Next Generation
NCLEX-RN®

STUDENT WORKBOOK

CAT

"PRECISION TESTING: TARGETED NCLEX APPROACHES"

S

ITEM 1 OF 1

Nurses' Note

The nurse in the neonatal intensive care unit has completed the morning assessment of a preterm infant.

0934: Client receiving continuous tube feeding via 5 Fr nasogastric tube in the right nare. Abdomen was taut and distended. Dry diaper. Hypoactive bowel sounds in all four quadrants. Large gastric residual that was undigested formula with some bile. Skin hot to the touch and pale pink in tone. Vital signs: T 100° F (37.8° C), P 137, RR 49.

Complete the sentence below by choosing from the list of options

ITEM 1 OF 1

The client is at the highest risk for developing [ ]

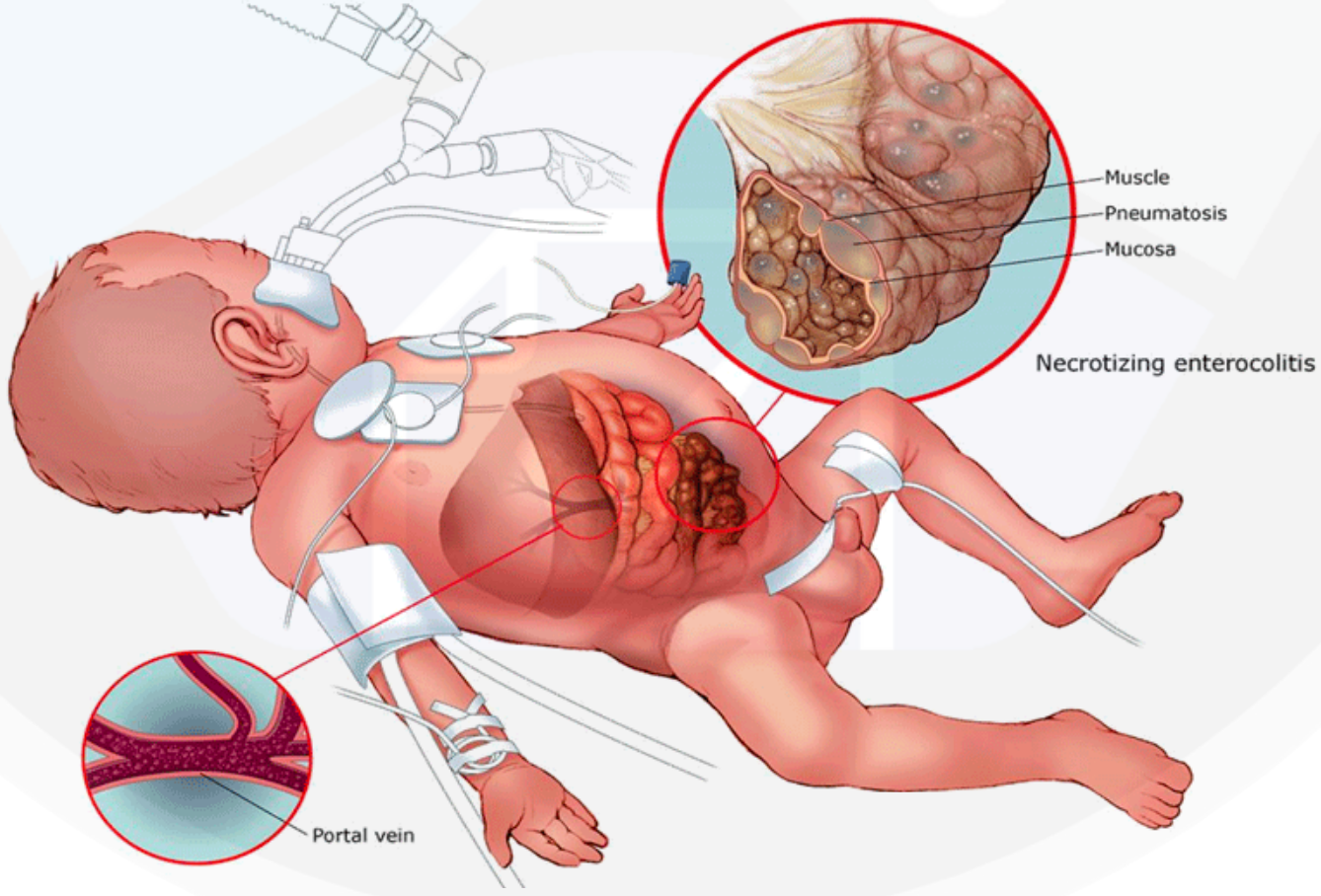
Select...

1. fluid volume overload.
2. necrotizing enterocolitis (NEC).
3. hyperbilirubinemia

NOTES:

REMEMBER

NEC is a serious disease that affects premature infants (prematurity is a significant risk factor). NEC is an inflammatory condition of the gastrointestinal tract that can lead to sepsis if not treated. Manifestations of NEC include a distended abdomen, high gastric residues, and blood in the stool. The infant often appears sick and may have a fever. Treatment is through preventive measures, including withholding oral feedings from infants believed to have suffered birth asphyxia for 24-48 hours and minimizing exposure to enteral feedings.



ITEM 1 OF 1

History and Physical | Vital Signs

Emergency Department

0930:
A 60-year-old with a history of peptic ulcer disease arrives at the emergency department for severe upper abdominal pain that is radiating to the back and shoulders. The client states, "I tried to take antacids and nothing is helping, the pain is just getting worse." The client appears uncomfortable with abdominal distention and rigidity and absent bowel sounds. The client has vomited x1 since arrival. The client is awake, alert, and oriented x3. Skin is pale with diminished radial pulses bilaterally.

ITEM 1 OF 1

The nurse reviews the Nurses' Notes and Vital Signs for a client in the emergency department.

Which **immediate** nursing interventions should the nurse **anticipate** for this client? Select all that apply.

1. Insert a large-bore venous access device (VAD)
2. Provide oxygen via a nonrebreather
3. Prepare the client for a paracentesis
4. Perform a type and screen blood test
5. Administer an IV bolus of lactated Ringer's solution

NOTES:

ITEM 1 OF 1

Nurses' Note

The nurse is caring for a client at the obstetrician's office and reviews the Nurses' Notes from 1100.

1100:
Client is single and sexually active with three partners. She uses oral contraception for birth control in addition to spermicide. Client has a history of IV drug use; however, her toxicology screen has remained negative for the last year. She has a history of syphilis that was treated with penicillin and does not consent to any vaccinations.

ITEM 1 OF 1

Which of the following findings increase the **client's risk** of contracting a sexually transmitted infection (STI)? **Select all that apply.**

1. History of syphilis
2. Vaccination refusal
3. History of IV drug use
4. Three sexual partners
5. Client's contraceptive choices

NOTES:

REMEMBER

The 5 Ps Risk Assessment for Sexually Transmitted Infection (STI)	
Description	**Risk of STI**
Number of sexual partners	Multiple partners increase the risk of exposure and transmission of STIs
Sexual practices, including oral, anal, and vaginal sex	Unprotected sex increases the risk of STI transmission. Anal intercourse is high-risk for STI exposure.Some STIs (e.g., gonorrhea) can be spread by oral-genital intercourse.
Use of protection, such as condoms or other barrier methods	Lack of barrier method protection increases the risk for STI transmission.
Past history of previous STIs	Having had an STI in the past increases the risk of acquiring or transmitting STIs.
Assesses client's desire for pregnancy and whether contraception is important	Allows for open communication about STI prevention. Pregnancy can complicate the treatment of STIs and increase the risk of transmission to the unborn child.

ITEM 1 OF 1

Medical History

The nurse is planning care for a client in the emergency department following a high-impact motor vehicle collision.

The client has blood present to the nares bilaterally and bruising and abrasions along the chest in the pattern of a seat belt. The client reports facial pain and severe abdominal pain. Abdominal distention is present with decreased bowel sounds x4 quadrants. The client appears pale with weak radial and pedal pulses.

ITEM 1 OF 1

For each potential nursing intervention, click to specify whether the intervention is indicated or not indicated for the care of this client.

Nursing Interventions	Indicated (A)	Not Indicated (B)
1. Provide warm blankets		
2. Remove all of the client's clothing		
3. Draw blood for a complete blood count (CBC)		
4. Prepare the client for a blood transfusion		
5. Prepare to insert a nasogastric (NG) tube		
6. Prepare the client for an MRI of the abdomen		
7. Gather supplies to administer oxygen		
8. Request an order to administer an IV fluid bolus		
9. Prepare to insert two large-bore peripheral venous access devices (VADs)		

NOTES:

ITEM 1 OF 1

Nurses' Note | Labs Results | Vital Signs

The nurse in the emergency department is caring for a 66-year-old male

0315: Client presents for altered mental status and was brought to the ED by his wife. The wife reports that she was awakened by him not being beside her and found him in the living room knocking objects over and was unable to communicate effectively. The wife reports that the CPAP he uses overnight was damaged, and has been unable to use for the past two nights. On assessment, the client is anxious and confused. He responds to verbal commands but has no insight into why he is in the ED. Lung sounds are diminished in the bases, with wheezes in the upper lobes. Peripheral pulses are 2+. The client has a history of chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, diabetes mellitus, and dyslipidemia.

ITEM 1 OF 1

Nurses' Note | **Labs Results** | Vital Signs

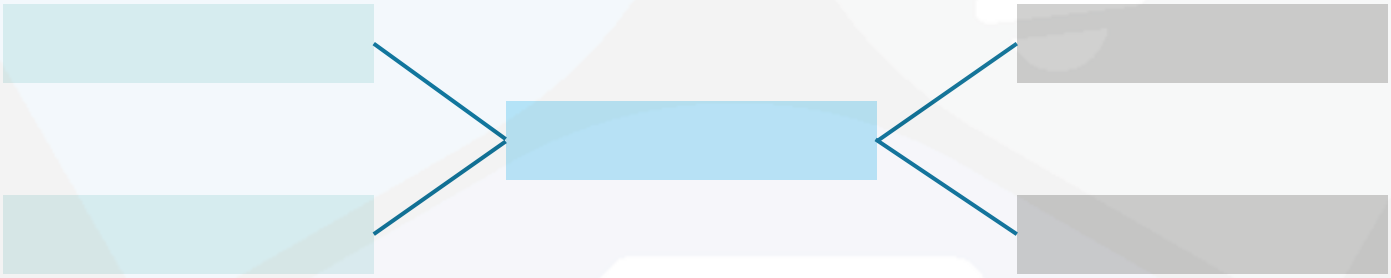
Laboratory	Result	Reference
pH	7.30	7.35 - 7.45
PaCO2	75 mm Hg	35-45 mm Hg
HCO3-	23 mEq/L	22-28 mEq/L
PaO2	82 mm Hg	80-100 mm Hg
Capillary blood glucose	83 mg/dL	70-110 mg/dL

NOTES:

ITEM 1 OF 1

Nurses' Note | **Labs Results** | **Vital Signs**

Vital Sign	Result
Respirations	23/mins
Pulse	99
Blood pressure	(BP 139/89 mmHg)
Temperature	99.5°F (37.5°C)
Oxygen Saturations	91%



Action to Take

1. Administer oxygen via non-rebreather mask
2. Obtain a prescription for glucagon
3. Obtain a prescription for a benzodiazepine
4. Obtain a prescription for a bronchodilator
5. Obtain a prescription for bilevel positive airway pressure (BiPap)

Potential Conditions

1. Metabolic acidosis
2. Hypoglycemia
3. Respiratory acidosis
4. Respiratory alkalosis

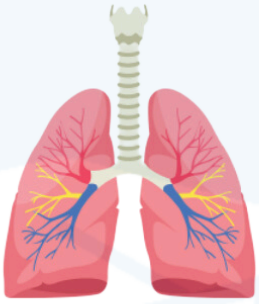
Parameters to Monitor

1. Capillary blood glucose
2. Urinary output
3. Neurological status
4. Arterial blood gas

REMEMBER

Next Gen PASSERS NCLEX

Acid-Base Balance



PH < 7.35
Acidosis

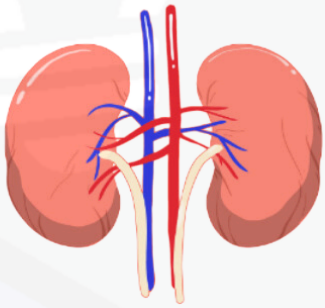
CO2 > 45
Respiratoria

HCO3 < 22
Metabólica

PH > 7.45
Alcalosis

CO2 < 35
Respiratoria

HCO3 > 28
Metabólica



NOTES:

ITEM 1 OF 6

Nurses' Note

Day 1
Outpatient healthcare clinic
1100:

Client is a 45-year-old male presenting today for evaluation. Client is casually dressed; clothing appears rumpled and hair unwashed. He agreed to come in today at the urging of his brother due to "not acting like himself." Client states, "I don't want my brother to worry. I'm such a burden on him the way it is." The client reports that he recently lost his job and is getting a divorce. He is not sleeping well and often feels fatigued. He endorses feelings of low mood and sadness over the past month; though, he states, "It's fine; I won't have to feel this way much longer anyway." Client reports he now lives alone as he recently gifted his dog to his brother stating, "My brother likes my dog, and this way, I know she will be taken care of." Client reports history of cannabis use in his early 20s. Reports increased alcohol use over the past 2 weeks, stating he will sometimes drink 5 or more drinks in one evening. He is prescribed atorvastatin 40 mg daily, though states he soon won't be able to afford his medication.

ITEM 1 OF 6

Click the findings below that would be **most important** to follow up on at this visit.

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ITEM 2 OF 6

Which **3 cues** are warning signs that the client may be at imminent risk for suicide?

1. Feeling fatigued
2. Not sleeping well
3. Feelings of low mood and sadness
4. Recently gifted his dog to his brother
5. Lost his job and is going through a divorce
6. Stating, "I won't have to feel this way much longer."
7. Increasing alcohol use, sometimes drinking ≥5 alcoholic drinks per evening

REMEMBER

Diagnostic Criteria for a Major Depressive Episode
Must be present: **depressed mood** and/or **anhedonia**
+ 5 or more of the following symptoms • Significant weight loss or weight gain • Sleep disturbances (e.g., hypersomnia, insomnia) • Psychomotor agitation or retardation • Fatigue • Feelings of worthlessness or guilt • Difficulty concentrating or making decisions • Suicidal ideation
★ Symptoms must be present during the same timeframe for at least two weeks. ★ Depressed mood or anhedonia must be present for most of the day, nearly every day. ★ Symptoms must represent a change from the client's baseline, cause significant distress, and be severe enough to cause impairments in daily functioning (e.g., occupational, academic, social).

NOTES:

ITEM 3 OF 6

Drag the 2 inquiries the nurse should ask next to the box on the right.

Potential Inquiries	Most Important Inquires
1. Are you having financial trouble? 2. Are you having thoughts of suicide? 3. Tell me more about your sleep schedule. 4. Are you having thoughts about harming others? 5. Tell me about what has you feeling so down today. 6. You mentioned that your alcohol use has increased. Would you tell me about that? 7. Most Important Inquires	

ITEM 4 OF 6

Nurses' Note

Day 1
Outpatient healthcare clinic

1115:
Upon questioning, the client reports he has been experiencing thoughts of suicide.

ITEM 4 OF 6

The nurse reviews updated Nurses' Notes from 1115.

Which of the following interventions are indicated at this time? Select all that apply.

1. Administer a breathalyzer
2. Check the client's vital signs
3. Maintain 1:1 supervision of the client
4. Call an ambulance for immediate transfer
5. Complete a more in-depth suicide risk assessment
6. Provide information about resources to help with medication costs

ITEM 5 OF 6

The nurse continues to assess the client's risk for suicide. Click to specify if each potential inquiry is appropriate or inappropriate for the nurse to follow up with at this time.

Potential Inquiries	Appropriate	Inappropriate
1. "Do you have a plan for how you will harm yourself?"		
2. "Wouldn't your family feel so awful if you hurt yourself?"		
3. "When are you planning to act on the suicidal thoughts?"		
4. "Can we call your brother to see if he can stay with you tonight?"		
5. "Do you have access to the items you plan to harm yourself with (e.g., firearms, excess medications)?"		

SAFETY PLANNING

Completed Safety Plan Example

Warning signs that indicate a crisis may be developing

Examples:

1. Thinking about my divorce
2. Stressing about finances or worrying I won't find a new job
3. Feeling worthless and hopeless

Internal coping strategies

- Things I can do for myself to help relax or improve my mood

Examples:

1. Listen to upbeat music
2. Go for a walk
3. Watch my favorite TV show

External coping strategies

- Things I can do with others to help relax or improve my mood

Examples:

1. Visit my brother or call him to come over
2. Play with my dog
3. Go to my local coffee shop

People I can call for help:

1. John Doe (brother) Phone #: (123) 456-7899
2. Jane Doe (sister-in-law) Phone #: (234) 567-8912
3. John Smith (friend) Phone #: (345) 678-9123

Professionals I can contact during a crisis:

Clinician Name (e.g., psychiatry clinic nurses' line, on-call therapist) Phone #: (456) 789-1234

Local emergency room: Emergency Department
123 Main St.
Anywhere, USA 98765

Crisis hotline: (e.g., county services, national hotline)
Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Things I can do to make the environment safer:

1. Have my brother take my firearms to his house
2. Remove alcohol and any excess medication from my house

ITEM 6 OF 6

Nurses' Note

1130:
The client reports he has suicidal ideation with a plan to inflict a fatal gunshot wound this evening. He reports having access to firearms at his house. The healthcare provider determined that the client is an imminent risk to himself, and therefore, a higher level of care is warranted. Client agreed to a voluntary admission to inpatient psychiatry.

Inpatient psychiatric unit

1300:
Client was admitted to the inpatient psychiatric unit following reports of suicidal ideation with plan, intent, and access to harm himself. Upon admission, his dose of fluoxetine has increased to 40 mg daily. He has been compliant with medications and has been attending group therapy on the unit. Updated suicide risk assessment is being completed.

ITEM 6 OF 6

The nurse reviews updated Nurses' Notes from day 1 at 1130 and day 5 at 1300.
Which of the following client statements indicate a reduced risk for suicide? Select all that apply.

1. "I think I'll ask my brother to keep my dog."
2. "Things will be the same when I go home."
3. "It's important to take my fluoxetine every day."
4. "I have no desire to drink alcohol when I go home."
5. "I plan to attend a support group after I leave here."
6. "I asked my brother to remove firearms from my house."
7. "I plan to go fishing with my brother after I am discharged."
8. "I'm working out a plan with my brother to do some part-time work for his company."

NOTES:

REMEMBER

Examples of Suicide Risk and Protective Factors	
Risk Factors:	**Protective Factors:**
Modifiable: • Access to lethal means (e.g., firearms, excess medications) • Feeling isolated • Significant life stressors (e.g., divorce, loss, legal or financial concerns) • Substance use Nonmodifiable: • Current mood disorder (e.g., depression, bipolar) • Previous suicide attempt • Previous exposure to suicide (e.g., knowing someone who has attempted or committed suicide) • History of abuse or trauma • Chronic physical illness or pain • Family history of mental illness	• Strong social support network • Community involvement • Problem-solving skills • Easy access to mental healthcare • Ability to contact resources (e.g., mental healthcare team, crisis hotline) • Identifies reasons to live (e.g., children, family, beloved pet) • Religious affiliations (e.g., belief that suicide is immoral)

NOTES:

ITEM 1 OF 1

Medical History

Client is a 48-year-old female with obesity who arrives at the emergency department with nausea and multiple episodes of vomiting and pain in the right upper abdomen and right shoulder after eating fried seafood. She has mild tachycardia and reports pain that is 8/0-10 scale and is worse when pressing on the right side of her abdomen. Bowel sounds are present in all four quadrants with no abdominal distention present.

ITEM 1 OF 1

The nurse should anticipate an order for Select...

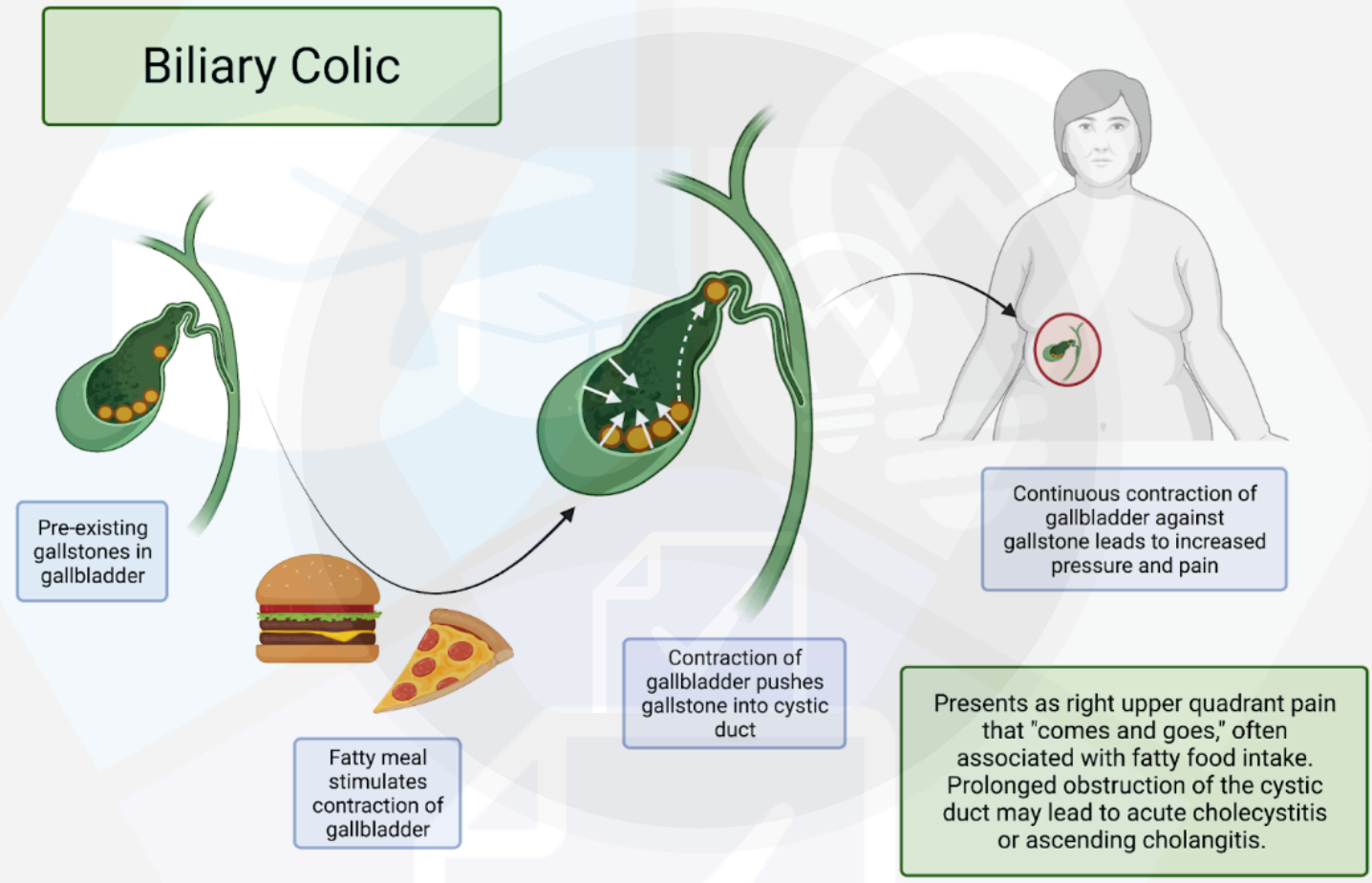
1. an endoscopy an abdominal
2. ultrasound
3. abdominal x-ray
4. 12-lead electrocardiogram

to diagnose a suspected Select...

1. peptic ulcer
2. cholecystitis
3. bowel obstruction
4. myocardial infarction

NOTES:

REMEMBER



NOTES:

ITEM 1 OF 1

Nurses' Note | **Orders**

The nurse in the physician's office is providing education to a client with diabetes mellitus (type one)

1655: Client reports to the clinic with an interest in a prescription for an insulin pump. The client reports that he has been inconvenienced by injecting himself with insulin over the past year, considering he is traveling more for work. The client indicates that he heard about insulin pumps and thinks it would be a good fit for his lifestyle.

Nurses' Note | **Orders**

The nurse in the physician's office is providing education to a client with diabetes mellitus (type one)

1730:

- Continuous subcutaneous insulin infusion (insulin pump)

The nurse evaluates the client's understanding following a teaching session regarding the newly prescribed continuous subcutaneous insulin infusion (insulin pump)

Click to specify if the client statement indicates effective understanding or requires follow-up

Client Statement	Effective Understanding (A)	Requires Follow-up (B)
1.I will load my aspart insulin into my pump.		
2. I will change the infusion set every 5-7 days.		
3. By having this pump, I will be able to check my glucose level less often.		
4. I will keep an extra vial of insulin in my car.		
5. If I remove my pump, it could cause me to develop hypoglycemia.		
6. Using this pump will lower my risk for diabetic ketoacidosis.		
7. I should roll my vial of insulin prior to putting it into the pump.		
8. I should rotate sites when replacing my infusion set.		

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