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(Option 3) Clients who are able to remove and reinsert the pessary on their own will have the choice to remove it weekly, possibly even nightly, for cleaning. Clients who are sexually active may prefer to remove the pessary prior to intercourse, although this is not necessary. When the client cannot remove the pessary regularly, removal by an HCP at 2- to 3-month intervals is recommended.

(Option 4) Increased vaginal discharge is a common side effect. However, if an odor is present, the client should be instructed to notify the HCP to be treated for a possible infection.

Educational objective:

A pessary is a vaginal support device recommended for pelvic organ prolapse. Pessaries are fitted by an HCP; many clients can then remove, clean, and replace these themselves. Clients can remain sexually active with a pessary in place.

2) A client diagnosed with end-stage renal disease comes to the dialysis clinic for treatment. Which actions should the nurse take to prepare the client for hemodialysis? **Select all that apply**.

1. *Administer subcutaneous heparin to decrease clotting during dialysis*

2. *Administer the client's morning doses of carvedilol and lisinopril*

3. *Check the client's medical records to determine the last post-dialysis weight*

4. *Obtain a set of client vital signs and the client's current weight*

5. *Palpate the fistula in the client's arm for a thrill and auscultate for a bruit*

✓Answer: 3, 4, 5

Prior to dialysis treatment, the nurse should assess the client's fluid status (weight, blood pressure, peripheral edema, lung and heart sounds), vascular access (arteriovenous fistula, arteriovenous grafts), and vital signs **(Option 4)**.

The amount of fluid removed (ultrafiltration) is determined by calculating the difference between the last post-dialysis weight and the client's current pre-dialysis weight **(Option 3)**.

After the client is connected to the dialysis machine, **IV heparin is added to the blood** from the client to prevent clotting that can occur when blood contacts a foreign substance. Giving subcutaneous heparin prior to initiation is not necessary **(Option 1)**.

(Option 2) During dialysis, excess fluid is removed, making the client prone to hypotension. In addition, medications are removed from the blood during hemodialysis, making them ineffective. Many medications that are taken once daily can be held until after the dialysis treatment to prevent their removal. If blood pressure medications are given prior to dialysis, the client can develop hypotension during the dialysis and then uncontrolled hypertension (decreased drug concentrations).

(Option 5) Arteriovenous fistulas are created by anastomosing an artery to a vein; a **thrill** can be **felt** when palpating the fistula, and a **bruit** can be heard during **auscultation** when the fistula is functioning properly.

Educational objective:

The nurse is responsible for assessing the client diagnosed with end-stage renal disease for risks associated with dialysis. These risks include medication removal, hemodialysis access dysfunction, hypotension, and fluid and electrolyte imbalances.

3) The nurse is conducting a pain assessment on a client with dysuria. Which pain description is **most likely** associated with pyelonephritis?

1. *Constant; increased by pressure over the suprapubic area*

2. *Dull and continuous; occasional spasms over the suprapubic area*

3. *Dull flank pain; extending toward the umbilicus*

4. *Excruciating; sharp flank pain radiating to the groin*

✓Answer: 3

1. *Douche with a water and vinegar solution after intercourse*

2. *Increase daily intake of fluids*

3. *Use a spermicidal contraceptive jelly*

4. *Use fragrance-free perineal deodorant products*

5. *Void immediately after intercourse*

6. *Wear underwear with a cotton crotch*

✓Answer: 2, 5, 6

The nurse should encourage a sexually active female client to implement the following interventions to help **prevent recurrent UTIs**:

• **Take all antibiotics as prescribed** even if symptoms have improved as bacteria may still be present.

• **Increase fluid intake**; this dilutes the urine (minimizing bladder irritation), promotes frequent urination, and prevents urinary stasis. The client should void at least every 2-4 hours. Some health care providers recommend drinking cranberry juice as it inhibits bacterial attachment to the bladder wall, but there is no clinical evidence to support its effectiveness in preventing UTIs **(Option 2)**.

• **Wipe from front to back** to prevent introducing bacteria from the vagina and anus into the urethra

• **Avoid synthetic fabrics** as these materials (eg, nylon, spandex) seal in moisture and create an environment conducive to bacterial proliferation; cotton underwear is recommended instead **(Option 6)**.

• **Void after sexual intercourse** to flush out bacteria that may have entered the urethra **(Option 5)**.

(Options 1 and 4) Avoid douching and using **feminine perineal products** (eg, deodorants, powders, sprays), as they can alter the vaginal pH and normal flora, increasing the risk for infection. Take showers instead of baths as bath products (eg, bubble bath, oils) and bacteria in bath water can irritate the urethra and increase the risk of infection.

(Option 3) Avoid spermicidal contraceptive jelly as it can suppress the production of protective vaginal flora. Discontinue diaphragm use temporarily (until symptoms subside and antibiotic course is completed); a diaphragm increases pressure on the urethra and bladder neck, which may inhibit complete bladder emptying.

Educational objective:

Interventions to help prevent recurrent UT's in sexually active female clients include avoiding use of feminine perineal products, vaginal douches, and spermicidal contraceptive jelly. Protective factors include wearing cotton underwear, increasing water intake, and voiding immediately after sexual intercourse.

5) The nurse assesses a client diagnosed with chronic kidney disease who had an internal arteriovenous fistula performed on the left arm yesterday. Which assessment finding would require **immediate** follow-up?

1. *A bruit cannot be auscultated over the fistula site*

2. *Capillary refill of 2 seconds is assessed on the left hand*

3. *Client reports squeezing a rubber ball with the left hand several times daily*

4. *Incision is dry with no redness and has sterile skin closures in place*

✓Answer: 1

An **arteriovenous fistula** is a surgical connection of an artery to a vein created to provide vascular access for hemodialysis therapy in clients with kidney disease. Arterial blood flowing through this vein causes it to engorge and thicken (mature) over a period of several weeks, after which it can sustain frequent access by 2 large-bore needles required for dialysis. Maturing of the fistula is aided by having the client perform hand exercises, such as **squeezing a rubber ball**, that increase blood flow through the vein.

Following fistula placement, it is important to monitor for patency. A palpable **thrill (vibration)** over the fistula or an auscultated **bruit** (blowing or swooshing sound caused by turbulent blood flow) indicates a patent fistula. Absence of the thrill or bruit can indicate potential clot formation in the fistula. Client reports of numbness or tingling as well as decreased capillary refill can also signal potential clotting.

(Option 2) Capillary refill of < 3 seconds is considered normal and indicates acceptable blood flow to the area.

(Option 3) Daily hand exercises such as squeezing handgrips or a rubber ball are performed to help properly mature the fistula.

(Option 4) A dry surgical incision without redness, warmth, and induration is an optimal finding. Sterile skin closures (eg, Steri-Strips) are used to help hold the incision together as it heals.

Educational objective:

Following placement of an arteriovenous fistula, it is imperative to monitor for signs of potential clotting of the fistula such as absence of a bruit, absence of a thrill, decreased capillary refill, and coolness of the extremity below the fistula.

6) The nurse provides post-procedure teaching for a female client who had a cystoscopy as an outpatient. Which client statement indicates the **need for additional instruction**?

1. *"I can expect pink-tinged urine for at least 24 hours."*

2. *"I can take a warm bath and acetaminophen if I have discomfort or bladder spasms."*

3. *"I should expect frequency and burning when I urinate."*

4. *"I should expect to see blood clots in my urine for up to 24 hours."*

✓Answer: 4