



PREVIEW COPY

This document contains selected pages from the original study resource.

The complete document can be downloaded from StudyLast.



Scan to browse thousands of verified study resources.

<https://studylast.com>

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

The nurse assesses a patient admitted to the medical-surgical unit who has a diagnosis of type I diabetes mellitus. The nurse notes that the patient's urine is cloudy and foul-smelling. Which of the following diagnostic tests does the nurse anticipate will be ordered based on this finding?

1. urine culture and sensitivity (C&S)
2. blood urea nitrogen (BUN)
3. creatinine clearance
4. residual urine

Correct Answer: 1

Rationale: Urine culture and sensitivity (C&S) is correct because cloudy and foul-smelling urine indicates a urinary tract infection. The diagnostic test to identify the organism responsible is a urine C&S. Blood urea nitrogen (BUN) measures the amount of urea (end product of protein metabolism) in the blood plasma. It does not identify infection. Creatinine clearance is a 24-hour urine test used to identify renal function; it will not identify an infection. Residual urine measures the amount of urine left in the bladder after voiding, and does not identify an infection.

When preparing a patient for an intravenous pyelogram (IVP), the nurse reviews diagnostic data, noting all of the following. Which of these findings requires notification of the physician before proceeding with the test?

1. blood urea nitrogen (BUN) 55 mg/dL
2. serum creatinine 1.3 mg/dL
3. urine culture <10,000 organisms/mL
4. residual urine of 80 mL

Correct Answer: 1

Rationale: Blood urea nitrogen (BUN) 55 mg/dL is correct because this level is elevated, indicating that there might be a problem of renal function. The physician will need to be notified because an IVP involves the injection of dye that must eventually be cleared by the kidney, and if there is already compromised renal function, the test may not be administered. Serum creatinine 1.3 mg/dL, urine culture <10,000 organisms/mL, and residual urine of 80 mL are all incorrect because these values are all within the normal range, and therefore will not require physician notification.

A nurse working in a postoperative unit is caring for a patient who states, "I voided a small amount of urine, but I feel as if I need to void more and am unable to do so." The patient receives a prescription for a post-voiding residual urine test. The nurse correctly prepares to perform the procedure by gathering supplies that include which of the following?

1. a urine collecting device and a straight urinary catheter
2. a urine collecting device and a voiding diary

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

3. explain pain medications available during this procedure.
 4. discuss the typical experience of a patient using conscious sedation.
- Correct Answer: 1

Rationale: A renal ultrasound is a noninvasive test conducted to detect renal or perirenal masses, identify obstructions, and diagnose renal cysts and solid masses. It is done by applying a conductive gel to the skin and placing a small external ultrasound probe on the patient's skin. Sound waves are recorded on a computer as they are reflected off tissues. There is no discomfort associated with the test and pain medications are not needed. When the patient understands the typical experience for a patient having this test, fears of a painful experience will be addressed and resolved. A public health nurse is performing teaching for a patient who will be obtaining a sample of urine for a urinalysis at home. Which of these patient comments will cause the nurse to provide clarifying information?

1. "I will get the specimen as soon as I get home this evening."
2. "I won't touch the inside of the cup or lid."
3. "I will refrigerate the specimen until I bring it to the laboratory tomorrow."
4. "I will give the laboratory a list of the medications I am taking."

Correct Answer: 1

Rationale: An early morning specimen is preferred. The patient is bringing the specimen to the laboratory tomorrow, so an early morning specimen is possible and the most accurate and useful specimen. The other options are correct information.

Which of these laboratory results would be most important for a nurse to monitor for a patient who has lower abdominal pain and urinary urgency?

1. serum creatinine 1.20 mg/dL
2. urine Osmolality 400 mOsm/kg H₂O
3. BUN 30 mg/dL
4. urine culture 150,000 organisms/mL

Correct Answer: 4

Rationale 1: BUN and serum creatinine tests are use primarily to evlauate kidney function.

Rationale 2: Urine osmolality is used to evaluate increaded and decreased urine output.

Rationale 3: BUN and serum creatinine tests are use primarily to evlauate kidney function.

A nurse is advising a nursing student who is preparing a teaching presentation for fellow students regarding urinalysis. Which of these teaching points, if made by the student, requires intervention by the nurse?

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

- a) "Make sure to eat enough fiber to prevent constipation."
- b) "Try drinking coffee throughout the day."
- c) "Use scented powders to disguise any odor."
- d) "Limit the number of times you urinate during the day."
- a) "Make sure to eat enough fiber to prevent constipation."

Explanation: Suggestions to manage urinary incontinence include avoiding constipation such as eating adequate fiber and drinking adequate amounts of fluid. Scented powders, lotions, or sprays should be avoided because they can intensify the urine odor, irritate the skin, or cause a skin infection. Stimulants such as caffeine, alcohol, and aspartame should be avoided. The client should void regularly, approximately every 2 to 3 hours to ensure bladder emptying.

A client is frustrated and embarrassed by urinary incontinence. Which measure should the nurse include in a bladder retraining program?

- a) Restricting fluid intake to reduce the need to void
- b) Establishing a predetermined fluid intake pattern for the client
- c) Encouraging the client to increase the time between voidings
- d) Assessing present voiding patterns
- D) Assessing present voiding patterns

Explanation: The guidelines for initiating bladder retraining include assessing the client's present intake patterns, voiding patterns, and reasons for each accidental voiding. Lowering the client's fluid intake won't reduce or prevent incontinence. The client should be encouraged to drink 1.5 to 2 L of water per day. A voiding schedule should be established after assessment.

A nursing instructor is reviewing with the class the steps in urine formation. Place in the correct order from first to last the sequence the instructor would present.

- Filtrate enters Bowman's capsule
- Plasma filtered through glomerulus
- Formed urine drains from the collecting tubules, into the renal pelvis, and down each ureter to the bladder
- Filtrate moves through tubular system of the nephron and is either reabsorbed or excreted
- Plasma filtered through glomerulus
- Filtrate enters Bowman's capsule
- Filtrate moves through tubular system of the nephron and is either reabsorbed or excreted
- Formed urine drains from the collecting tubules, into the renal pelvis, and down each ureter to the bladder

A client is admitted for treatment of chronic renal failure (CRF). The nurse knows that this disorder increases the client's risk of:

- a) a decreased serum phosphate level secondary to kidney failure.
- b) an increased serum calcium level secondary to kidney failure.
- c) water and sodium retention secondary to a severe decrease in the

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

C) Recent hx of streptococcal infection

Explanation: Glomerulonephritis can occur as a result of infections from group A beta-hemolytic streptococcal infections, bacterial endocarditis, or viral infections such as hepatitis B or C or human immunodeficiency virus (HIV). A history of hyperparathyroidism or osteoporosis would place the client at risk for developing renal calculi. A history of pyelonephritis would increase the client's risk for chronic pyelonephritis.

A client presents at the testing center for an intravenous pyelogram. What question should the nurse ask to ensure the safety of the client?

- a) "Have you any artificial joints?"
- b) "Do you have a pacemaker?"
- c) "Do you have any allergies?"
- d) "Who has come with you today?"

C) Do you have any allergies?

Explanation: Many contrast dyes contain iodine. Therefore, it is essential for the nurse to determine whether the client has any allergies, especially to iodine, shellfish, and other seafood.

Which type of incontinency refers to the involuntary loss of urine due to medications?

- a) Overflow
- b) Urge
- c) Reflex
- d) Iatrogenic
- D) Iatrogenic

Explanation: Iatrogenic incontinence is the involuntary loss of urine due to medications. Reflex incontinence is the involuntary loss of urine due to hyperreflexia in the absence of normal sensations usually associated with voiding. Urge incontinence is the involuntary loss of urine associated with a strong urge to void that cannot be suppressed. Overflow incontinence is the involuntary loss of urine associated with overdistention of the bladder.

The nurse is to check residual urine amounts for a client experiencing urinary retention. Which of the following would be most important?

- a) Catheterize the client immediately after the client voids.
- b) Check for residual after the client reports the urge to void.
- c) Set up a routine schedule of every 4 hours to check for residual urine.
- d) Record the volume of urine obtained.

A) Catheterize the client immediately after the client voids

Explanation: To obtain accurate residual volumes, it is important that clients void first and that catheterization occur immediately after the attempt. The nurse should record both the volume voided (even if it is zero) and the volume obtained by catheterization. Intermittent catheterizations are performed based on a schedule, usually 3 to 4 times per day. Residual urine refers to the amount remaining in the bladder after voiding. It is essential that the client voids.

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

intake. Hyperventilation leads to excess carbon dioxide (CO_2) loss, which causes alkalosis — indicated by this client's elevated pH value. With respiratory alkalosis, the kidneys' bicarbonate (HCO_3^-) response is delayed, so the client's HCO_3^- level remains normal. The below-normal value for the partial pressure of arterial carbon dioxide (PaCO_2) indicates CO_2 loss and signals a respiratory component. Because the HCO_3^- level is normal, this imbalance has no metabolic component. Therefore, the client is experiencing respiratory alkalosis.

You are caring for a client with severe hypokalemia. The physician has ordered IV potassium to be administered at 10 mEq/hr. The client complains of burning along their vein. What should you do?

- a) Change the electrolyte.
- b) Switch to an oral formulation.
- c) Increase the speed of transfusion.
- d) Dilute the infusion.
- D) Dilute the infusion

Treatment of severe hypokalemia requires treatment with IV infusion of potassium. Clients may experience burning along the vein with IV infusion of potassium in proportion to the infusion's concentration. If the client can tolerate the fluid, consult with the physician about diluting the potassium in a larger volume of IV solution. Oral potassium may not be enough in severe cases hypokalemia. Hypokalemia requires treatment with potassium and not any other electrolyte.

Below which serum sodium level may convulsions or coma can occur?

- a) 140 mEq/L
- b) 135 mEq/L
- c) 142 mEq/L
- d) 145 mEq/L
- B) 135 mEq/L

Normal serum concentration level ranges from 135 to 145 mEq/L. When the level dips below 135 mEq/L, there is hyponatremia. Manifestations of hyponatremia include mental confusion, muscular weakness, anorexia, restlessness, elevated body temperature, tachycardia, nausea, vomiting, and personality changes. Convulsions or coma can occur if the deficit is severe.

Values of 140, 142, and 145 mEq/L are within the normal range.

The calcium level of the blood is regulated by which mechanism?

- a) Androgens
- b) Adrenal gland
- c) Parathyroid hormone (PTH)
- d) Thyroid hormone (TH)
- C) PTH

The serum calcium level is controlled by PTH and calcitonin. The thyroid hormone, adrenal gland, or androgens do not regulate the calcium level in the blood.

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

imbalance that causes Trousseau's sign (carpopedal spasm induced by inflating the blood pressure cuff above systolic pressure). Homans' sign (pain on dorsiflexion of the foot) indicates deep vein thrombosis. Hegar's sign (softening of the uterine isthmus) and Goodell's sign (cervical softening) are probable signs of pregnancy.

A nurse is caring for a client with metastatic breast cancer who is extremely lethargic and very slow to respond to stimuli. The laboratory report indicates a serum calcium level of 12.0 mg/dL, a serum potassium level of 3.9 mEq/L, a serum chloride level of 101 mEq/L, and a serum sodium level of 140 mEq/L. Based on this information, the nurse determines that the client's symptoms are most likely associated with which electrolyte imbalance?

- a) Hypocalcemia
- b) Hyperkalemia
- c) Hypokalemia
- d) Hypercalcemia
- D) Hypercalcemia

The normal reference range for serum calcium is 9 to 11 mg/dL. A serum calcium level of 12 mg/dL clearly indicates hypercalcemia. The client's other laboratory findings are within their normal ranges, so the client doesn't have hypernatremia, hypochloremia, or hypokalemia.

Which of the following electrolytes is a major cation in body fluid?

- a) Potassium
- b) Bicarbonate
- c) Chloride
- d) Phosphate
- A) Potassium

Potassium is a major cation that affects cardiac muscle functioning. Chloride is an anion. Bicarbonate is an anion. Phosphate is an anion.

Which conditions lead to chronic respiratory acidosis in older adults?

- a) Thoracic skeletal change
- b) Overuse of sodium bicarbonate
- c) Decreased renal function
- d) Erratic meal patterns
- A) Thoracic skeletal change

Poor respiratory exchange as the result of chronic lung disease, inactivity, or thoracic skeletal changes may lead to chronic respiratory acidosis.

Decreased renal function in older adults can cause an inability to concentrate urine and is usually associated with fluid and electrolyte imbalance. A poor appetite, erratic meal patterns, inability to prepare nutritious meals, or financial circumstances may influence nutritional status, resulting in imbalances of electrolytes. Overuse of sodium bicarbonate may lead to metabolic alkalosis.

A client with a suspected overdose of an unknown drug is admitted to the emergency department. Arterial blood gas values indicate respiratory acidosis. What should the nurse do first?

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

specifically used to treat hemostasis. Platelets are helpful, but the best answer is cryoprecipitate and fresh frozen plasma.

To prevent the spread of hepatitis A virus (HAV) infection the nurse is especially careful when:

A) Disposing of food trays B) Emptying the bed pan C) Taking an oral temperature D) changing IV tubing

Correct: B.....Rationale: HAV is transmitted primarily person-to-person by the fecal-oral route. Food can be a method of transmission but needs to be fecally contaminated. Since the transmission of hepatitis A is fecal-oral and not saliva or blood like hepatitis B, taking a temperature and changing IV tubing would not spread hepatitis A

The family of a patient newly diagnosed with hepatitis A asks the nurse what they can do to prevent becoming ill themselves. Which of the following responses by the nurse is most appropriate? "A:"The hepatitis vaccine will provide immunity from this exposure and future exposures."

B:"I am afraid there is nothing you can do since the patient was infectious before admission."

C:"You will need to be tested first to make sure you don't have the virus before we can treat you."

D: "An injection of immunoglobulin will need to be given to prevent or minimize the effects from this exposure.""

Correct D:

Immunoglobulin provides temporary (1-2 months) passive immunity and is effective for preventing hepatitis A if given within 2 weeks after exposure. It may not prevent infection in all persons, but it will at least modify the illness to a subclinical infection. The hepatitis vaccine is only used for preexposure prophylaxis.

A 40-year-old woman has been diagnosed with hepatitis A and asks the

nurse if other members of her family are at risk for

""catching"" the disease. The

nurse's response should be based on the understanding that

hepatitis A is transmitted primarily:" "1. during sexual intercourse

2. by contact with infected body secretions.

3. through fecal contamination of food or water.

4. through kissing that involves contact with mucous membranes."

Correct 3: "Hepatitis A is primarily transmitted through ingestion of organisms on fecally contaminated hands, food, or water. Care should be taken in the handling

of food and water as well as contaminated items such as bed linens, bedpans, and

URINARY - NURSING EXAM WITH QUESTIONS & ANSWERS (ACTUAL 2025/2026) GRADED A+ 100% GUARANTEED PASS

Nursing responsibilities when giving osmotic diuretics include which of the following? Select all that apply.

1. Check mannitol (Osmitol) solution for crystallization prior to IV administration.
2. Evaluate urine output after test dose is given.
3. Assess for signs of worsening heart failure
4. Assess for orthostatic hypotension.
5. Monitor patient for signs of ototoxicity.

Correct Answer: 1,2,3

Rationale: Osmotic diuretics commonly used are mannitol and urea (Ureaphil), which pull extracellular water into the vascular system and increase the glomerular filtration rate (GFR). They are given intravenously and mannitol solution should be checked for crystallization prior to administration. A test dose may be given and urine output is evaluated for an adequate response. The patient should be assessed for signs of worsening heart failure because of the increased vascular volume that occurs with these medications. Orthostatic hypotension is not an issue due to the increase in intravascular volume but should be assessed when giving loop diuretics. Ototoxicity is a concern with high doses of loop diuretics. Home care teaching for the patient after a radical nephrectomy should include which of the following?
Select all that apply.

1. Avoid contact sports and falls.
2. Older males should schedule routine screening exams for prostatic hypertrophy.
3. Monitor weight.
4. Monitor for signs of rejection.
5. Maintain prescribed fluid restrictions.

Correct Answer: 1,2

Rationale: Home care teaching focuses on protecting the remaining kidney including measures to prevent infection, calculi, hydronephrosis, and trauma. Patients should avoid contact sports and use measures to prevent motor vehicle accidents and falls that could damage the kidney. Older male patients should know manifestations of prostatic hypertrophy and schedule routine screening exams. Perineal hygiene, maintaining fluid intake of 2000-2500 mL per day, urinating frequently, and watching for manifestations of urinary tract infections are included in teaching. Monitoring weight, noting any signs of rejection, and maintaining prescribed fluid restrictions are concerns for the patient after a kidney transplant.
Steps to inserting an indwelling catheter