** The test taker should select the option that is potentially life threatening, or a complaint that would require the medication to be adjusted or discontinued. The nurse should notify the HCP if the medication is causing an adverse effect, not an expected side effect.
MAKING NURSING DECISIONS: The NCLEX-RN® blueprint includes dosage calculations under Pharmacological and Parenteral Therapies. This category is included under Physiological Integrity, which promotes physical health and wellness by providing care and comfort, reducing client risk potential, and managing health alterations.

56. 1. Reverse Trendelenburg position has the nurse elevating the client’s chair, which will not help the client’s dizziness and light-headedness.
2. Decreasing the volume of blood being removed is an appropriate intervention, but it will not help the client’s dizziness and light-headedness as fast as will infusing normal saline.
3. Normal saline infusion increases the amount of volume in the bloodstream, which will decrease the client’s light-headedness and dizziness.
4. Hypotension is an expected occurrence in clients receiving dialysis; therefore, the HCP does not need to be notified.


MAKING NURSING DECISIONS: When the question asks, “Which intervention should be implemented first?” it means all the options are things a nurse could implement, but only one should be implemented first. The nurse should use the nursing process and remember: If the client is in distress, do not assess; if the client is not in distress, the nurse should assess.

57. 3, 4, and 5 are correct.
1. TPN is a hypertonic solution that has enough calories, proteins, lipids, electrolytes, and trace elements to sustain life. It is administered via a pump to prevent too rapid infusion. It should not be administered without a pump or via a gravity intravenous line.
2. TPN contains 50% dextrose solution; therefore, the client is monitored to ensure that the pancreas is adapting to the high glucose levels. The glucose level is checked every 6 hours, not every 24 hours.
3. The client is weighed daily in the same clothes and at the same time to monitor for fluid overload and evaluate daily weight.
4. The IV tubing is changed with every bag because the high glucose level can cause bacterial growth.
5. Intake and output are monitored to observe for fluid balance.


MAKING NURSING DECISIONS: This is an alternate type of question included in the NCLEX-RN®. The nurse must be able to select all of the options that answer the question correctly. There are no partially correct answers.

58. Correct Answer: 2, 1, 4, 5, 3
2. The client has signs of phlebitis and the IV must be removed to prevent further complications.
1. A new IV will be started in the right hand after the IV is discontinued.
4. A warm washcloth placed on an IV site sometimes provides comfort to the client. If this is done, it should be done for 20 minutes four times a day.
5. All pertinent situations should be documented in the client’s chart.
3. Depending on the healthcare facility, this may or may not be done, but client care comes before documentation.


MAKING NURSING DECISIONS: This is an alternate type of question included in the NCLEX-RN® blueprint. The nurse must be able to perform skills in the correct order. Documentation is always completed after direct client care.

59. 1. An unlicensed assistive personnel (UAP) can empty the catheter and measure the amount.
2. The UAP can record intake and output on the I&O sheet.
3. The nurse cannot delegate teaching to the UAP.
4. The client has a disease, but all the UAP is being asked to do is take water to the client.


MAKING NURSING DECISIONS: This is an “except” question. The nurse could determine
which task is appropriate to delegate to the UAP; three options would be appropriate to delegate. The nurse should implement the task that is not appropriate to delegate. Remember, the nurse cannot delegate assessment, teaching, evaluation, medications, or an unstable client to the UAP.

60. **Answer: 890 mL.** First, determine the amount of irrigation fluid: 3,000 – 1,550 = 1,450 mL of irrigation fluid. Then, subtract 1,450 irrigation fluid from the drainage of 2,340 to determine the urine output: 2,340 – 1,450 = 890 mL of urine output

Content – Medical/Surgical: Category of Health

### MAKING NURSING DECISIONS: The NCLEX-RN® blueprint includes dosage calculations under Pharmacological and Parenteral Therapies. This category is included under Physiological Integrity, which promotes physical health and wellness by providing care and comfort, reducing client risk potential, and managing health alterations.

61. 1. TURPs may cause a sexual dysfunction, but if there were a sexual dysfunction, it is not priority over a physiological problem, such as hemorrhaging.
2. This may be a possible nursing diagnosis, but it is not priority over hemorrhaging, which is the priority nursing diagnosis.
3. All postoperative clients have the risk of infection, but the client with a TURP priority nursing concern is hemorrhaging due to the surgical procedure.
4. **This is a potential life-threatening nursing diagnosis and is the client’s priority.** This is the reason for the three-way continuous bladder irrigation.

Content – Medical/Surgical: Category of Health

### MAKING NURSING DECISIONS: The NCLEX-RN® integrates the nursing process throughout the Client Needs categories and subcategories. The nursing process is a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation, and evaluation. The nurse will be responsible for identifying nursing diagnoses for clients.

62. 1. The unlicensed assistive personnel (UAP) cannot increase the irrigation fluid because this requires assessment and judgment. This behavior warrants intervention by the nurse.
2. Elevating the scrotum on a towel for support is an intervention a UAP can implement. It does not require judgment and the client is stable; therefore, action does not warrant intervention by the nurse.
3. The UAP can empty catheter bags, since this does not require any judgment. This action does not warrant intervention by the nurse.
4. The client can bring ice water to the client’s bedside, since the client is not NPO.

Content – Medical/Surgical: Category of Health

### MAKING NURSING DECISIONS: “Delegation” means the nurse is responsible for the UAP’s actions and performance. The nurse must correct the UAP’s performance to ensure the client is cared for safely, in the hospital or the home.

63. 1. The client should use a urinal, so the nurse can strain the urine prior to placing it in the commode.
2. **Assessment is the first part of the nursing process and is always priority.** The intensity of the renal colic pain can be so intense it can cause a vasovagal response, with resulting hypotension and syncope.
3. Increased fluid increases urinary output, which will facilitate movement of the renal stone through the ureter and help decrease pain, but it is not the first intervention.
4. The nurse should strain the client’s urine to determine if the renal calculi have been passed via the urine.

Content – Medical/Surgical: Category of Health

### MAKING NURSING DECISIONS: When the question asks, “Which intervention should be implemented first?” it means that all the options are things a nurse could implement, but only one should be implemented first. The nurse should use the nursing process and remember: if the client is in distress, do not assess; if the client is not in distress, the nurse should assess.
64. 1. A KUB is an x-ray and does not include administering any type of contrast dye.
   2. Food, fluids, and ordered medication are not restricted prior to a KUB.
   3. An x-ray should not be completed on a client who may be pregnant. The x-rays could harm the fetus.
   4. The client with renal calculi is expected to have pain, depending on where the calculi are located, but this statement would not warrant intervention for the KUB.


   **MAKING NURSING DECISIONS:** This question asks the nurse to identify which statement warrants intervention, which indicates three of the options are appropriate for the disease process or disorder but one is incorrect. This is an “except” question, but it does not say all the options are correct “except.”

   65. 3 and 5 are correct.
   1. The healthcare provider may order certain foods and medications when obtaining a 24-hour urine collection to evaluate for calcium oxalate or uric acid, but the client will not be NPO.
   2. When the collection begins, the client should completely empty the bladder and discard that urine. The first urine specimen should not be included.
   3. All urine for 24 hours should be saved and put in a container with a preservative, refrigerated, or put on ice, as indicated. Not following specific instructions will result in an inaccurate test result.
   4. The urine is obtained in some type of urine collection device such as a bedpan, bedside commode, or commode hat. The client is not catheterized.
   5. Posting signs will help ensure that all the urine is saved during the 24-hour period. If any urine is discarded, the test may result in inaccurate information or the need to start the test over.


   **MAKING NURSING DECISIONS:** This is an alternate type of question included in the NCLEX-RN®. The nurse must be able to select all of the options that answer the question correctly. There are no partially correct answers.

66. 1. The urine must be assessed for bleeding and cloudiness. Initially, the urine is bright red, but the color soon diminishes, and cloudiness may indicate an infection. This assessment should not be delegated to an unlicensed assistive personnel (UAP).
   2. The UAP cannot transcribe a healthcare provider’s orders.
   3. The UAP can strain the client’s urine. This task does not require judgment or evaluation. Any sediment should be placed in a sterile container and sent to the laboratory for analysis.
   4. The kidney is highly vascular. Hemorrhaging and the resulting shock are potential complications of lithotripsy, so the nurse should not delegate vital signs post-procedure.


   **MAKING NURSING DECISIONS:** The nurse cannot delegate assessment, teaching, evaluation, medications, or an unstable client to a UAP. Tasks that cannot be delegated are nursing interventions requiring nursing judgment.

67. 1. This potassium level is within normal limits, 3.5 to 5.5 mEq/L.
   2. Hematuria is not uncommon after removal of a kidney stone, but cause for further assessment by the nurse. It may indicate hemorrhaging, which is life threatening.
   3. A normal creatinine level is 0.8 to 1.2 mg/100 mL.
   4. This white blood cell count is elevated; normal is 5,000–10,000 mm.


   **MAKING NURSING DECISIONS:** The nurse must be knowledgeable of normal laboratory values. These values must be memorized, and the nurse must be able to determine if the laboratory value is normal for the client’s disease process or for medications the client is taking.

68. 1. The nurse should assess first to determine the etiology of the incontinence before the treatment plan can be formulated. By palpating the bladder after voiding, the nurse can determine if the incontinence was the result of overdistention of the bladder.
2. Medications—for instance, anticholinergic agents such as oxybutynin—can cause adverse effects. Non-pharmacological methods of treatment are preferred before medications are administered.

3. The nurse should ensure the client does not have skin breakdown secondary to urinary incontinence, but the first intervention is assessment.

4. The nurse should instruct the client to go to the bathroom every 2 hours to attempt to urinate, which may decrease the number of incontinent episodes.

MAKING NURSING DECISIONS: When the question asks, “Which intervention should be implemented first?” it means that all the options are things a nurse could implement, but only one should be implemented first. The nurse should use the nursing process and remember: If the client is in distress, do not assess; if the client is not in distress, the nurse should assess.

69. 1. This vital signs are within normal limits and would not require further investigation.

2. When an elderly client’s mental status changes, the nurse should notify the HCP because it is not normal or expected. This could indicate a urinary tract infection secondary to an indwelling catheter. Elderly clients often do not present with classic signs and symptoms of infection.

3. The client’s urine should be clear and light yellow, but cloudy urine with sediment is not life threatening. The nurse would not need to notify the client’s HCP.

4. The client should have no discomfort and pain; therefore, this would not warrant further investigation.

MAKING NURSING DECISIONS: When the question asks, “Which data set warrants notifying the HCP?” it is an “except” question. Three of the data sets are expected with the client’s disease process or condition, one is not expected and warrants notifying the HCP.

70. 1. The client’s catheter should be secured on the leg to prevent manipulation, which increases the risk for a urinary tract infection. This warrants immediate intervention by the nurse.

2. The unlicensed assistive personnel (UAP) must adhere to Standard Precautions when providing care to the client; therefore, this doesn’t warrant immediate intervention by the nurse.

3. The drainage bag should be kept below the level of the bladder to prevent reflux of urine into the renal system; therefore, this does not warrant intervention by the nurse.

4. Hand hygiene is important before and after handling any portion of the drainage system; therefore, this does not warrant intervention by the nurse.
The correct answer number and rationale for why it is the correct answer are given in boldface type. Rationales for why the other possible answer options are incorrect also are given, but they are not in boldface type.

1. **Ms. Debbie, the UAP, can assist the radiology technician with the portable chest x-ray. The RN cannot delegate assessment, teaching, evaluation, medications, or an unstable client. If Ms. Debbie is pregnant, then the nurse should not delegate this task.**

2. **Ms. Debbie can obtain the client’s intake and output, but the nurse must evaluate the data to determine if interventions are needed or if interventions are effective.**

3. **In some units, UAPs can perform urinary catheterization, but of the four options, the nurse should delegate the least invasive task.**

4. **This is a medication enema, and Ms. Debbie cannot administer medications. Also, for this to be ordered, the client must be unstable with an excessively high serum potassium level.**

5. **Answer: 1,000 mL. First, determine the amount of irrigation fluid: 4,000 – 2,000 = 2,000 mL of irrigation fluid. Then, subtract 2,000 of irrigation fluid from the drainage of 3,000 to determine the urine output: 3,000 – 2,000 = 1,000 mL of urine output.**

6. **1 and 5 are correct.**

1. **The laboratory findings are low, but would not require a blood transfusion. These laboratory findings are often expected in a client who is anemic secondary to ESRD.**

2. **The dialysis access is compromised; therefore, this client warrants intervention because Mr. Ray cannot perform hemodialysis.**

3. **It is not uncommon for a client undergoing dialysis to be exhausted and sleep through the treatment; therefore, this does not warrant intervention.**

4. **The client in end-stage renal disease would not have urinary output; therefore, this does not warrant intervention from Mr. Ray.**

5. **Ms. Mary can restart the client’s IV access without notifying the healthcare provider.**

6. **Hypoactive bowel sounds may be abnormal, but airway problems take priority over gastrointestinal distress. Remember Maslow’s Hierarchy of Needs.**

7. **The client may be developing pneumonia or acute respiratory distress syndrome; therefore, Ms. Mary should notify the healthcare provider. This is a complication of surgery.**

8. **A 2+ pedal pulse is expected data; therefore, Ms. Mary does not need to notify the healthcare provider.**
8. 1. The urine must be assessed for bleeding and cloudiness. Initially, the urine is bright red, but the color soon diminishes, and cloudiness may indicate an infection. This assessment should not be delegated to Ms. Debbie.
2. Teaching cannot be delegated to Ms. Debbie, and the client with renal calculi should not have an indwelling urinary catheter.
3. The client’s urine must be strained to determine if the renal stone was dissolved and is being passed out of the body. Straining the urine is not assessment, teaching, evaluation, medications, or an unstable client; therefore, this can be delegated to Ms. Debbie.
4. The client is not on strict bed rest after lithotripsy; therefore, Ms. Debbie should not implement this intervention.

9. 1. The client with a palpable thrill is stable; therefore, Ms. Brenda would not need to see this client first.
2. The client with acute glomerulonephritis is expected to have hematuria and proteinuria; therefore, Ms. Brenda should not assess this client first.
3. The sign/symptom of bladder cancer is painless hematuria; therefore, Ms. Brenda would not need to see this client first.
4. An ileal conduit is a procedure that diverts urine from the bladder and provides an alternate cutaneous pathway for urine to exit the body. Urinary output should always be at least 30 mL per hour. This client should be assessed to make sure that the stents placed in the ureters have not become dislodged, or to ensure that edema of the ureters is not occurring.

10. 1. Teaching cannot be assigned to an LPN, no matter how knowledgeable the LPN.
2. This client has the laboratory symptoms of an infection; therefore, Ms. Mary cannot assign an unstable client to the LPN.
3. Antineoplastic medication can only be administered by a qualified registered nurse.
4. The LPN can administer narcotic analgesics to a client; therefore, this would be an appropriate assignment.