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Adult-Gerontology Primary Care Nurse Practitioner

Questions And Answers PDF Format:

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Question: 1

A client reports to the nurse that after delivering a baby, she loses small amounts of urine each time she sneezes or laughs hard. Which type of incontinence does the nurse anticipate?

A. urinary retention
B. cloudy, foul odor
C. bedside commode
D. stress

Answer: D

Question: 2

Several of the clients on a geriatric subacute medicine unit are experiencing urinary incontinence from differing causes. Which statement suggests that the client requires further education?

A. The client is dehydrated.
The BUN test measures the amount of urea nitrogen in the blood. Urea, the major nitrogenous end-waste product of metabolism, is formed in the liver. The bloodstream carries urea from the liver to the kidneys for excretion. When the kidneys are diseased, they are unable to excrete urea adequately, and urea begins to accumulate in the blood, causing BUN to rise. Normal BUN is 8 to 25 mg/100 mL. Because other factors, such as high dietary intake of protein, fluid deficit, infection, gout, or excessive breakdown of protein stores, can also elevate BUN, it is not a highly sensitive indicator of impaired renal function.
inittent urethral catheter
B. An inittent urethral catheter (straight catheter) is a catheter inserted through the urethra into the bladder to drain urine for a short period of time (5 to 10 minutes). With an indwelling urethral catheter (retention or Foley catheters), a catheter (tube) is inserted through the urethra into the bladder for continuous drainage of urine; a balloon is then inflated to ensure that the catheter remains in the bladder once it is inserted.
C. Limiting fluid intake is not a healthy practice, and clients should be encouraged not to use fluid restriction as an incontinence management strategy. Promoting fluid intake is beneficial for most clients who do not possess a contraindication, and it is appropriate and useful to take diuretics in the morning to avoid nocturia. Even though it may involve work for both the client and the nurse, clients who want to use a bathroom or commode rather than an adult absorbent brief should be encouraged to do so.
"Let's review the types of fluids that your child drinks in the morning."
D. Bladder irritants such as caffeine can cause urge incontinence; it is appropriate to deine whether the child is consuming fluids that contain caffeine. The child's urge incontinence is not extremely abnormal, and this physiological response is not related to gender. It is too soon to refer the client to the healthcare provider without taking a history, and it is impractical to simply recommend incontinence undergarments.

Answer: C

Question: 3

A client is preparing to give a clean-catch specimen. Which instruction will the nurse provide?

A. greater than normal urinary volume
Polyuria means greater than normal urinary elimination. It may accompany minor dietary variations. For example, consuming higher than normal amounts of fluids, especially those with mild diuretic effects (e.g., coffee, tea), or taking certain medications actually can increase urination.
Other definitions:
Oliguria is inadequate elimination of urine. Anuria means the absence of urine. Dysuria is difficult or uncomfortable voiding.
B. straight catheter
Inittent urethral catheters, or straight catheters, are used to drain the bladder for shorter periods.
If a catheter is to remain in place for continuous drainage, an indwelling urethral catheter is used.
Indwelling catheters are also called retention or Foley catheters
C. A clean-catch specimen is collected in mid-stream. It is not reasonable, nor necessary, to collect the entire urinary output. It is not correct to collect the first urine expelled or to wait until the void is almost over.
D. Document the findings as normal, recognizing that they have been caused by an accumulation of uric acid crystals.

Answer: C

Question: 4

A client with a history of advanced liver disease comes to the emergency department (ED) with dehydration. White blood cell count shows elevation in bands and neutrophils. When preparing to catheterize the client, what color urine does the nurse anticipate will drain?

A. neurogenic bladder.
B. anuria
C. dark brown, cloudy
D. cloudy, foul odor

Answer: C

Question: 5

The nurse is providing education to a client who is being discharged to home with an indwelling urinary catheter in place. What information is important for the nurse to discuss with the client?

A. The birth can cause perineal swelling.
Trauma from vaginal birth causes swelling in the perineal area, which can obstruct the flow of urine and cause urinary retention during the early postpartum period.
B. Leave the catheter in place as a marker and attempt to insert a new sterile catheter directly above the misplaced catheter.
Start the procedure over and attempt to place the new catheter directly above misplaced catheter. Once the new catheter is correctly in place, remove the catheter in the vaginal orifice. Never remove a catheter from the vagina and insert it in the urethra as this action can cause cross-contamination.
C. The client has an enlarged prostate.
Enlargement of the prostate gland is commonly seen in men over age 50 and may interfere with urinary catheterization.
D. The catheter can be connected to a smaller leg bag for ambulation.
Educational points related to an indwelling urinary catheter include instructions on connecting the catheter to a smaller leg bag for ambulation; maintaining adequate fluid intake; keeping the catheter free of kinks (avoid clamping the catheter tubing); emptying the drainage bag at regular intervals; and avoiding a full drainage bag that may lead to reflux of urine.

Answer: D

Question: 6

A client's BUN test results are significantly elevated. When reviewing the client's history, which finding is consistent with BUN elevation other than renal compromise?

A. the first voiding of the day
The nurse would discard the first void of the day. The bladder has collected urine that has been produced by the kidneys overnight. The first voided urine of the day is usually more concentrated than other urine excreted during the day. Because the first urine of the day is not fresh, but rather an accumulation of a number of hours of kidney output, this urine may or may not be used as a specimen for certain tests.
B. one or both of the ureters are surgically implanted elsewhere
The nurse should understand that in a urinary diversion, one or both of the ureters are surgically implanted elsewhere. This procedure is done for various life-threatening conditions. Incontinence is the inability to control either urinary or bowel elimination. Catheter care means the hygiene measures used to keep meatus and adjacent area of the catheter clean. In order to collect a catheter specimen, the nurse uses a catheter to collect a sample of urine in a sterile environment.
C. The client is dehydrated.
The BUN test measures the amount of urea nitrogen in the blood. Urea, the major nitrogenous end-waste product of metabolism, is formed in the liver. The bloodstream carries urea from the liver to the kidneys for excretion. When the kidneys are diseased, they are unable to excrete urea adequately, and urea begins to accumulate in the blood, causing BUN to rise. Normal BUN is 8 to 25 mg/100 mL. Because other factors, such as high dietary intake of protein, fluid deficit, infection, gout, or excessive breakdown of protein stores, can also elevate BUN, it is not a highly sensitive indicator of impaired renal function.

D. greater than normal urinary volume
Polyuria means greater than normal urinary elimination. It may accompany minor dietary variations. For example, consuming higher than normal amounts of fluids, especially those with mild diuretic effects (e.g., coffee, tea), or taking certain medications actually can increase urination.
Other definitions:
Oliguria is inadequate elimination of urine. Anuria means the absence of urine. Dysuria is difficult or uncomfortable voiding.

Answer: C

Question: 7

A nurse drains the bladder of a client by inserting a catheter for 5 minutes. What type of catheter would the nurse use in this instance?

A. Limiting fluid intake is not a healthy practice, and clients should be encouraged not to use fluid restriction as an incontinence management strategy. Promoting fluid intake is beneficial for most clients who do not possess a contraindication, and it is appropriate and useful to take diuretics in the morning to avoid nocturia. Even though it may involve work for both the client and the nurse, clients who want to use a bathroom or commode rather than an adult absorbent brief should be encouraged to do so.
B. inittent urethral catheter
An inittent urethral catheter (straight catheter) is a catheter inserted through the urethra into the bladder to drain urine for a short period of time (5 to 10 minutes). With an indwelling urethral catheter (retention or Foley catheters), a catheter (tube) is inserted through the urethra into the bladder for continuous drainage of urine; a balloon is then inflated to ensure that the catheter remains in the bladder once it is inserted.
C. one or both of the ureters are surgically implanted elsewhere
The nurse should understand that in a urinary diversion, one or both of the ureters are surgically implanted elsewhere. This procedure is done for various life-threatening conditions. Incontinence is the inability to control either urinary or bowel elimination. Catheter care means the hygiene measures used to keep meatus and adjacent area of the catheter clean. In order to collect a catheter specimen, the nurse uses a catheter to collect a sample of urine in a sterile environment.
D. Contact the health care provider to decrease furosemide.
Voiding over 3000 mL/day is considered abnormal. The client may benefit from a reduction in the amount of furosemide that is prescribed. Therefore, it is appropriate to contact the healthcare provider to decrease furosemide. Documenting the finding as normal, increasing IV fluids, and administering an additional dose of furosemide are not appropriate nursing actions.

Answer: B

Question: 8

The nurse is caring for a client with urinary incontinence who has a prescription for a postvoid residual (PVR) collection. 45 mL of amber urine is returned via PVR. Which appropriate action would the nurse take with this data collection?

A. Document the finding.
A PVR of less than 50 mL indicates the bladder is adequately emptying, so the nurse should document the findings. Since this normal there is no need to encourage more fluids, re-catheterize the client, or perform a bladder scan.
B. Kegel exercises should be performed by tightening the internal muscles used to prevent or interrupt urination for 10 seconds, followed by a period of 10 seconds of relaxation. The client should be instructed to perform this regimen 3-4 times daily for 2 weeks to 1 month.
C. Boys may take longer for daytime continence than girls.
Children in North American cultures usually achieve daytime urinary continence by 3 years of age; boys may take longer than girls.
Nighttime continence may not occur until 4 or 5 years of age.
D. Leave the catheter in place as a marker and attempt to insert a new sterile catheter directly above the misplaced catheter.
Start the procedure over and attempt to place the new catheter directly above misplaced catheter. Once the new catheter is correctly in place, remove the catheter in the vaginal orifice. Never remove a catheter from the vagina and insert it in the urethra as this action can cause cross-contamination.

Answer: A

Question: 9

A client has a cerebrovascular accident and is incontinent of bowel and bladder. Incontinence of urine in this client is related to a

A. stress
B. neurogenic bladder.
C. dark brown, cloudy
D. urinal

Answer: B

Question: 10

The nurse is preparing to irrigate a Foley catheter. What is the nurse's initial action?

A. Anuria
B. Neurogenic bladder.
C. Check electronic health record for medical order.
D. Dark brown, cloudy

Answer: C

Question: 11

The nurse is working with a client who requires continence training. Which client teaching about pelvic floor muscle exercises (Kegel exercises) will the nurse include?

A. The catheter can be connected to a smaller leg bag for ambulation.
Educational points related to an indwelling urinary catheter include instructions on connecting the catheter to a smaller leg bag for ambulation; maintaining adequate fluid intake; keeping the catheter free of kinks (avoid clamping the catheter tubing); emptying the drainage bag at regular intervals; and avoiding a full drainage bag that may lead to reflux of urine.
B. Document the finding.
A PVR of less than 50 mL indicates the bladder is adequately emptying, so the nurse should document the findings. Since this normal there is no need to encourage more fluids, re-catheterize the client, or perform a bladder scan.
C. The birth can cause perineal swelling.
Trauma from vaginal birth causes swelling in the perineal area, which can obstruct the flow of urine and cause urinary retention during the early postpartum period.
D. Kegel exercises should be performed by tightening the internal muscles used to prevent or interrupt urination for 10 seconds, followed by a period of 10 seconds of relaxation. The client should be instructed to perform this regimen 3-4 times daily for 2 weeks to 1 month.

Answer: D

Question: 12

The nurse is preparing to insert an indwelling urinary catheter into a female client's bladder. The nurse has opened the sterile catheterization tray using sterile technique, donned sterile gloves and has opened all sterile supplies. Arrange the following steps in the correct order.

A. Kegel exercises should be performed by tightening the internal muscles used to prevent or interrupt urination for 10 seconds, followed by a period of 10 seconds of relaxation. The client should be instructed to perform this regimen 3-4 times daily for 2 weeks to 1 month.
B. The birth can cause perineal swelling.
Trauma from vaginal birth causes swelling in the perineal area, which can obstruct the flow of urine and cause urinary retention during the early postpartum period.
C. Clean each labial fold, then the area directly over the meatus.
Insert the lubricated catheter into the urethra.
Advance the catheter until there is a return of urine.
Inflate the balloon with the correct amount of sterile saline.
Discard used supplies.
D. Document the finding.

A PVR of less than 50 mL indicates the bladder is adequately emptying, so the nurse should document the findings. Since this normal there is no need to encourage more fluids, re-catheterize the client, or perform a bladder scan.

Answer: C

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