1. The nurse is analyzing the pediatric client's serum laboratory report. Based on the findings, which HCP's order should the nurse prepare to implement next?

Serum Laboratory Test	Client's Value	Normals
BUN	26	5–25 mg/dL
Creatinine	2.0	0.5–1.5 mg/dL
Na	140	135–145 mEq/L
K	5.0	3.5–5.3 mEq/L
Cl	100	95–105 mEq/L
CO	28	22–30 mEq/L
Phosphate	2.0	1.7–2.6 mEq/L
Calcium	10	9–11 mg/dL
Hgb	15	13.5–17 g/dL
Hct	45	40%–54%
PTH	30	11–54 pg/mL

A. Obtain a urine culture.
B. Obtain a blood count (CBC).
C. Obtain a urinalysis.
D. Obtain liver function tests.

ANSWER: C

A. A urine culture would identify the presence of a UTI, is not specific to kidney function, and would not be indicated at this time.
B. A CBC is not kidney function specific and is not indicated at this time.
C. The elevated BUN and serum creatinine indicate abnormal kidney function; a UA is an additional study to further explore kidney function.
D. Liver function tests would not be indicated at this time because they are not specific to kidney function.

2. The Somali parents bring their 1-year-old child to the ER of a large urban hospital. The child is lethargic and has bloody urine and blood seeping through a diaper. The child's parents do not speak English. Which intervention should the nurse implement first?

A. Check the child's BP.
B. Arrange for an interpreter.
C. Inspect the child's genitalia.
D. Obtain urine and blood cultures.

ANSWER: B

A. The BP is important to assess perfusion, but the parents may not allow the child to be touched without first communicating through an interpreter.
B. The nurse should first request an interpreter because parental consent is needed for assessment and treatment of the child. Most major health care facilities usually have an on-site interpreter or have. made arrangements for on demand remote video or telephone interpreting services.
C. Although blood seeping through the diaper and the fact that the parents are Somali may lead the nurse to think about female genital mutilation, there is no information to substantiate this. The genitalia may need to be inspected, but parental consent is needed first-
D. Blood and urine cultures may need to be obtained to determine if the child has a UTI or is septic or dehydrated, but an interpreter is needed first to explain the tests to the parents.

3. The nurse is teaching the hospitalized adolescent about collecting a 24—hour urine sample. The adolescent voids, and the nurse discards the void. The adolescent saves all the urine voided in the subsequent 24 hours, and the urine is poured in a collection container that is placed on ice. On the twenty-fourth hour after collection begins, the client voids. What should the nurse do regarding this urine?

A. Discard the urine.
B. Add it to the urine container.
C. Measure and then discard it.
D. Pour it into a new container.

ANSWER: B

A. If the specimen is discarded, the test would need to be restarted.
B. At the completion of the 24-hour period, the client is asked to void, and the specimen is added to the container. This would complete the 24-hour urine sample.
C. The final specimen should not be discarded.
D. It would be inappropriate to pour it into a new container unless the other container is full.

4. The nurse is preparing the adolescent female client for a renal/bladder ultrasound. Which explanation is most appropriate?

A. "Do not void before the procedure; a full bladder helps to identify important structures."
B. "Void immediately before the procedure; a full bladder impairs seeing important structures."
C. "You will be asked to void during the procedure in order to obtain the best results."
D. "A urinary catheter will be inserted to ensure that your bladder is empty during the test."

ANSWER: A

A. A full bladder is important during a renal ultrasound to permit the best visualization of structures.
B. Voiding before the procedure is not recommended.
C. Voiding during the procedure is not recommended.
D. A urinary catheter would not be inserted because it would empty the bladder and structures would not be visualized.

5. The nurse is preparing to collect a urine specimen from the female infant. Prioritize the steps that the nurse should take to apply a urine-collection bag and collect the urine specimen from a female infant.

A. Check that the bag adheres firmly around the perineal area.
B. Explain the procedure to the parents, prepare supplies, and position the infant.
C. Check the bag frequently and remove as soon as the specimen is available.
D. Carefully replace the diaper.
E. Cleanse and dry the perineum, and apply the adhesive portion of the collection bag.

ANSWER: B, E, A, D, C

B. Explain the procedure to the parents, prepare supplies, and position the infant. Teaching and gathering supplies should be completed prior to performing the procedure to place the parent and infant at ease.

E. Cleanse and dry the perineum and apply the adhesive portion of the collection bag. The perineum needs to be cleansed and dried to ensure that the sample is not contaminated and that the adhesive sticks to the infant's skin.

A. Check that the bag adheres firmly around the perineal area. Adherence to skin is necessary to prevent urine leakage.

D. Carefully replace the diaper. The diaper will help to hold the collection bag in place.

C. Check the bag frequently and remove as soon as the specimen is available. If a too full bag is left in place, it will begin to leak urine. Urine on the skin can be irritating.

6. The nurse is taking a history of the 9-month-old. Which finding is most important for the nurse to report to the HCP for further follow-up?

A. Last diaper had urine that was odorless
B. Last diaper was stained with dark amber urine
C. Has not had a wet diaper in a 24-hour period
D. Usual urinary output about 250 mL per day

ANSWER: C

A. Infants often have odorless urine.
B. Dark amber urine may require more inquiry, although it is not the most important finding to report.
C. Anuria, or a lack of urine production, may be a sign of altered renal function.
D. Output for a 9-muntll-old is usually between 250 and 500 mL daily.

7. The adolescent who had a T10 complete SCI reports leaking of urine at fairly regular intervals. The nurse should plan interventions for which type of incontinence?

A. Functional urinary incontinence
B. Reflex urinary incontinence
C. Stress urinary incontinence
D. Urge urinary incontinence

ANSWER: B

A. Functional incontinence is the inability to hold urine due to causes other than neurological, urological, or lower urinary tract dysfunction, such as functional incontinence due to a UTI. Functional incontinence does not occur at fairly regular intervals.
B. Reflex urinary incontinence occurs when receptors in the bladder wall are triggered from a full or filling bladder. Signals are sent to the spinal cord, and an autonomic response causes the bladder to empty.
C. Stress incontinence occurs when activities that increase abdominal pressure cause a sudden leakage of urine. Stress incontinence does not occur at fairly regular intervals and is not associated with an SCI.
D. Urge incontinence occurs when there is involuntary passage of urine soon after feeling a strong sense of needing to void. Urge incontinence does not occur at fairly regular intervals and is not associated with an SCI.

8. The nurse is caring for multiple clients preparing for placement of an external diversional urinary system. Which client has the greatest need for interventions to promote a positive body image?

A. An infant who has spina bifida
B. A toddler recently toilet trained
C. A school-aged child in foster care
D. An adolescent who is sexually active

ANSWER: D

A. An infant's developmental stage is trust versus mistrust The infant is unaware of body alterations.
B. A toddler's developmental level is autonomy versus shame and doubt; the child could be at risk for altered body image, depending 011 the response of parents and others.
C. A school-aged child's developmental level is industry versus inferiority. The child would be at risk for body image disturbzmce if unable to develop competence with the device or if unable to achieve a sense of wholeness (one of Havighurst's develop- mental tasks).
D. Because of the client's developmental stage and sexual activity status, an external urinary device places the adolescent at the greatest risk for body image disturbance, and thus the client has the greatest need for intervention. Developmentally, according to Havighurst, an adolescent's developmental task is to accept one's physique and use the body effectively; according to Erikson. The adolescent's task is to achieve a coherent sense of self.

9. The nurse is caring for multiple clients. Which client would be most appropriate for the nurse to plan to instruct on the use of intermittent self-urinary catheterization?

A. The 15-ycar-old preparing to have a cesarean section
B. The l8-year-old newly diagnosed with multiple sclerosis
C. The 13-year-old with an SCI and no awareness of urge to void
D. The 16-year-old who is 8 months pregnant and reports dribbling

ANSWER: C

A. The 15-year-old would need only temporary indwelling urinary catheterization.
B. The 18-year-old newly diagnosed with MS would likely not have bladder involvement requiring intermittent catheterization. This may occur later in the disease process.
C. The 13-year-old with SCI and no awareness of urge to void would require a means to empty the bladder.
D. Dribbling is common in the third trimester of pregnancy. Cathetcrization would be avoided.

10. The nurse is educating the parent of the child with vesicoureteral reflux. The therapeutic use of which treatment is important to include in the teaching?

A. Steroidal therapy for at least 3 to 6 months
B. Acetaminophen three times daily for pelvic pain
C. Prophylactic antibiotics until the condition resolves
D. Growth hormone (GH) injections to prevent renal failure

ANSWER: C

A. Steroids are anti-inflammatory agents and unnecessary.
B. High doses of acetaminophen can lead to renal impairment.
C. Vesicoureteral reflux is retrograde flow of urine from the bladder into the ureters from an incompetent valve that: prevents backflow. Because urine is retained in the ureters after voiding, stasis of this urine leads to infection. Infection is managed with prophylactic antibiotic therapy until such an age as the condition resolves.
D. GH injections are used to treat a deficiency of GH, which is unrelated.

11 . The nurse is completing preoperative teaching with the parents of the child who has hypospadias. Which principal objectives regarding surgical correction of hypospadias should be addressed? Select all that apply.

A. To preserve a sexually active organ
B. To descend an undescended testicle
C. To circumcise immediately after hypospadias is identified
D. To improve the physical appearance of the penis for psychological reasons
E. To enhance the child's ability to void a straight stream while in the standing position

ANSWER: A, D, E

A. Because the penis will be operated on during surgery, a surgical objective is to preserve its ability to be a sexually active organ.
B. An undescended testicle is unrelated to hypospadias repair.
C. Circumcision may be delayed to save the foreskin to use in the hypospadias repair, if needed.
D. The principal objectives of hypospadias repair include improving the physical appearance of the genitalia for psychological reasons.
E. In hypospadias, the urethra does not properly exit the penis at the tip. It can be a mild defect, with the urethral opening slightly out of place, or a severe defect, with the urethral opening closer to the scrotum. The objectives of the repair include voiding enhancement.

12. The nurse is educating the parent of the male infant with phirnosis. Which statement should the nurse include in teaching?

A. “Every day retract the foreskin away from the glans penis to prevent urinary retention.”
B. “Watch for and report enlargement of the testicles because fluid is likely to accumulate.”
C. “Occasionally, the narrowing obstructs the flow of urine, resulting in a dribbling stream.”
D. “Once the infant is older and begins toilcting, urinating a straight stream will be impossible.“

ANSWER: C

A. In phimosis, the foreskin is already retracted and is causing the urinary problems.
B. Fluid does not accumulate in the testicles with phimosis; a hydrocele is the presence of fluid in the sac surrounding the testicles that causes an enlarged scrotum.
C. Phimosis is a narrowing of the preputial opening that prevents retraction of the foreskin over the glans penis. Occasionally, the narrowing obstructs the flow of urine, resulting in a dribbling stream or the foreskin ballooning with accumulated urine during voiding.
D. Hypospadias is a condition in which the urethral opening is located below the glans penis or any-where along the ventral surface. If not corrected, a straight stream may not be possible. Hypospadias is unrelated to phirnosis.

13. The nurse is assigned to care for the infant newly diagnosed with ambiguous genitalia. Which interventions should the nurse anticipate? Select all that apply.

A. Biochemical tests
B. Chromosome analysis
C. Radiographie contrast studies
D. Immediate surgical intervention
E. Referral for a pediatric urologist

ANSWERS: A, B, C, E

A. Biochemical tests help detect adrenocortical syndromes and are important components of the assessment to determine gender assignment.
B. Chromosome analysis will help determine chromosome abnormalities and precise genetic karyotype to help determine gender assignment.
C. Radiographie contrast studies are completed to identify the presence, absence, or nature of internal genital and urinary structures to help determine gender assignment.

D. The assignment of a gender followed by immediate surgical intervention was the traditional approach to treatment for ambiguous genitalia. A multidisciplinary team approach is now used to assign gender, and surgical reconstruction may be delayed to avoid irreversible surgical interventions.
E. A referral to a specialist such as a pediatric urologist is necessary so the identification of appropriate gender is completed with precision and accuracy.

14. The nurse is caring for the child going home with an indwelling urinary catheter. Which important component should the nurse include in the discharge instructions?

A. Keep the urine drainage bag below the level of the child's bladder.
B. Pull and tape the catheter securely down the length of the child's leg.
C. Have the child tub bathe instead of showering to minimize standing time.
D. Reduce the child's fluid intake to limit the need for frequent bag emptying.

ANSWER: A

A. Keeping the drainage bag below the level of the bladder prevents reflux of urine back into the bladder, which increases the risk of a bladder infection.
B. Placing tension on the catheter increases the risk of injury to the urinary meatus.
C. Showering rather than bathing minimizes the risk for contaminating the urinary drainage bag.
D. Fluid intake should be increased to reduce bacterial growth.

15. The pediatric client requires clean intermittent catheterization while at home. Which early signs of infection should the nurse teach the parents to report immediately?

A. Tachypnea, tachycardia, hypertension
B. Mental confusion, diarrhea, dehydration
C. Increased appetite, anuria, sweet-smelling urine
D. Fever, pulse in the upper range of normal, foul-smelling urine

ANSWER: D

A. Elevated respiratory rate, pulse, and BP could be related to infection but would not likely be the early signs parents would be instructed to monitor.
B. Symptoms such as mental confusion, diarrhea, and dehydration would not be early signs of infection.
C. Changes in appetite and in the odor of urine could be signs of infection or other conditions and need to be properly evaluated. Anuria, or the absence of urine production, requires immediate evaluation and intervention but is not an early sign of infection.
D. Fever, increased pulse rate, and foul-smelling urine are early signs of infection that the parent should report to the HCP immediately.

16. The nurse is preparing to administer an analgesic for short-term mild pain to the child who has a history of acute renal insufficiency. Which medication should the nurse select from the list of options from the HCP's symptom control protocol?

A. Ibuprofen
B. Meperidine
C. Acetaminophen
D. Morphine sulfate

ANSWER: C

A. Ibuprofen (Motrin) could contribute to renal impairment.
B. Meperidine (Demerol) is a narcotic analgesic and is best used for moderate to severe pain.
C. Acetaminophen (Tylenol) is an appropriate analgesic for short-term mild to moderate pain and will not contribute to the child's renal insufficiency.
D. Morphine sulfate is a narcotic analgesic and is best used for moderate to severe pain.

17. The parent of the child with acute poststreptococeal glomerulonephritis is concerned about care of the child after discharge. The nurse should educate the parent on which important concepts? Select all that apply.

A. The prolonged recovery time, which may take 2 years
B. Returning to pre-illness activities as soon as possible
C. Avoiding kissing to prevent Spreading the infection
D. Administering antibiotics that are likely to be prescribed
E. Weighing the child daily to determine fluid retention or loss
F. Giving an antihypertensive if the diastolic BP exceeds 90 mm Hg

ANSWER: A. E. F

A. The recovery period may be as long as 2 years in AGN.
B. Fatigue may restrict the return to the previous activity level. After 1 to 2 weeks, the child can attend school and engage in normal activities, except competitive activities because these stress the kidneys.
C. Acute poststreptocoecal glomerulonephritis is not infectious; it is caused by an antigen-antibody inflammatory response to a past infection.
D. Antibiotics are usually ineffective because the disease is caused not by an active infection but by an antigen-antibody inflammatory response to a past infection.
E. The best indicator of fluid loss or retention is daily weight. Salt restriction may be needed to control edema, but most children do well on a normal diet with normal salt and protein content.

F. Antihypertensive therapy with calcium channel blockers is used to treat a diastolic BP >90 mm Hg.

18. The parent of the child recently diagnosed with acute poststreptocoecal glomerulonephritis (APSGN) is concerned about the usual prognosis. The new nurse instructs the parent on the prognosis of APS GN. Which statement did the new nurse make in error?

A. "All children with glomerulonephritis will develop chronic disease."
B. "Death from complications of APSGN may occur but fortunately are rare."
C. "Almost all children correctly diagnosed with APSGN recover completely."
D. "Specific immunity is conferred so that subsequent recurrences are uncommon."

ANSWER: A

A. A few children with APSGN will develop chronic disease, but many of these cases are believed to be different glomerular diseases misdiagnosed as poststreptocoecal disease.
B. Death from complications of APSGN may occur but fortunately are rare. This statement is correct.
C. Almost all children correctly diagnosed with APSGN recover completely. This statement is correct.
D. Specific immunity is conferred so that subsequent recurrences are uncommon in APSGN. This statement is correct.

19. The nurse caring for the hospitalized school-aged child writes a nursing problem of Altered urinary elimination in the child's plan of care. Which outcome is best for the nurse to include?

A. Urinates six to eight times per day
B. Enuresis diminishes to every other day
C. Improved excretory function of the kidney
D. Amhulates to the bathroom independently.

ANSWER: A

A. The elimination system reaches maturity during school age, so the child should urinate six to eight times per day.
B. Enuresis is no longer expected in this age group.
C. An improved excretory function is not measurable; thus, option 1 is a better option.
D. Ambulating to the bathroom independently relates to mobility and not urinary elimination.

20. The 5-year—old with periorbital edema, anorexia, decreased urine output, and passage of colacolored urine is brought to the ED by the parent. Which history information reported by the child's parent is most important to report to the HCP?

A. Fell from a skateboard the night before admission
B. Traveled internationally to Europe two months ago
C. Had a "cold" 10 days before onset of these symptoms
D. Ate food two days ago that the child ate for the first time

ANSWER: C

A. A fall is not likely to cause kidney injury; if injury to the kidneys does occur, the child would also have flank pain.
B. If an illness from international travel occurred a month ago, symptoms would occur soon after the travel, not 2 months later.
C. Periorbital edema, anorexia, and cola-colored urine (also tea colored, reddish-brown, or smoky from hematuria) are the initial signs of nephrotic reaction in a child with AGN. Often, the child has been in good health with no history of infection except for symptoms described as a mild cold approximately 10 days before onset.
D. The symptoms can be seen with an allergic reaction to food, but the onset would not be delayed by two days.

21 . The nurse is reviewing the medical record of the school-aged child with AGN and finds that the child has proteinuria on UA and an elevated serum BUN, creatinine, and uric acid levels. The child has had an elevated BP and low urine output for 24 hours. What should the nurse do first?

A. Contact the health care provider.
B. Have the child drink more water.
C. Check the child's neurological status.
D. Document the findings in the medical record.

ANSWER: C

A. The HCP should be contacted only after the child has been assessed by the nurse.
B. The increased BUN, serum creatinine and uric acid levels, and proteinuria on UA are due to the accumulation of the by-products of metabolism from the failing renal function. Fluids would usually be limited.
C. Hypertensive encephalopathy is a major complication that can occur during the acute phase of AGN. The child's neurological status should be assessed before notifying the HCP because the findings may affect the treatment plan.
D. Documenting the findings is important, but the client is priority.

22. The nurse is caring for the child with renal insufficiency from impaired blood flow to the kidneys sustained during an MVA. Which assessment finding related to renal insufficiency should be reported immediately to the HCP?

A. Oliguria
B. Dysuria
C. Frequency
D. Urgency

ANSWER: A

A. Oliguria, or low urine output, could indicate impaired kidney function.
B. Dysuria means voiding that is either painful or difficult; it is often associated with an infection.
C. Urinary frequency is voiding at frequent intervals; it is often associated with an infection.
D. Urgency is the sudden strong desire to void; it is often associated with an infection.

23. The nurse is evaluating whether treatment is effective for the 8-year-old with CRF who is receiving sevelamer hydrochloride. Place an X on each laboratory test result that indicates that the medication is effective.

Serum Laboratory Test	Client's Value	Normal Values
Potassium	4.0	3.4–4.7 mEq/L
2163.Calcium	9.2	8.8–10.8 mg/dL
Phosphorus	5.0	3.7–5.6 mg/dL
Albumin	4.0	3.7–5.1 g/dL
RBCs	4.9	3.89–4.96 m/mm^3
WBC	15	4.5–11.1 K/microL or /mm3
Hgb	12	10.2–13.4 g/dL
Hct	36%	31.7%–39.3%

PHARM ANSWER:

Calcium	9.2 X	8.8–10.8 mg/dL
Phosphorus	5.0 X	3.7–5.6 mg/dL

Sevelamer hydrochloride (Renagel, Renvela) reduces absorption of phosphorus from the intestines. It will elevate the serum calcium level, thus decreasing the serum phosphorus level. Phosphorus is elevated in CRF because the kidneys are unable to excrete it.

24. The pediatric client with CKD is hospitalized. The nurse should monitor for which associated complications? Select all that apply.

A. Anemia
B. Dehydration
C. Hypocalcemia
D. Osteodystrophy
E. Metabolic. alkalosis

ANSWER: A, B, C, D

A. Erythropoietin, which is formed by the kidneys, stimulates RBC production. Anemia develops with decreased erythropoietin and RBC production.
B. The few functioning nephrons cannot reabsorb enough sodium to maintain a functioning level of body fluid, so dehydration occurs.
C. Hypocalcemia and hyperphosphatemia occur due to the kidney's inability to excrete phosphate.
D. Osteodystrophy (bone disease) occurs as calcium is withdrawn from bones to compensate for hypocalcemia.

25. While caring for the 4-year—old with CRF, the nurse identifies a potential problem of Risk for interrupted family processes. The nurse evaluates that this risk is diminished when which observation is made?

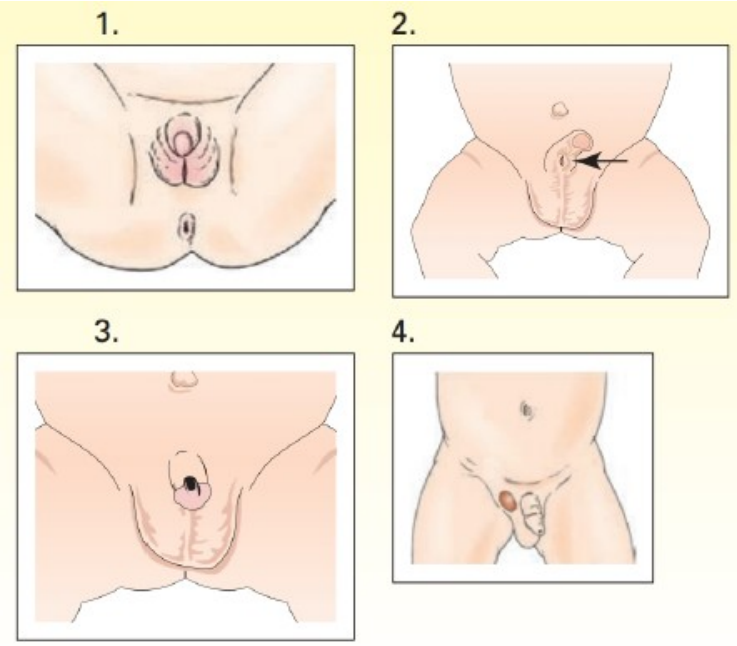
A. Parents stay with the child continuously while hospitalized.
B. Parents provide their child's hygiene during hospitalization.
C. Parents notify the hospital staff when they are unable to visit.
D. Parents find child care for children at home so they can visit.
E. Metabolic acidosis, not alkalosis, occurs from the kidney's inability to excrete hydrogen ion.

ANSWER: B

A. Continuously staying with the child doesn't demonstrate normal family processes, where parents should be taking time for themselves.

B. Because the parents should be assisting with the child's care when the child is healthy, then participating in the child's care when ill should promote family processes.
C. Informing the nurses when they are unable to visit is unrelated to the risk for interrupted family processes.
D. In normal family processes, the parent should be involved with the child and not just visiting.

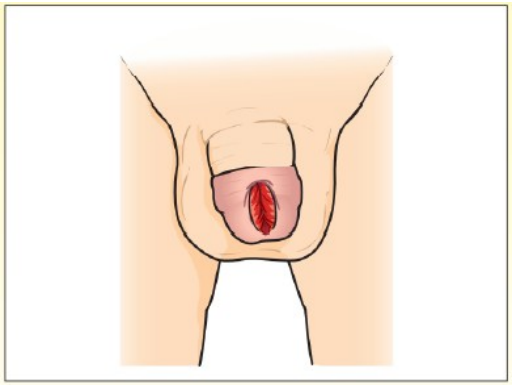
26. The nurse is planning care for the child to be admitted for a hypospadias repair. Which illustration best reflects the nurse's critical thinking about the child's condition?



ANSWER: B

A. Option 1 is ambiguous genitalia in which external reproductive organs cannot be easily identified as male or female. Note the urethra on the testicle.
B. Hypospadias is a congenital anomaly involving the abnormal location of the urethral meatus on the ventral surface of the penis.
C. In epispadias (option 3) the urethral opening is on the dorsal surface of the penis.
D. Option 4 is undescended testicle and is unrelated to epispadias.

27. The nurse assessed the genitalia illustrated of the 6-month-old male infant. Which documentation by the nurse is most accurate?



A. Hypospadias noted on the upper area of the penis
B. Urethral opening noted at the dorsum of the penis
C. Penis normal in color, size, and appearance for a 6-month-old male
D. Ulcerations present at tip of penis extending almost to the foreskin

ANSWER: B

A. The urethral opening in hypospadias is on the lower aspect or underside of the penis.
B. The child is presenting with an epispadias. In epispadias the urethra ends in an opening on the upper aspect (the dorsum) of the penis. This documentation is accurate.
C. The penis is malformed because of the presence of an epispadias, and not normal.
D. The reddened area is the urethral opening and not ulcerations.

28. The nurse is caring for the infant after epispadias repair. Which interventions should the nurse include when noting that the infant has a urinary stent in place after the epispadias repair? Select all that apply.

A. Notifies the health care provider if the penis becomes bluish-tinged
B. Notifies the health care provider if the urine becomes blood-tinged
C. Sponge bathes the infant rather than immersing the infant in water
D. Places the distal end of the stent between a first and second applied diaper
E. Has the parent hold the infant by straddling the infant on the parent's hip

ANSWER: A, C, D

A. A bluish-tinged discoloration of the penis could indicate impaired circulation.
B. The urine will be blood-tinged for several days after surgery. The HCP should not be notified of an expected finding.
C. Immersion in water when a stent is in place increases the risk for a [IT].
D. In double diapering, the inner diaper collects stool, and the outer diaper collects urine from the draining stent.

E. Straddling the infant on the parent's hip can cause dislodgement of the stent.

29. The pediatric client with CKD has elevations in serum creatinine and BUN. The nurse interprets this to mean that the child has a reduction in which component?

A. Growth hormone
B. Serum erythropoietin
C. Glomerular filtration rate
D. Blood flow to the kidneys

ANSWER: C

A. OH is an anabolic hormone that promotes protein application and mobilizes glucose and free fatty acids; it will not affect the serum creatinine and BUN.
B. Serum erythropoietin is a measurement of the degree of hormonal stimulation to the bone marrow to stimulate the release of RBCs; it will not affect the serum creatinine and BUN .
C. A reduction in CF R results in an accumulation of nitrogenous wastes. This is reflected in an elevation of the serum creatinine and BUN.
D. Reduced blood flow to the kidneys is but one cause of CKD; other causes can also elevate the serum creatinine and BUN.

30. The ED nurse is triaging a group of pediatric clients. Which child should the nurse attend to first?

A. A child with periorbital edema that is worse in the morning
B. A previously well child who begins to gain weight insidiously over a few days
C. A child with a recent renal transplant who has hypertension and decreased urinary output
D. A child with fever, foul-smelling urine, dysuria, and frequency and urgency on urination

ANSWER: C

A. This child likely has AGN. Almost all clients with this condition who are properly diagnosed and treated will recover completely.
B. This child likely has nephrotic syndrome, for which the prognosis for ultimate recovery in most cases is good.
C. The child with recent renal transplantation with these symptoms needs to be evaluated immediately for possible rejection.
D. This child likely has a UTl. Adequate treatment at the time of diagnosis will usually result in an excellent prognosis.

31 . The nurse is preparing the peritoneal dialysis treatment for the 10-year—old. To promote a sense of control, what should the nurse allow the child to do?

A. Cleanse the abdomen before inserting the needle for the local anesthetic

B. Select, from a list of options, liquids to drink during the dialysis procedure
C. Play with a cloth doll that has a removable catheter inserted in the abdomen
D. Play with a toy that is only allowed during the peritoneal dialysis procedure

ANSWER: B

A. Allowing a 10-year—old to cleanse the abdomen is not the best option. The nurse needs to ensure sterility of supplies and prevent infection.
B. Because the bulk of peritoneal fluid causes pressure on the stomach and causes a feeling of fullness, a child is provided with a liquid diet or small, frequent feedings. Allowing the child to choose the preferred, allowable liquid ensures a sense of control.
C. Therapeutic play is used to enhance self-esteem and reduce anxiety.
D. Playing with a toy allowed only during dialysis helps to reduce boredom.

32. The nurse is developing a teaching plan for the pediatric client and the child's parents for home peritoneal dialysis (PD). Which statement should the nurse omit from the teaching plan?

A. "The instilled solution remains for a variable length of time."
B. "A cooled solution is allowed to enter the peritoneal cavity by gravity."
C. "A sterile dialysis solution is instilled through a surgically implanted catheter."
D. "The solution is infused and the dialysate drained through a single catheter."

ANSWER: B

A. The "dwell" time (time in the peritoneal cavity) varies by the type of PD.
B. In PD, a warmed and not cooled solution enters by gravity. The solution is warmed to prevent a drop in core body temperature. This incorrect statement should be omitted from the teaching plan.
C. Tire sterile dialysis solution is instilled through a surgically implanted catheter into the peritoneal cavity. The catheter has an access on the abdomen for attaching the dialysis solution tubing.
D. A single catheter is used for infusing and draining the dialysis solution.

33. The 9-year—old is to have a kidney transplant. What information should the nurse consider when preparing to teach the child and the child's parents? Select all that apply.

A. A kidney transplant will eliminate dependence on dialysis.
B. A kidney for transplant is restricted to blood relatives as donors.
C. A kidney transplant will eliminate the need for dietary restrictions.
D. A kidney transplant may result in rejection, hypertension, or infection.
E. A kidney for transplant may be from living, non—heart heating, or deceased donors.

ANSWER: A, C, D, E

A. Transplant does eliminate dependence on dialysis. However, dialysis may be used postoperatively, depending on the type of kidney donor.
B. Kidney transplant donors are not restricted to blood relatives.
C. Kidney transplant eliminates the need to restrict the diet because the kidney should be able to remove nitrogenous wastes and assume the function lost by the diseased kidneys.
D. Kidney transplant may result in rejection, hypertension, or infection. The nurse needs to address signs and symptoms of these in postoperative teaching.
E. Donors may be living, non—heart heating, or deceased. Blood and tissue typing is done to determine a match to prevent rejection.

34. The nurse is assessing the l4-year-old who has a transplanted kidney. The nurse should notify the HCP when the child has which symptoms associated with organ rejection? Select all that apply.

A. Cloudy urine at 35 mL/hr
B. Respiratory rate of 20 bprn
C. Serum creatinine of 0.9 mg/dL
D. Blood pressure of 142/92 mm Hg
E. Oral temperature of 101 .8°F (38. 8°C)

ANSWER: D, E

A. Cloudy urine may indicate a UTl, but not rejection.
B. The RR is WNL.
C. A serum creatinine of 0.9 ing/dL is normal for this age group.
D. A BP of 142/92 mm Hg is high and also associated with possible rejection-
E. An oral temperature of 101.8°F represents fever, which is a sign of organ rejection.

35. The 5-year—old who received a kidney transplant is receiving cyclosporine. Which laboratory finding should the nurse recognize as indicating that the treatment is having an adverse effect?

A. Hemoglobin 0f9.0 g/dL
B. Total cholesterol of 220
C. Ammonia of 65 mg/dL
D. Random blood glucose of 60 mg/dL

ANSWER: A

A. Hgb of 9.0 g/dL indicates anemia in a child this age and is an adverse effect related to the use of cyclosporine (Gengraf, Neoral, Sandimmune).
B. Total cholesterol of 220 is normal for a 5—year—old.
C. An ammonia level of 65 mg/dL is normal for a 5-year—old.

D. A random blood glucose of 60 mg/dL is normal for a 5-year—old.

36. The adolescent with a history of a renal transplant has not been taking medications as pre- scribed. The result has been loss of the kidney. The multidisciplinary team, which includes the nurse, is considering whether the client should receive a second transplant. What should be the next. Course of action?

A. Allow the client to decide.
B. Allow the managing health care provider to decide.
C. Refer the case to the institution's ethics committee.
D. Perform another transplant only if the bill can be paid.

ANSWER: C

A. Actions may include discussing the decision with the client, but allowing the client to decide is not the next action.
B. Actions may include discussing the decision with the HCP, but allowing the HCP to decide is not the next action.
C. Because of a scarcity of donors, expense of the procedure, and costly medications, this case should be referred to the institutional ethics committee.
D. Performing another transplant only if the bill can be paid is unethical.

37. The child is hospitalized following renal trauma. The nurse should assess for signs of which complication first?

A. Anuria
B. Hypertension
C. Internal bleeding
D. Electrolyte imbalance

ANSWER: C

A. Assessing for absence of urine is important but is not the first consideration.
B. Hypertension may occur due to loss of kidney function but is not the first consideration.
C. Following renal trauma, the client is at risk for internal bleeding. This assessment should be first because the blood supply to the kidney constitutes approximately one-fifth of the total cardiac output.
D. Electrolyte imbalances can occur due to alteration in kidney function, but this is not the first consideration.

38. The toilet-trained child presents with incontinence, strong-smelling urine, frequency, and urgency. What laboratory specimen should the nurse collect first?

A. Serum creatinine
B. Routine urinalysis (UA)

C. Complete blood count (CBC)
D. Blood culture and sensitivity

ANSWER: B

A. Serum creatinine evaluates kidney function. This may be part of the workup for this child but would not be the first test to be performed.
B. Incontinence in a toilet-trained child, strong- smelling urine, frequency, and urgency are signs that should be evaluated for [IT]. Routine UA is the first test to be performed. If the UA results suggest a UTI, then a urine specimen should be obtained through catheterization.
C. A CBC is a test that may be used to evaluate for infection, as it includes a W BC count, although it is unlikely that it would be the first specimen the nurse should collect.
D. A urine culture and sensitivity may be obtained to evaluate for the presence of bacteria and to determine appropriate antibiotic therapy, but a blood culture would not be necessary unless the child has an elevated temperature and other symptoms of sepsis.

39. The 6-year—old is being seen in a clinic with possible cystitis. Which findings on the nurse's assessment are consistent with cystitis? Select all that apply.

A. Enuresis
B. Hematuria
C. Suprapubic pain
D. Strong-smelling urine
E. Costovertebral angle tenderness

ANSWER: A, B, C, D

A. Enuresis (bedwetting in a previously potty- trained child) is due to inflammatory edema in the bladder wall that stimulates stretch receptors, producing urgency and frequency.
B. Hematuria (bloody urine) occurs due to inflammation of the urethra and bladder wall from bacteria.
C. Suprapubic pain occurs from inflammation and the effects of the bacteria on the urethra and bladder wall.
D. Strong-smelling urine results from the accumulation of nitrates.
E. Costovertebral angle tenderness is seen with an upper UTI such as pyelonephritis.

40. The 6-year—old with fever and painful urination is brought to the clinic by the parent. Which finding on UA completed that morning is most important for the nurse to report to the health care provider?

A. Hematuria
B. Trace ketones

C. Urine pH 6.5
D. Specific gravity 1.010

ANSWER: A

A. Hematuria (RBCs in the urine) is an abnormal finding and should be reported, as it may be a sign of infection.
B. Urine pH of6.5 is normal (normal 5—9). Urine is slightly acid in the morning (pH = 6.5—7.0) and more alkaline by evening (pH = 7.5—8.0).
C. Trace ketones may be abnormal but could be a result of mild dehydration.
D. Specific gravity of 1.010 is normal (normal = 1001—1029).

41 . The nurse completed teaching on strategies to prevent UTI recurrence with the female adolescent who is sexually active. Which statements made by the adolescent indicate that teaching was effective? Select all that apply.

A. "I should void after intercourse."
B. "I should be wearing silky underwear."
C. "I should drink 34 ounces of water daily."
D. "I should drink blueberry or cranberry juice."
E. "I should be sure that my partner uses a latex condom."

ANSWER: A, D

A. Voiding after intercourse helps to flush the bacteria that may be present on the urethra.
B. Cotton underwear is recommended, rather than silk; silky underwear holds moisture and can promote bacterial growth.
C. Drinking 34 ounces of water daily is insufficient and amounts to a little over a liter. The adolescent should be consuming 2 to 3 liters of fluid daily.
D. Blueberry and cranberry juice reduce bacterial adherence to the epithelial lining of the urinary tract.
E. While condoms may prevent STIs, they do not prevent UTIs.

42. The nurse is educating the parents of the pediatric client with recurrent UTIs about perineal hygiene. The nurse's rationale for including this component is that 80% of cases of UTI are caused by which bacteria?

A. Klebsiella
B. Candida albicans
C. Escherichia coli
D. Staphylococcus aureus

ANSWER: C

A. Klebsiella is a gram-negative bacteria normally found in the mouth, skin, and intestinal tract, where it initially does not cause disease. It accounts for a small number of UTIs, generally in older women.
B. Candida albicans is a fungal infection, and not bacterial, which can cause a yeast infection.
C. The perineal area and urethra can easily become contaminated with Escherichia coli from fecal material and is responsible for 80% of cases of UTI.
D. Staphylococcus aureus, present on the skin, accounts for a small number of UTIs.

43. The ED nurse is triaging four children. Which child should be the nurse's priority?

A. A child with vomiting and diarrhea for 24 hours
B. A child with a 3-cm facial laceration from a fall
C. A child with dyspnea and a palpable abdominal mass
D. A child with an oral temperature of 102.1°F (389°C)

ANSWER: C

A. Vomiting and diarrhea are important to address, but this is not the priority.
B. Facial lacerations may require sunning, but this is not the priority.
C. The nurse's priority should be the child who has dyspnea, which suggests respiratory compromise, and a palpable mass. The most common presenting sign of 'Wilms' tumor is a swelling or mass in the abdomen. Priority nursing care involves ensuring swift diagnosis and surgical intervention.
D. Fever is important to address, but this is not the priority.

44. The nurse is caring for the pediatric client with nephrotic syndrome. Which medication should the nurse anticipate administering to treat nephritic syndrome?

A. Prednisone
B. Ibuprofen
C. Ampicillin
D. Hydrochlorothiazide

ANSWER: A

A. An immunological mechanism is involved in nephrotic syndrome. Corticosteroids, such as prednisone (Deltasone), reduce infiamrnation and proteinuria. A corticosteroid is given until diuresis without protein loss is accomplished.
B. Ibuprofen (Motrin) is an NSAID used to treat mild inflammation,
C. Ampicillin (Principen) is an antibiotic used to treat infection. Infection is not the cause of nephrotic syndrome.

D. Hydrochlorothiazide (Microzide, Oretic) is a thiazide diuretic used to treat hypertension or edema. It is not commonly used because it tends to decrease blood volume, which is already decreased in nephrotic syndrome.

45. The nurse is catheterizing the female adolescent who has nephrosis- In performing this procedure, the nurse uses the nondominant hand to gently separate then pull up the labia minora to see the meatus. What should the nurse do next with the nondominant hand?

A. Pick up the sterile catheter 4—6 inches from the end.
B. Cleanse the urinary meatus with povidone-iodine swabs.
C. No longer use it during the remainder of the procedure.
D. Continue separating the labia minora during the procedure.

ANSWER: D

A. The nondominant hand is no longer sterile after touching the skin and should not be used to pick up the sterile catheter.
B. Without visualization of the meatus because the hand has now moved to the swabs, it would be difficult to cleanse the urinary meatus adequately.
C. The hand needs to remain for the duration of the procedure to continue separating the labia. This hand may not be used to pick up sterile materials.
D. In catheterizing the female client, the nurse uses the nondominant hand to continue to gently separate and then pull up the labia minora. This visualizes the meatus for cleansing and then catheter insertion.

46. The child with ARF has not had a stool for a week. The resident physician prescribes a sodium biplrosplrate and sodium phosphate enema. What should the nurse do?

A. Administer the enema as prescribed by the resident physician.
B. Give the enema as prescribed after teaching is completed with the parent.
C. Give the enema as prescribed after consulting with another health care provider.
D. Not give the enema and inform the resident physician of the enema’s lethal risk.

ANSWER: D

A. The enema should not be administered.
B. Teaching the parent is irrelevant when the enema should not be administered.
C. Consulting with another HCP does not prevent a lethal error from occurring.
D. The use of a sodium biphosphatc and sodium phosphate enema (Fleet enema) in a child with ARF is potentially lethal due to the kidney’s inability to excrete phosphate and the resulting hyperphosphatemia. The enema should not be given, and the resident should be informed of its lethal risk.

47. The nurse is analyzing laboratory values for hospitalized children. If the glomerular filtration and absorption rates were in the normal range. the nurse should expect which children to have their GFR values furthest from the annual adult range of 90—120 ml /min/ 1 .73 m2?

A. Infants between 1 and 2 weeks of age
B. Children older than 2 years of age
C. Preschool- and school-aged children
D. Adolescents at the onset of puberty

ANSWER: A

A. Glomerular filtration and absorption are relatively low and do not reach adult values until between the ages of l and 2 years. The range for the GFR is 39—47 mL/min/l.73 m2 at age 1—2 weeks.
B. For children older than 2 years of age, glomerular filtration and absorption rates are at the same values as those for adults.
C. For preschool- and school-aged children, glomerular filtration and absorption rates are at the same values as those for adults.
D. For adolescents at the onset of puberty, glomerular filtration and absorption rates are at the same values as those for adults.

48. The 6-year-old with enuresis is to begin taking imipramine. The nurse should notify the HCP when the parent identifies that the child's history includes which problems? Select all that apply.

A. Asthma
B. Infantile seizures
C. Diabetes mellitus
D. Gastroesophageal reflux
E. Congenital heart disease

ANSWER: B, E

A. lmiprarnine is not contraindicated when the client has a history of asthma.
B. lmipramine (Tofranil) is contraindicated in clients with seizure disorders. The nurse should clarify whether the medication is safe if the child had infantile seizures.
C. Imipramine is not contraindicated when the client has a history of DM.
D. lmipramine is not contraindicated when the client has a history of GERD.
E. TCAS, such as imipraminc, may cause dysthymias and are contraindicated in heart disease unless their use has been cleared by a specialist who has noted that the child does not have a QTc prolongation. The nurse should notify the HCP.

49. The child is to receive 20 meg intranasal desmopressin acetate (DDAVP) at bedtime for enuresis. The medication is supplied in a nasal spray pump of 10 incg/spray in a 5-mL bottle (0.1 mg/mL), which contains 50 doses of DDAVP. How many nasal sprays should the nurse instruct the parent to deliver at bedtime?

_____ nasal sprays at bedtime (Record your answer as a whole number.)

ANSWER: 2

Use a proportion formula

10 meg : 1 spray :: 20 meg :X spray; 10X = 20; X = 20 + 10; X = 2

50. At the end of a shift, the nurse is calculating the total urine output for a hospitalized l8-month-old. The child had 6 wet diapers during the 8-hour shift weighing 24 g, 24 g, 30 g, 31 g, 22 g, and 30 g. The weight of a dry diaper is 15 g. What amount in milliliters (mL) should the nurse document for the infant's total urine output for the 8 hours?

_____ mL (Record your answer as a whole number.)

ANSWER: 71

One milliliter of urine output equals 1 g of body weight. First add the total weight of each diaper: 24 + 24 + 30 + 31 + 22 + 30 = 161. Next determine the dry diaper weight for 6 diapers: 15 x 6 = 90. Finally subtract the dry weight from the total weight of the diapers to determine the total urine output for 8 hours: 161 — 90 = 71. The 71 g of fluid loss equals 71 mL of urine output.