

1. The nurse is providing care to a patient who states, "My doctor says I am experiencing renal colic. What does that mean? Which response by the nurse is most appropriate?"
  - A. "It means you have pain in your flank and it may be radiating to your groin."
  - B. "It means you have the sudden urge to void immediately."
  - C. "It means you are getting up frequently at night to urinate."
  - D. "It means you are unable to completely empty your bladder."
2. The nurse is caring for a patient admitted with a diagnosis of AKI. The patient asks the nurse, "Are my kidneys failing? Will I need a kidney transplant?" Which response by the nurse is the most appropriate?
  - A. No, don't think that. You're going to be fine.
  - B. Your condition can be reversed with prompt treatment and usually will not destroy the kidney.
  - C. Kidney transplantation is likely, and it would be a good idea to start talking to family members
  - D. When the doctor come to see you, we can talk about whether you will need a transplant.
3. The nurse is caring for a patient with chronic kidney disease who is pale and experiencing fatigue. The nurse attributes these symptoms to anemia secondary to chronic kidney disease. The patient's spouse asks why the patient is anemic. Which response by the nurse is the most appropriate?
  - A. Your spouse has a genetic tendency for the development of anemia
  - B. The increased metabolic waste products in the body depress the bone marrow and cause anemia.
  - C. There is a decreased production by the kidneys of the hormone erythropoietin, which is the cause of anemia.
  - D. The patient is not eating enough iron-rich foods, which is causing anemia.
4. A patient with a history of hypertension is diagnosed with chronic kidney disease. When the patient asks the nurse how this occurred, which response by the nurse is the most appropriate?
  - A. Thickening of the kidney structures and gradual death of nephrons has caused this diagnosis
  - B. Cysts compress renal tissue that destroys the kidneys, causing this diagnosis
  - C. High blood pressure reduces renal blood flow and harms the kidney tissue, causing this diagnosis.
  - D. Immune complexes for in the kidney tissue that cause inflammation, causing this diagnosis.
5. The nurse is preparing to administer hemodialysis treatment for a patient with chronic kidney disease. Which laboratory values does the nurse anticipate prior to the patient's treatment? Select all that apply.
  - A. Increased BUN
  - B. Decreased calcium and potassium
  - C. Decreased phosphorus and sodium
  - D. Increased H&H
  - E. Increased creatinine

6. The nurse is reviewing discharge instructions for a patient diagnosed with a UTI. Which statement made by the patient indicates the need for further education?
  - A. I should drink plenty of water to prevent damage to my kidneys while I am on the antibiotics for the infection.
  - B. Drinking cranberry juice will decrease the risk for developing another UTI.
  - C. I will contact the health-care provider prior to taking over-the-counter medications while on my antibiotic.
  - D. I will continue to hold my urine while in public to prevent someone else from getting an UTI.
7. A patient admitted to the hospital with a diagnosis of gout has also been diagnosed with uric acid renal calculi. When planning meals for this patient, which diet will the nurse anticipate?
  - A. Low-purine diet
  - B. High-sodium diet
  - C. High calcium diet
  - D. Low calcium diet
8. The nurse is providing care to a patient who is experiencing urine leakage when coughing or laughing. Which type of incontinence should the nurse include in the patient's plan of care?
  - A. Urge
  - B. Stress
  - C. Overflow
  - D. Functional
9. The nurse is providing care to a patient with BPH. Which drug classification should the nurse include in the patient's plan of care?
  - A. Diuretic
  - B. Anticholinergic
  - C. Topical estrogen
  - D. Alpha-adrenergic agonist