

* NGN NCLEX 2026 — VISUAL REFERENCE LIBRARY

Urological *Procedures* Nursing Care Guide

A comprehensive review of diagnostic and therapeutic urological procedures — covering pre-procedure preparation, intra-procedure positioning, post-procedure monitoring, complication recognition, and discharge teaching for the NCLEX 2026 candidate.

SYSTEM • RENAL/URINARY

DOMAIN • PROCEDURAL CARE

SKILL • PRE/POST-OP NURSING

PRIORITY • BLEEDING & INFECTION

NGN • CLINICAL JUDGMENT

SECTION 01 • OVERVIEW

1

Definition & *Why It Matters*

Urological procedures are **diagnostic or therapeutic interventions** performed on the kidneys, ureters, bladder, urethra, and prostate. NCLEX questions focus on the nurse's role **before, during, and after** the procedure — especially recognizing bleeding, infection, and obstruction.

- Pre-procedure priorities:** verify informed consent, assess allergies (especially iodine/shellfish for contrast studies), confirm NPO status, check baseline labs (BUN, creatinine, coagulation studies).
- Post-procedure priorities:** monitor urine output (color, clarity, amount), assess for bleeding, infection, and obstruction. Pink-tinged urine is often expected; bright red bleeding or clots is a red flag.
- Universal teaching:** increase fluid intake (2–3 L/day unless contraindicated) to flush the urinary tract and prevent stasis, clots, and infection.

SECTION 02 • PROCEDURE PATHWAY

2

The *Universal* Pre/Post Flow



CONSENT



NPO STATUS



BASELINE LABS



PROCEDURE



RECOVERY

STEP 1

Pre-Procedure

Verify **consent**, check allergies, confirm NPO, baseline labs (BUN, Cr, PT/INR, CBC), void before procedure.

STEP 2

Positioning

Most procedures use **lithotomy** (cystoscopy) or **prone** (renal biopsy). Provide privacy and warmth.

STEP 3

Intra-Procedure

Monitor vital signs, level of consciousness, sterile technique. Report adverse reactions immediately.

STEP 4

Post-Procedure

Assess **urine output** (color/clarity/volume), VS, pain, signs of bleeding/infection. Encourage fluids.

STEP 5

Discharge Teaching

Fluid intake **2–3 L/day**, signs of complications to report, activity restrictions, follow-up care.

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SECTION 03 • PROCEDURE-BY-PROCEDURE

Major Urological Procedures

Cystoscopy

BLADDER VISUALIZATION VIA SCOPE

Direct visualization of the bladder and urethra; can biopsy, remove small stones, or treat strictures.

PRE-PROCEDURE

- ▶ Informed consent verified
- ▶ NPO 6–8 hours if general anesthesia (local: no NPO)
- ▶ Void immediately before procedure
- ▶ Administer pre-op sedation as ordered
- ▶ Position: lithotomy

POST-PROCEDURE

- ▶ Monitor urine: pink-tinged is expected
- ▶ Encourage fluids 2–3 L/day
- ▶ Warm sitz baths for discomfort
- ▶ Mild analgesics for back/pelvic pain
- ▶ Bed rest for short period

COMPLICATIONS

- ⚠ **Bright red urine / clots = hemorrhage**
- ⚠ **Sharp abdominal pain + rigidity = bladder perforation**
- ▶ Urinary retention (notify HCP)
- ▶ UTI: fever, cloudy urine, dysuria

TEACHING

- ▶ Burning on urination 24–48 hr is normal
- ▶ Report fever, chills, heavy bleeding
- ▶ Avoid alcohol 24 hr if sedation given

IVP / IV Urogram

INTRAVENOUS PYELOGRAM — CONTRAST DYE STUDY

X-ray of kidneys, ureters, and bladder using IV iodinated contrast.

PRE-PROCEDURE

- ⚠ **Assess iodine/shellfish allergy**
- ▶ Check BUN/creatinine (kidney function)
- ▶ Hold metformin per HCP (lactic acidosis risk)
- ▶ NPO 8 hours; bowel prep (laxative night before)
- ▶ Informed consent

POST-PROCEDURE

- ▶ Force fluids to flush dye from kidneys
- ▶ Monitor for delayed allergic reaction
- ▶ Assess urine output (≥ 30 mL/hr)
- ▶ Monitor BUN/Cr for contrast nephropathy

COMPLICATIONS

- ⚠ **Anaphylaxis: hives, wheezing, hypotension**
- ⚠ **Contrast-induced nephropathy: $\uparrow$ Cr**
- ▶ Metallic taste, warmth — usually transient

TEACHING

- ▶ Drink extra fluids 24 hr after procedure
- ▶ Report rash, itching, swelling
- ▶ Resume metformin only when HCP clears

Renal Biopsy

PERCUTANEOUS KIDNEY TISSUE SAMPLING

Needle biopsy of kidney tissue for diagnosis of renal disease, transplant rejection, or unexplained hematuria.

PRE-PROCEDURE

- 🚨 **Type & cross-match blood (bleeding risk!)**
- Coagulation studies (PT/PTT/INR/platelets)
- Hold anticoagulants per HCP order
- NPO 6–8 hours
- Position: PRONE with pillow under abdomen
- Informed consent

POST-PROCEDURE

- 🚨 **Strict bed rest 24 hours, supine**
- Pressure dressing on biopsy site
- VS q15 min × 1 hr, then taper
- Monitor H&H, urine for hematuria
- I&O strictly; encourage fluids

COMPLICATIONS

- 🚨 **Hemorrhage: flank pain, hypotension, tachycardia, ↓ H&H**
- 🚨 **Gross hematuria > 24 hr**
- Hematoma at biopsy site
- Infection (delayed)

TEACHING

- No heavy lifting × 2 weeks
- No strenuous activity × 2 weeks
- Report bright red blood in urine, fever, dizziness
- Avoid aspirin/NSAIDs per HCP

ESWL (Lithotripsy)

EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

Non-invasive shock waves break kidney/ureteral stones into passable fragments.

PRE-PROCEDURE

- Informed consent
- NPO 6–8 hours (sedation/anesthesia)
- Pregnancy test (women of childbearing age)
- Check coagulation studies
- Empty bladder before procedure

POST-PROCEDURE

- 🚨 **STRAIN ALL URINE — collect fragments for analysis**
- Hematuria expected 24–48 hr (pink/red)
- Encourage fluids 3–4 L/day to flush fragments
- Bruising on flank common
- Analgesics for renal colic
- Ambulate to promote stone passage

COMPLICATIONS

- 🚨 **Obstruction by stone fragments (severe flank pain, ↓ urine output)**
- 🚨 **Sepsis from infected stone**
- Persistent gross hematuria
- Steinstrasse ("stone street" of fragments blocking ureter)

TEACHING

- Strain ALL urine until HCP says stop
- Diet modifications based on stone composition (e.g., low oxalate for calcium oxalate stones)
- Maintain fluids 2–3 L/day for life to prevent recurrence
- Report fever, severe pain, no urine output

TURP

TRANSURETHRAL RESECTION OF PROSTATE

Surgical removal of prostate tissue via the urethra for BPH; resectoscope shaves enlarged prostate.

PRE-PROCEDURE

- ▶ Informed consent (retrograde ejaculation risk)
- ▶ NPO 8 hours
- ▶ Hold anticoagulants per HCP
- ▶ Bowel prep may be ordered
- ▶ Type & cross-match (bleeding common)

POST-PROCEDURE

- ▶ **Continuous Bladder Irrigation (CBI) with 0.9% NS**
- ▶ 3-way Foley catheter; titrate CBI to keep urine PINK
- ▶ Subtract irrigation volume from total output to get true urine output
- ▶ Avoid Valsalva (no straining, no enemas)
- ▶ Stool softeners to prevent straining
- ▶ Monitor for bladder spasms (give antispasmodics like B&O suppositories)

COMPLICATIONS

- ▶ **Hemorrhage:** bright red ARTERIAL bleeding, clots → notify HCP; dark/burgundy VENOUS bleeding → ↑ CBI rate
- ▶ **TURP syndrome:** hyponatremia from absorbed irrigant — confusion, ↓ Na⁺, HTN, bradycardia, ↓ LOC
- ▶ Clot retention / bladder distention
- ▶ UTI, incontinence, retrograde ejaculation

TEACHING

- ▶ No heavy lifting (> 10 lbs), no driving × 2–4 weeks
- ▶ No sexual activity × 2–6 weeks
- ▶ Kegel exercises for continence
- ▶ Fluids 2–3 L/day; avoid caffeine/alcohol
- ▶ Report frank red bleeding, inability to void, fever

Nephrostomy Tube

PERCUTANEOUS RENAL DRAINAGE TUBE

Tube placed directly into renal pelvis through skin to bypass ureteral obstruction.

PRE-PROCEDURE

- ▶ Informed consent
- ▶ Coagulation studies, type & cross
- ▶ NPO 6–8 hours
- ▶ Antibiotics prophylactically per order

POST-PROCEDURE

- ▶ **NEVER clamp a nephrostomy tube (hydronephrosis risk)**
- ▶ Keep drainage bag BELOW kidney level
- ▶ Sterile dressing changes
- ▶ Monitor output (should be ≥ 30 mL/hr; report decreased)
- ▶ Bed rest initially; supine
- ▶ Strict I&O; assess for bleeding

COMPLICATIONS

- ▶ **Hemorrhage:** flank pain, ↓ BP, ↓ H&H
- ▶ **Tube dislodgement** — cover site, notify HCP STAT
- ▶ **Sudden ↓ urine output = obstruction**
- ▶ Infection / urosepsis

TEACHING

- ▶ Never clamp or kink tubing
- ▶ Keep bag below kidney at all times
- ▶ Report fever, flank pain, drainage changes
- ▶ Clean skin site daily; secure tubing

Ureteral Stent

INTERNAL URETERAL SUPPORT / DRAINAGE

Hollow tube placed in ureter to maintain patency, often after stone removal or for obstruction.

PRE-PROCEDURE

- ▶ Informed consent
- ▶ NPO 6–8 hours
- ▶ Coagulation labs
- ▶ Empty bladder before procedure

POST-PROCEDURE

- ▶ Hematuria expected initially
- ▶ Encourage fluids 2–3 L/day
- ▶ Analgesics for flank pain
- ▶ Monitor for fever, decreased output
- ▶ Track stent string if external

COMPLICATIONS

- ⚠ **Stent migration / displacement**
- ⚠ **Obstruction / encrustation**
 - ▶ UTI / pyelonephritis
 - ▶ Bladder spasms, urinary urgency/frequency

TEACHING

- ▶ Mild flank discomfort during urination is common
- ▶ Avoid heavy lifting / vigorous exercise
- ▶ Stent must be removed/replaced at scheduled time (cannot stay indefinitely)
- ▶ Report fever, severe pain, no urine output

Urinary Catheterization

INDWELLING (FOLEY) OR STRAIGHT CATHETER

Insertion of catheter into bladder via urethra for drainage, irrigation, or specimen collection.

PRE-PROCEDURE

- ▶ Verify HCP order and indication
- ▶ Explain procedure; provide privacy
- ▶ Gather sterile catheter kit; size appropriate
- ▶ Position: supine (female) or supine with legs flat (male)

POST-PROCEDURE

- ▶ Use STRICT sterile technique during insertion
- ▶ Secure catheter to thigh (female) or abdomen (male)
- ▶ Drainage bag BELOW bladder level — never on floor
- ▶ Keep system closed; do not disconnect
- ▶ Perineal care BID with soap and water
- ▶ Monitor I&O, urine color, clarity

COMPLICATIONS

- ⚠ **CAUTI — most common HAI; fever, cloudy urine**
- ⚠ **Bladder spasms / trauma**
 - ▶ Urethral injury (forced insertion)
 - ▶ Encrustation, blockage

TEACHING

- ▶ Keep bag below bladder always
- ▶ Fluids 2–3 L/day unless contraindicated
- ▶ Wipe perineum front to back
- ▶ Report fever, cloudy urine, leaking, no drainage

Cystogram / VCUG

VOIDING CYSTOURETHROGRAM

Contrast instilled into bladder via catheter; X-rays taken before, during, and after voiding to detect reflux.

PRE-PROCEDURE

- ▶ Assess for iodine allergy
- ▶ Informed consent
- ▶ Empty bladder before procedure
- ▶ Explain that catheter will be placed

POST-PROCEDURE

- ▶ Force fluids to flush dye
- ▶ Monitor for dysuria, hematuria (mild expected)
- ▶ Assess for allergic reaction to contrast
- ▶ Warm sitz bath for urethral discomfort

COMPLICATIONS

- ❗ UTI from instrumentation
- ❗ Contrast allergy
- ▶ Bladder rupture (rare; overdistention)

TEACHING

- ▶ Drink extra fluids × 24 hours
- ▶ Burning with urination 24 hr is normal
- ▶ Report fever, chills, severe pain

Urodynamic Studies

BLADDER FUNCTION TESTING

Series of tests measuring bladder pressure, capacity, urine flow, and sphincter function for incontinence or retention workup.

PRE-PROCEDURE

- ▶ Explain procedure thoroughly (alleviate anxiety)
- ▶ No NPO required typically
- ▶ Hold anticholinergics/bladder meds per HCP
- ▶ Empty bladder before some tests; arrive with full bladder for others

POST-PROCEDURE

- ▶ Encourage fluids
- ▶ Monitor for dysuria, hematuria
- ▶ Sitz bath for comfort
- ▶ Resume usual medications per HCP

COMPLICATIONS

- ❗ UTI from catheterization
- ▶ Transient dysuria, frequency
- ▶ Autonomic dysreflexia (in spinal cord injury patients)

TEACHING

- ▶ Fluids 2–3 L/day for 1–2 days post-test
- ▶ Mild discomfort may persist 24 hr
- ▶ Report fever, persistent bleeding, severe pain

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SECTION 04 • COMPLICATION RECOGNITION

Signs & *Red Flags* Across Procedures

EXPECTED / NORMAL

- Pink-tinged urine for 24–48 hours after most procedures
- Mild dysuria, urinary frequency, urgency
- Low-grade discomfort, pelvic/flank soreness
- Slight bruising (after biopsy/ESWL)
- Metallic taste / warmth during IV contrast
- Bladder spasms after TURP (treat with antispasmodics)

❗ RED FLAGS — NOTIFY HCP

- **Bright red urine with clots** — arterial hemorrhage (post-TURP, biopsy, cystoscopy)
- **Sharp abdominal pain + rigidity** — bladder/ureteral perforation
- **Hypotension + tachycardia + ↓ H&H** — internal hemorrhage
- **Fever > 101°F (38.3°C), chills** — infection or urosepsis
- **Sudden ↓ urine output (< 30 mL/hr)** — obstruction, AKI, retention
- **Hives, wheezing, hypotension** — anaphylaxis to iodine contrast
- **Confusion + ↓ Na+ + ↑ BP + bradycardia** — TURP syndrome
- **No drainage from nephrostomy/Foley** — assess for kink, dislodgement, clot

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SECTION 05 • PRIORITY NURSING CARE

Interventions — *ABC Framework*

A • AIRWAY

Watch for Anaphylaxis

Contrast dye allergy can cause laryngeal edema. Have **epinephrine, diphenhydramine, oxygen, and emergency equipment** ready before IVP/VCUG.

B • BREATHING

Monitor Respiratory Status

After sedation, assess **O2 sat, respiratory rate, depth**. Wheezing or stridor = anaphylaxis. Position upright if dyspneic.

C • CIRCULATION

Hemorrhage Surveillance

Monitor **BP, HR, H&H** frequently. Bright red urine with clots = arterial bleed. Hypotension + tachycardia + flank pain = internal bleeding.

D • DRAINAGE

Urine Output & Catheter Care

Maintain output **≥ 30 mL/hr**. Keep drainage bag below bladder/kidney. Never clamp nephrostomy tubes. Strict I&O for all urological patients.

E • EDUCATION

Fluids & Activity

Encourage **2–3 L/day fluid** (unless contraindicated). Limit activity per procedure-specific guidelines. Teach signs to report.

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SECTION 06 • PHARMACOLOGY

Drugs Used in *Urological Care*

DRUG / CLASS	USE	MECHANISM	KEY NURSING CONSIDERATIONS
Ciprofloxacin / Ceftriaxone	Prophylactic & treatment antibiotics	Inhibits bacterial growth (fluoroquinolone / cephalosporin)	Assess for allergy; monitor renal function; full course completion; report tendon pain (cipro)
Phenazopyridine (Pyridium)	Urinary analgesic	Topical anesthetic effect on urinary mucosa	Turns urine ORANGE/RED (warn patient); stains clothes; take with food; short-term use only
Oxybutynin / Tolterodine	Bladder spasms, urge incontinence	Anticholinergic — relaxes bladder smooth muscle	Dry mouth, blurred vision, constipation, urinary retention; caution in elderly, glaucoma
B&O Suppositories (Belladonna & Opium)	Severe bladder spasms post-TURP	Anticholinergic + opioid analgesic	Rectal route; assess for sedation, constipation, urinary retention
Tamsulosin (Flomax)	BPH symptoms; aids stone passage	Alpha-1 blocker — relaxes prostate/bladder neck smooth muscle	Orthostatic hypotension (first-dose syncope); take at bedtime; rise slowly
Finasteride (Proscar)	BPH — shrinks prostate	5-alpha reductase inhibitor	Takes 6 months for effect; pregnant women must NOT touch (teratogenic); ↓ PSA levels
Iodinated Contrast (Omnipaque)	IVP, VCUG, cystogram	Radiopaque dye	Assess iodine/shellfish allergy; hydrate before/after; hold metformin; monitor BUN/Cr
Furosemide (Lasix)	Diuretic; sometimes used pre-test or for fluid overload	Loop diuretic — inhibits Na/K/Cl reabsorption	Monitor K+ (hypokalemia), BP, daily weights, ototoxicity with rapid IV push
Docusate (Colace)	Stool softener (post-TURP, post-biopsy)	Reduces surface tension of stool	Prevents Valsalva straining that can cause bleeding; encourage fluids

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SECTION 07 • NCLEX TEST TRAPS

Common *Pitfalls & Priorities*

✗ **WRONG THINKING**

"Pink-tinged urine after TURP is a sign of hemorrhage — call HCP immediately."

✓ **RIGHT ANSWER**

Pink-tinged urine is **expected**. Bright red urine with clots, hypotension, and tachycardia = hemorrhage. Pink = adjust CBI rate to maintain that color.

✗ **WRONG THINKING**

"Clamp the nephrostomy tube during ambulation to prevent reflux."

✓ **RIGHT ANSWER**

NEVER clamp a nephrostomy tube — causes hydronephrosis and kidney damage. Keep drainage bag below kidney level instead.

✗ **WRONG THINKING**

"Total urine output post-TURP equals everything that comes out of the Foley."

✓ **RIGHT ANSWER**

Subtract irrigation volume from total output to determine true urine output. Output should equal or exceed irrigant volume.

✗ **WRONG THINKING**

"Patient post-renal biopsy can ambulate within 4 hours."

✓ **RIGHT ANSWER**

Strict bed rest for 24 hours, lying supine. Activity = risk of hemorrhage from biopsy site.

✗ **WRONG THINKING**

"Diabetic patient should continue metformin before and after IVP — no changes needed."

✓ **RIGHT ANSWER**

Hold metformin before and 48 hr after contrast (risk of lactic acidosis with contrast-induced nephropathy). Resume only when HCP clears and creatinine is stable.

✗ **WRONG THINKING**

"TURP patient is confused — must be from anesthesia, give time to wake up."

✓ **RIGHT ANSWER**

Confusion + HTN + bradycardia + low sodium = **TURP syndrome** (water intoxication from absorbed irrigant). Notify HCP immediately; expect Na⁺ replacement and diuretics.

✗ **WRONG THINKING**

"Strain urine only when stone pain is severe after ESWL."

✓ **RIGHT ANSWER**

Strain ALL urine until HCP says to stop. Fragments must be collected for composition analysis to guide prevention diet.

✗ **WRONG THINKING**

"After cystoscopy, patient with sharp abdominal pain just needs more analgesics."

✓ **RIGHT ANSWER**

Sharp abdominal pain + rigidity = **bladder perforation**. Notify HCP STAT; do NOT mask with analgesics first.

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SECTION 08 • PATIENT EDUCATION

Discharge *Teaching Pearls*

Hydration & Diet

-  Drink **2–3 liters of fluid daily** unless contraindicated (heart failure, CKD) to flush urinary tract, prevent stasis, and reduce stone recurrence.
-  After ESWL: **3–4 L/day for several days** to flush fragments.
-  Stone-specific diet teaching (low oxalate for calcium oxalate stones; reduce animal protein and sodium).
-  Avoid caffeine and alcohol post-TURP (bladder irritants).

Report Immediately

-  Fever > 101°F (38.3°C) or chills
-  Bright red urine or clots in urine
-  Inability to urinate or sudden ↓ urine output
-  Severe flank, back, or abdominal pain
-  Drainage tube falls out or stops draining
-  Rash, hives, or breathing difficulty (contrast allergy)

Activity Restrictions

-  **Renal biopsy:** No heavy lifting or strenuous activity × 2 weeks.
-  **TURP:** No driving, sex, or lifting >10 lbs × 2–6 weeks; no straining (use stool softeners).
-  **Cystoscopy:** Resume activity in 24–48 hours.
-  **Nephrostomy/stent:** Avoid vigorous activity; protect tubing.

Routine Care

-  Perineal hygiene: **wipe front to back**; daily catheter care with soap and water.
-  Keep drainage bags **below the level of the bladder or kidney** — never above, never on the floor.
-  Kegel exercises post-TURP to improve continence.
-  Take all antibiotics until completed even if feeling better.
-  Strain ALL urine after ESWL until HCP discontinues order.

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SECTION 09 • MEMORY BOOSTERS

Mnemonics & *Pattern Recognition*

"PINK is OK" Rule

- P** ink urine post-TURP = expected
- I** f bright red with clots = hemorrhage
- N**otify HCP for ARTERIAL bleeding
- K** eep CBI titrated to maintain pink color

"TURP" Complications

- T** = Trauma (bleeding — arterial vs venous)
- U** = Urine retention from clots
- R** = Retrograde ejaculation
- P** = Post-op TURP syndrome (↓ Na+)

Before IV Contrast: "SAID"

- S** hellfish/iodine allergy check
- A** ssess BUN/creatinine
- I** nformed consent obtained
- D** iscontinue metformin per HCP

Catheter Care: "CLEAN"

- C** losed system — never disconnect
- L** ow — bag below bladder always
- E** mpty bag q8h or when 2/3 full
- A** septic perineal care BID
- N** ever clamp nephrostomy tubes

Post-Renal Biopsy: "REST"

- R** est in bed 24 hours supine
- E** valuate VS and H&H frequently
- S** train output; watch for hematuria
- T** each: no lifting × 2 weeks

ESWL: "STRAIN"

- S** train ALL urine
- T** each fluids 3–4 L/day
- R** eport severe flank pain (obstruction)
- A** nalgesics for renal colic
- I** nspect for bruising on flank
- N** ote stone composition for diet teaching

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SECTION 10 • NGN CLINICAL JUDGMENT

NCJMM *Case Walkthrough*

Clinical Scenario

A **68-year-old male** is admitted to the post-anesthesia care unit following a transurethral resection of the prostate (TURP) for benign prostatic hyperplasia. He has a three-way Foley catheter with continuous bladder irrigation (CBI) running at 100 mL/hr. Two hours post-op, the nurse notes the irrigation drainage bag is **bright red with clots**, the patient's blood pressure has dropped from 138/82 to 102/64, heart rate is 112 bpm, and he reports increasing lower abdominal pain rated 8/10. Last serum sodium drawn pre-op was 138 mEq/L.

1

RECOGNIZE CUES

What is most important to notice?

Bright red urine with clots (not pink-tinged as expected), **hypotension** (BP drop of 36 systolic), **tachycardia (112)**, and **increasing abdominal pain (8/10)**. The combination signals active bleeding and possible clot retention. CBI rate may need titration.

2

ANALYZE CUES

What do these findings mean together?

The pattern is consistent with **arterial hemorrhage post-TURP with possible clot retention**. Bright red bleeding = arterial source. Hypotension + tachycardia = volume loss. Abdominal pain may indicate **bladder distention from clot obstruction**. TURP syndrome (water intoxication, hyponatremia) is also a differential and must be excluded.

3

PRIORITIZE HYPOTHESES

What is the most likely problem and why?

Priority hypothesis #1: Active arterial hemorrhage with clot retention. Supported by bright red color, hemodynamic instability, and bladder pain. **Hypothesis #2: TURP syndrome** — less likely with bright red bleeding pattern but cannot be ruled out without electrolytes. Bleeding addresses ABC priority over electrolyte derangement.

4

GENERATE SOLUTIONS

What interventions are indicated?

① **Increase CBI rate** to dilute and flush clots while assessing patency. ② **Manually irrigate catheter** with 0.9% NS if obstructed (per protocol/order). ③ **Notify HCP STAT.** ④ Draw **STAT H&H, CBC, electrolytes (Na+), coagulation studies, type & cross.** ⑤ Establish second IV access; prepare for fluid resuscitation/blood transfusion. ⑥ Monitor VS q5–15 min. ⑦ Strict I&O including subtracting irrigation volume.

5

TAKE ACTION

What does the nurse do FIRST?

① **Increase the CBI rate immediately** to help flush clots and clear the catheter — this addresses both circulation and obstruction. ② **Notify the HCP and rapid response.** ③ Assess for bladder distention by palpation; gently manually irrigate if ordered. ④ Send STAT labs. ⑤ Place patient in modified Trendelenburg if hypotension worsens; prepare for blood products.

6

EVALUATE OUTCOMES

What indicates the intervention was effective?

Successful outcomes include: irrigation return color transitions from **bright red back to pink-tinged**, BP returns to baseline (≥ 120 systolic), HR < 100 , pain resolves to $\leq 3/10$, no further clots in tubing, H&H stable, sodium remains WNL (135–145 mEq/L), and urine output (subtracting CBI volume) ≥ 30 mL/hr. If bleeding persists despite CBI titration, the patient may require return to OR for cauterization.

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SOURCE NOTE: THIS TOPIC WAS NOT PRESENT IN THE UPLOADED REFERENCE NOTES. CONTENT COMPILED FROM STANDARD NGN NCLEX 2026 REFERENCES –
SAUNDERS COMPREHENSIVE REVIEW FOR THE NCLEX-RN EXAMINATION • ATI RN ADULT MEDICAL-SURGICAL NURSING • LIPPINCOTT ILLUSTRATED REVIEWS:
PHARMACOLOGY • AUA (AMERICAN UROLOGICAL ASSOCIATION) CLINICAL GUIDELINES