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Certified Peritoneal Dialysis Nurse (CPDN)

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Question: 1089

A PD unit manager is addressing a fire hazard after a small electrical fire in the storage room. The unit's fire safety protocol requires annual drills and compliance with NFPA 101 Life Safety Code. A patient on APD with a cycler reports smoke exposure, with a SpO2 of 92% and respiratory rate of 24 breaths/min. What should the manager include in the revised protocol to prevent future incidents?

A. Train staff to evacuate patients immediately upon any smoke detection
B. Limit cycler use to battery-powered models to reduce electrical risks
C. Require staff to store all electrical equipment in fireproof cabinets
D. Conduct fire drills biannually and install additional smoke detectors

Answer: D

Explanation: Conducting fire drills biannually and installing additional smoke detectors enhances fire safety per NFPA 101 while addressing the patient's smoke exposure risk (SpO2 92%). Limiting cycler use to battery-powered models is impractical and not standard. Storing equipment in fireproof cabinets is insufficient to address broader fire risks. Immediate evacuation may be unsafe without assessing the situation, especially for PD patients mid-treatment.

Question: 1090

A 55-year-old patient on CAPD develops severe abdominal pain and pneumoperitoneum on CT scan after a recent exchange. The patient is afebrile, and dialysate analysis shows no infection. The dialysate flow rate is 200 mL/min, and the patient uses 2.5% dextrose solution. What is the most likely cause of pneumoperitoneum, and how should it be managed?

A. Catheter introduction of air; reduce fill volume
B. Bowel perforation; urgent surgical consultation
C. Peritonitis; initiate intraperitoneal antibiotics
D. Visceral irritation; switch to 1.5% dextrose solution

Answer: A

Explanation: Pneumoperitoneum in peritoneal dialysis patients is often due to air introduced via the catheter during exchanges, especially in the absence of fever or infection. Reducing fill volume can minimize air entry and intra-abdominal pressure. Bowel perforation is unlikely without systemic signs or abnormal dialysate analysis. Peritonitis is ruled out by negative dialysate cultures. Switching to 1.5% dextrose solution addresses visceral irritation but not pneumoperitoneum.

Question: 1091

During transfer set change, which step is critical to reduce the risk of bacterial contamination?

A. Following sterile technique and disinfecting catheter hub with antimicrobial solution before and after

change
B. Disconnecting old transfer set and immediately applying the new set without disinfection
C. Flushing the peritoneal cavity with saline before changing the transfer set
D. Changing the transfer set only when visible contamination is present

Answer: A

Explanation: Disinfecting the catheter hub with antimicrobial solution before and after transfer set change and strict sterile technique are essential to minimize peritonitis risk. Immediate connection without disinfection and waiting for visible contamination are unsafe.

Question: 1092

What is the rationale for using 2.5% dextrose peritoneal dialysate solution compared to 1.5% in chronic PD patients?

A. To promote greater ultrafiltration in patients with fluid overload
B. To reduce glucose absorption and hyperglycemia risk
C. To decrease protein loss during dialysis
D. To enhance clearance of middle molecules

Answer: A

Explanation: Higher glucose concentration solutions like 2.5% provide greater osmotic gradient leading to increased ultrafiltration, useful in fluid overloaded patients. Higher glucose increases glucose absorption and hyperglycemia risk. Protein loss and middle molecule clearance are not significantly affected.

Question: 1093

A peritoneal dialysis patient develops acute dyspnea and decreased ultrafiltration volume. Imaging reveals a pleural effusion on the right side. What parameter in the dialysate fluid is most consistent with a pleural leak?

A. Presence of pleural fibrin strands
B. Decreased dialysate sodium concentration
C. Elevated dialysate potassium concentration
D. Increased dialysate glucose concentration in pleural fluid

Answer: D

Explanation: A pleural leak in peritoneal dialysis is usually due to diaphragmatic defects permitting dialysate to migrate from the peritoneal cavity into the pleural space, commonly on the right side. The hallmark diagnostic finding is a pleural effusion with a high glucose concentration, similar to dialysate fluid glucose (which is higher than serum).

Question: 1094

What is the most common route of transmission for biological agents causing peritoneal dialysis infections?

A. Vector-borne transmission via insects
B. Airborne particles in the dialysis unit
C. Touch contamination of catheter exit sites or connection systems
D. Waterborne transmission through dialysate solution

Answer: C

Explanation: Touch contamination during exchanges or poor exit site care mainly leads to infections. Airborne, vector, or waterborne routes are less common if proper procedures and solution manufacturing standards are followed.

Question: 1095

A 57-year-old patient on APD reports weight gain and shortness of breath. The nurse notes 1 L of ultrafiltration with 2.5% dextrose and a dwell time of 2 hours. What factor is most likely limiting ultrafiltration?

A. High peritoneal membrane permeability
B. Inadequate dwell time
C. Low dextrose concentration
D. Reduced membrane surface area

Answer: B

Explanation: Inadequate dwell time (2 hours) limits ultrafiltration in APD, as the osmotic gradient dissipates before optimal fluid removal (Inadequate dwell time). High permeability (High peritoneal membrane permeability) enhances, not limits, ultrafiltration. Low dextrose (Low dextrose concentration) is less likely with 2.5% dextrose. Reduced membrane area (Reduced membrane surface area) is uncommon without surgical history.

Question: 1096

A patient on peritoneal dialysis has a low serum albumin of 2.8 g/dL and is noted to have protein losses in dialysate of 7 g/day. Which nutritional intervention is most appropriate?

A. Restrict protein intake to reduce losses
B. Limit fluid intake to prevent dilution
C. Supplement dialysate with albumin
D. Increase dietary protein intake to 1.2-1.3 g/kg/day

Answer: D

Explanation: PD patients lose protein daily via dialysate, requiring increased dietary protein intake (1.2–1.3 g/kg/day) to maintain adequate nutrition and prevent malnutrition. Restriction worsens catabolism. Albumin supplementation in dialysate is ineffective. Fluid restriction does not address protein loss.

Question: 1097

A transplant candidate with a BMI of 34 kg/m² is undergoing evaluation. Which criterion is most likely to exclude them from transplantation?

A. Recent myocardial infarction within 3 months
B. History of non-compliance with dialysis
C. BMI alone if controlled with diet
D. Type 2 diabetes with HbA1c of 7.5%

Answer: A

Explanation: A recent myocardial infarction (within 3–6 months) is a contraindication to transplantation due to high perioperative cardiac risk. BMI of 34 may require optimization but is not an absolute exclusion. Non-compliance is a concern but not an automatic exclusion. Controlled diabetes is not a contraindication.

Question: 1098

Which lab value is most critical for evaluating peritoneal dialysis adequacy and should be monitored regularly?

A. Serum potassium level
B. Hemoglobin A1c
C. Serum albumin
D. Blood urea nitrogen (BUN) and creatinine clearance

Answer: D

Explanation: BUN and creatinine clearance are indicators of solute removal efficacy, vital for dialysis adequacy.

Question: 1099

A patient with ESRD from polycystic kidney disease is on PD. Which systemic complication is most frequently associated with this condition?

A. Intracranial aneurysms
B. Hyperkalemia
C. Pulmonary hypertension
D. Bone fractures

Answer: A

Explanation: Polycystic kidney disease is associated with increased risk of intracranial aneurysms due to vascular abnormalities.

Question: 1100

A chronic PD patient demonstrates inadequate dialysis clearance with a D/P creatinine ratio of 0.45 on the peritoneal equilibration test. What does this indicate?

A. Low transporter status with slow solute equilibration
B. High transporter status with rapid solute equilibration
C. Normal peritoneal membrane permeability
D. Dialysis catheter malfunction

Answer: A

Explanation: A D/P creatinine ratio below 0.5 indicates low transporter status, meaning slow equilibration of solutes and possibly reduced dialysis adequacy. High transporter status usually shows D/P >0.8.

Question: 1101

A 54-year-old patient on CAPD has a dialysate effluent with a WBC count of 200/mm³ and reports abdominal pain. The nurse is teaching the patient to recognize peritonitis. Which teaching activity should the nurse prioritize?

A. Demonstrate catheter site cleaning
B. Explain the significance of WBC counts >100/mm³
C. Provide a written guide on antibiotic therapy
D. Review the patient's exchange schedule

Answer: B

Explanation: Explaining the significance of WBC counts >100/mm³ directly addresses the cognitive need to recognize peritonitis, as the patient's effluent (200/mm³) indicates infection. Demonstrating cleaning is psychomotor, providing a guide is cognitive but less urgent, and reviewing the schedule is unrelated.

Question: 1102

A 60-year-old patient on automated peritoneal dialysis (APD) reports difficulty performing exchanges due to recent hand tremors. During the nursing assessment, the patient struggles to manipulate a syringe, dropping it twice. Which assessment tool should the nurse use to quantify the patient's fine motor coordination?

A. Visual Acuity Chart
B. Tinetti Balance Assessment
C. Nine-Hole Peg Test
D. Wong-Baker Pain Scale

Answer: C

Explanation: The Nine-Hole Peg Test is a standardized tool to assess fine motor coordination and dexterity, ideal for evaluating the patient's ability to handle dialysis equipment. The Tinetti Balance Assessment evaluates gait and balance, not fine motor skills. The Visual Acuity Chart tests vision, and the Wong-Baker Pain Scale assesses pain, neither of which address motor coordination.

Question: 1103

A patient on CAPD with a known catheter fracture undergoes splicing of the damaged catheter. Which is the most important step to prevent infection during this procedure?

A. Use of local anesthesia at the splice site
B. Flushing catheter with heparinized saline post-splice
C. Clamping of catheter proximal and distal before splicing
D. Strict sterile technique with prophylactic antibiotics administration

Answer: D

Explanation: Strict sterile technique and prophylactic antibiotics are crucial to prevent peritonitis during catheter splicing because this procedure exposes the sterile catheter lumen and peritoneal cavity to infection risks.

Question: 1104

In the peritoneum, which layer acts as the primary barrier to solute and fluid transport in PD?

A. Visceral peritoneum
B. Parietal peritoneum
C. Endothelium of peritoneal capillaries
D. Submesothelial interstitium

Answer: C

Explanation: The endothelium of peritoneal capillaries is the primary barrier regulating solute and fluid transport during PD. Both visceral and parietal peritoneum contribute, but the capillary endothelium is key in the transport process.

Question: 1105

Which of the following changes in pulmonary function are typically seen in patients undergoing chronic

peritoneal dialysis with large dialysate volumes?

A. Elevated diffusion capacity for carbon monoxide
B. Increased forced expiratory volume in 1 second (FEV1)
C. Decreased total lung capacity and reduced functional residual capacity
D. Bronchodilation due to metabolic alkalosis

Answer: C

Explanation: Large volumes of dialysate increase intra-abdominal pressure, impeding diaphragmatic excursion, resulting in decreased total lung capacity (TLC) and functional residual capacity (FRC). FEV1 usually does not increase. Diffusion capacity is not typically elevated. Bronchodilation due to metabolic alkalosis is not a known feature in PD patients.

Question: 1106

A PD nurse manager is revising staff training to address OSHA standards for biological hazard exposure. A patient's dialysate bag leaks during an exchange, and the fluid tests positive for Staphylococcus epidermidis. What should the training emphasize for handling this incident?

A. Use PPE and dispose of contaminated materials in a biohazard container
B. Clean the spill with an alcohol-based disinfectant
C. Neutralize the spill with a 1:100 bleach solution
D. Restrict the area and call an environmental safety team

Answer: A

Explanation: Using PPE and disposing of contaminated materials in a biohazard container aligns with OSHA standards for handling infectious fluids like dialysate with Staphylococcus epidermidis. Alcohol-based disinfectants are ineffective against certain pathogens. A 1:100 bleach solution is too dilute for biohazards. Calling a safety team is unnecessary for a routine spill.

Question: 1107

During a PD exchange, a 47-year-old patient reports poor dialysate outflow. The nurse confirms constipation via patient history and notes a dwell time of 4 hours with 1.5% dextrose. What is the most likely cause of poor outflow, and what should the nurse do next?

A. Catheter kinking; reposition the patient
B. Peritonitis; obtain effluent culture
C. Fibrin buildup; add heparin to dialysate
D. Constipation; administer a laxative

Answer: D

Explanation: Constipation is a common cause of poor dialysate outflow in PD, as fecal mass can obstruct

catheter flow (Constipation; administer a laxative). Administering a laxative addresses this issue. Catheter kinking (Catheter kinking; reposition the patient) is less likely without positional changes. Fibrin buildup (Fibrin buildup; add heparin to dialysate) typically causes cloudy effluent, not mentioned here. Peritonitis (Peritonitis; obtain effluent culture) is unlikely without cloudy effluent or fever.

Question: 1108

A patient on CAPD presents with fatigue and muscle weakness. Laboratory results show a serum potassium of 3.2 mEq/L. What should the nurse suspect?

A. Hyperkalemia from inadequate dialysis
B. Metabolic acidosis from dialysate pH
C. Hypokalemia from excessive potassium removal
D. Uremic neuropathy

Answer: C

Explanation: A serum potassium of 3.2 mEq/L indicates hypokalemia, likely due to excessive potassium removal during CAPD exchanges. Fatigue and muscle weakness are classic symptoms. Hyperkalemia is incorrect, as the potassium level is low. Metabolic acidosis is unrelated to these symptoms or potassium levels. Uremic neuropathy causes sensory changes, not primarily muscle weakness.

Question: 1109

A nurse presents a study at a CNNT meeting on the effect of patient education on ultrafiltration failure. The study reports a relative risk of 0.75 for educated versus non-educated patients. What does this relative risk indicate?

A. Educated patients have a 25% lower risk of ultrafiltration failure
B. Educated patients have a 25% higher risk of ultrafiltration failure
C. Non-educated patients have a 75% lower risk of ultrafiltration failure
D. No significant difference in ultrafiltration failure risk

Answer: A

Explanation: A relative risk of 0.75 indicates that educated patients have a 25% lower risk of ultrafiltration failure (1 - 0.75 = 0.25) compared to non-educated patients. A higher risk would have a relative risk >1. Non-educated patients are the reference group, so the reduction applies to educated patients. No difference would have a relative risk near 1 with a non-significant p-value.

Question: 1110

A PD nurse is evaluating a 56-year-old patient’s understanding of fluid balance after a teaching session. The patient calculates an ultrafiltration volume of 300 mL from a 2000 mL inflow and 2300 mL outflow. Which evaluation method should the nurse use to confirm cognitive learning?

A. Review the patient’s fluid intake records
B. Observe the patient measuring outflow
C. Provide a quiz on fluid balance principles
D. Ask the patient to repeat the calculation

Answer: D

Explanation: Asking the patient to repeat the calculation confirms cognitive learning by verifying the understanding of ultrafiltration (2300 mL - 2000 mL = 300 mL). Observing measurement is psychomotor, a quiz is broader, and reviewing records is unrelated to cognitive confirmation.

Question: 1111

A 60-year-old patient on CCPD using a cycler with a 2 L fill volume, 2.5% dextrose, and 5 cycles/night has a Kt/V of 1.4 and ultrafiltration (UF) of 600 mL/day. The PET shows a low transporter (D/P creatinine 0.48). Lab results indicate serum albumin of 3.0 g/dL and effluent protein loss of 8 g/day. Which prescription adjustment would best improve Kt/V and UF?

A. Use icodextrin for a long daytime dwell
B. Increase fill volume to 2.5 L, maintaining 2.5% dextrose and 5 cycles
C. Switch to CAPD with 2 L, 4.25% dextrose, 4 exchanges/day
D. Add a daytime exchange with 2 L, 1.5% dextrose

Answer: A

Explanation: A low transporter (D/P creatinine 0.48) benefits from longer dwell times for optimal solute clearance and UF. Icodextrin, a glucose polymer, provides sustained ultrafiltration over long dwells (e.g., 8–12 hours), improving UF and Kt/V (target ≥1.7). Low UF (600 mL/day) and hypoalbuminemia (3.0 g/dL) suggest protein loss contributes to reduced oncotic pressure, making icodextrin’s sustained UF effective. Adding a 1.5% dextrose daytime exchange may not sufficiently improve UF for a low transporter. Increasing fill volume without changing dwell time may not optimize clearance. Switching to CAPD with 4.25% dextrose is less effective due to shorter dwells unsuitable for low transporters.

Question: 1112

During ongoing assessment, a nurse notices a PD patient with unexplained weight loss, muscle wasting, and serum albumin 2.7 g/dL. What is the most likely contributing factor?

A. Iron deficiency anemia
B. Excessive fluid removal by dialysis
C. Protein-energy wasting from hypercatabolism
D. Peritoneal membrane infection

Answer: C

Explanation: Weight loss, muscle wasting, and low serum albumin suggest protein-energy wasting, a catabolic state common in dialysis patients due to inflammation and metabolic imbalance. Excessive fluid removal causes dehydration but not muscle wasting. Iron deficiency impacts anemia, and infection would cause systemic signs.

Question: 1113

A patient's dialysate analysis shows significant protein loss. What is the expected impact and nursing consideration?

A. Decrease dialysis solution volume
B. Monitor nutritional status and consider dietary protein supplementation
C. Increase dwell time to improve protein retention
D. Limit oral protein intake to reduce losses

Answer: B

Explanation: Protein loss through peritoneal dialysis can lead to malnutrition; monitoring and dietary adjustments are critical. Reducing solution volume or increasing dwell time does not affect protein losses. Limiting protein intake worsens nutritional status.

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