Next Generation
NCLEX-RN®

STUDENT WORKBOOK

CAT

"NAVIGATING CAT: NCLEX PATHWAY STRATEGIES"

S

Nurses' Notes | Vital Signs

ITEM 1 OF 6

The nurse cares for a 62-year-old female client.

Day 1: Emergency Department

1327:	The client arrives at the emergency department from her home via ambulance. The client was recently discharged from the hospital following treatment for a urinary tract infection. She appears drowsy but is responsive to verbal stimuli. The client states, "I called the ambulance today because I just wasn't feeling right. I am just tired, and I have some pain in my stomach and back. I think those antibiotics don't agree with my stomach." Client has an 18-gauge peripheral IV in the right hand inserted by emergency medical services that is saline-locked. No other interventions have been completed at this time.

The nurse cares for a 62-year-old female client.

ITEM 1 OF 6

Nurses' Notes | Vital Signs | History and Physical

1334	
T	101.2 F (38.4 C)
P	125
RR	25

BP	92/64
Pulse oximetry reading	91% on room air
Pain level	6/10
Weight	220 lbs (100 kg)

NOTES:

The nurse cares for a 62-year-old female client.

ITEM 1 OF 6

Nurses' Notes | Vital Signs | History and Physical

Body System	Findings
Neurological	Oriented to person and place; disoriented to time; appears drowsy but is responsive to verbal stimuli; reports lightheadedness
Pulmonary	Tachypneic; reports mild dyspnea on exertion; lung sounds clear throughout; reports dry, chronic cough; smokes 1 pack per day for the past 10 years
Cardiovascular	Sinus tachycardia; S1 and S2 present with no murmurs; 1+ peripheral pulses in bilateral upper and lower extremities; pulses weak and thready; capillary refill >3 seconds; history of hypertension
Gastrointestinal/ Genitourinary	Abdomen soft and nontender; bowel sounds hypoactive x 4 quadrants; lower abdominal and lower back pain; decreased appetite for 2-3 days; decreased urination with foul-smelling urine; recent hospital admission for urinary tract infection; discharged home with ciprofloxacin PO; antibiotic course complete
Skin	Skin and mucous membranes pink, dry, intact; skin warm with no rashes
Psychosocial	Widowed and lives alone; has one adult child that lives in another state; client is retired and volunteers once a week at a local library

ITEM 1 OF 6

Select the top 5 findings below that would require immediate follow-up.

1. Cough
2. Pulse rate
3. Lives alone
4. Urine output
5. Blood pressure
6. Smoking status
7. Respiratory rate
8. Capillary refill time
9. Recent hospitalization

NOTES:

ITEM 2 OF 6

Complete the following sentence by choosing from the lists of options.

The nurse recognizes that the client is experiencing [ ]

Select...
1. anaphylaxis
2. a pulmonary embolism
3. systemic inflammatory

response related to [ ]

Select...
1. infection
2. antibiotic administration
3. recent hospital admission

ITEM 3 OF 6

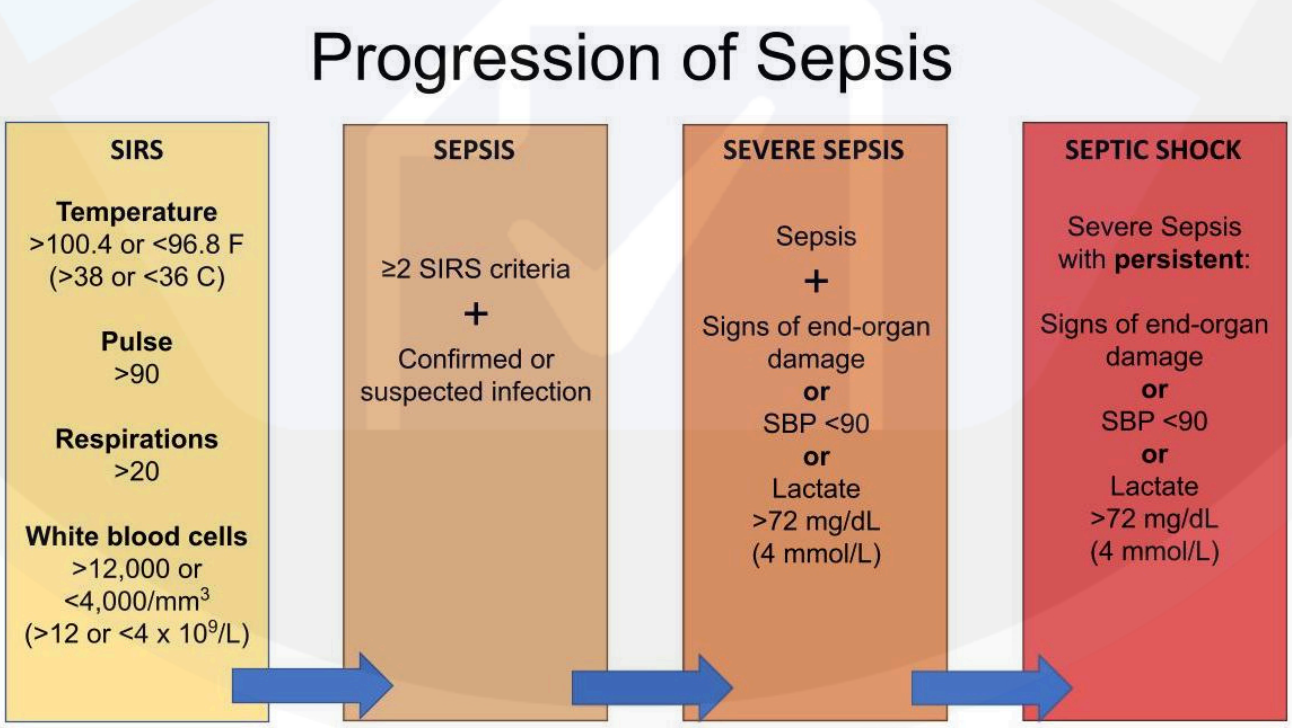
Which of the following complications is the client at **risk** of experiencing? Select all that apply.

1. Septic shock
2. Acute kidney injury
3. Acute respiratory distress syndrome
4. Chronic obstructive pulmonary disease exacerbation
5. Acute pancreatitis
6. Multiple organ dysfunction syndrome
7. Disseminated intravascular coagulation

NOTES:

REMEMBER

Systemic Inflammatory Response Syndrome (SIRS) Criteria	
Temperature	>100.4 or <96.8 F(>38 or <36 C)
Pulse	>90
Respirations	>20
White blood cell count	>12,000/mm3 (12.0 x 109/L) or <4,000/mm3(4.0 x 109/L) or ≥10% immature neutrophils

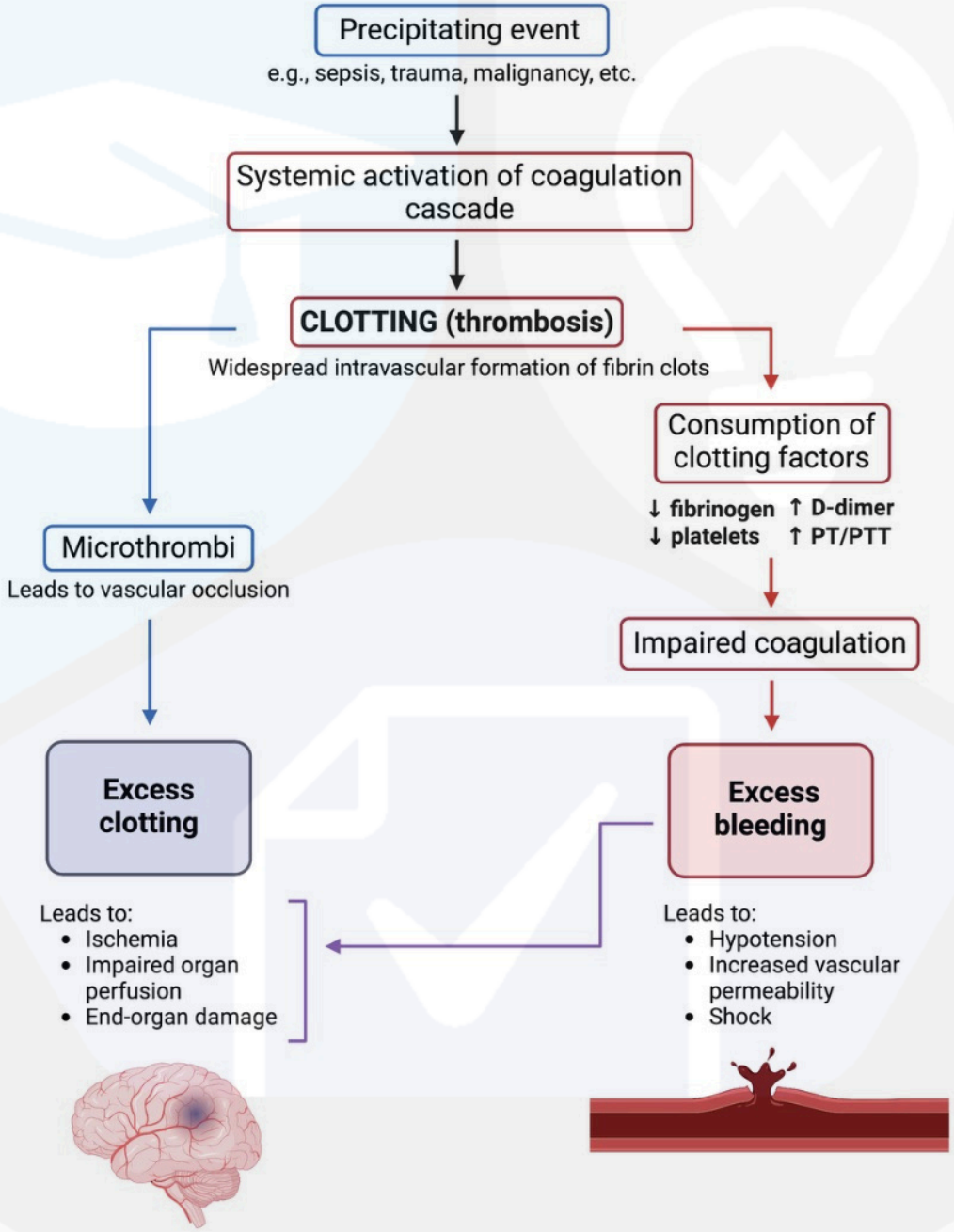


REMEMBER

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Disseminated Intravascular Coagulopathy (DIC)

Coagulation Cascade



Select whether each intervention is anticipated or not anticipated.

Potential Interventions	Anticipated	Not Anticipated
1. Administer Oxygen		
2. Prepare client for a head CT		
3. Draw blood for lactic acid levels		
4. Place client in Trendelenburg position		
5. Initiate continuous telemetry monitoring		
6. Administer 3 L IV bolus of normal saline		
7. Collect 2 sets of blood cultures from the client's IV line		

ITEM 4 OF 6



TRENDELENBURG POSITION

NOTES:

Vital Signs

	1334	1400
T	101.2 F (38.4 C)	101.4 F (38.5 C)
P	125	148
RR	25	32
BP	92/64	72/58
Pulse oximetry reading	91% on room air	94% on 2 L/min nasal cannula
Pain Level	6/10	6/10
Weight	220 lbs (100 kg)	220 lbs (100 kg)

Laboratory Results

Laboratory Test and Reference Range	1400
Creatinine 0.6–1.2 mg/dL (53–106 µmol/L)	6.0 mg/dL (458 µmol/L)
Blood urea nitrogen 10-20 mg/dL (3.6–7.1 mmol/L)	62 mg/dL (22 mmol/L)
Serum lactate 5–20 mg/dL (0.6–2.2 mmol/L)	72 mg/dL (4 mmol/L)

NOTES:

ITEM 5 OF 6

The nurse has reviewed the updated Vital Signs and Laboratory Results from 1400.

The healthcare provider diagnoses the client with **septic shock.** The nurse receives the following healthcare orders. Which order **should** the nurse perform first?

1. Administer a 3000 mL IV bolus of normal saline
2. Insert an indwelling urinary catheter using sterile technique
3. Collect 2 sets of blood for culture and sensitivity by venipuncture
4. Titrate IV norepinephrine infusion to keep systolic BP ≥90 mmHg

ITEM 6 OF 6

The nurse has reviewed the updated Nurses' Notes from 1832. Click to highlight the findings in the Nurses Notes' that indicate the client is experiencing complications of treatment.

Intensive Care Unit

1832:	Client transported to the intensive care unit with telemetry monitoring. Vital signs: T 100.9 F (38.3 C), P 108, BP 112/76, RR 29, pulse oximetry reading 93% on oxygen at 2 L/min via nasal cannula. A normal saline 3 L bolus has been administered and norepinephrine IV is currently infusing to the right hand with swelling and pallor at the IV site. Client reports dyspnea while at rest; fine crackles auscultated in bilateral bases. Cardiac monitor displays sinus tachycardia. Client reports mild nausea and is requesting sips of water for thirst and dry mouth. She also reports pain in her right hand.

NOTES:

REMEMBER

Next Gen PASSERS NCLEX

💉 Extravasation

Extravasation is the accidental leakage of a vesicant or irritant drug/IV solution from the vein into the surrounding tissues.

🧪 Key difference

- Infiltration 👉 leakage of non-vesicant solutions (e.g., normal saline).
- Extravasation 👉 leakage of vesicant or irritant drugs (e.g., chemotherapy, vasopressors), which can cause severe tissue damage.
-

⚠️ Complications

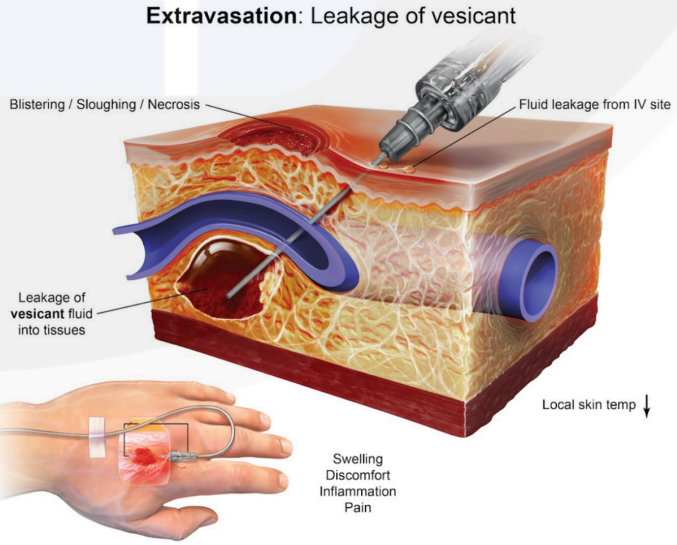
- Pain, burning, erythema (redness).
- Local swelling/edema.
- Tissue necrosis, ulceration, scarring.
- Loss of function in severe cases.
-

💊 Medications commonly causing extravasation

- Chemotherapy agents: Doxorubicin, Vincristine.
- Vasopressors: Norepinephrine, Dopamine.
- Hypertonic solutions: Parenteral nutrition, Mannitol.
- Electrolytes: Calcium chloride, Potassium.
-

🩺 Management steps

1. Stop the infusion immediately (but keep the IV cannula in place initially).
2. Aspirate any residual drug through the catheter.
3. Remove the IV line after aspiration.
4. Elevate the affected limb.
5. Apply cold or warm compresses (depending on
6. Administer specific antidotes if indicated (e.g.,
7. Document and report the incident.



ITEM 1 OF 1

Nurses' Notes

1300:	A 23-year-old female is brought into the emergency department by emergency services after being found wandering in traffic. The client is wearing tattered clothing and does not appear to have showered in several days. She is unable to provide her address or the name of a relative to contact. The client looks around the room and whispers, "Spies are everywhere, so I can't talk here. The prophets speak to me and tell me what to do next." She also states, "I'm able to stop moving cars with my mind." Toxicology screen negative.

ITEM 1 OF 1

The nurse reviews the 1300 Nurses' Notes.

Which of the following findings support a diagnosis of **schizophrenia**? Select all that apply.

1. Client has a negative toxicology screen.
2. Client states, "I'm able to stop moving cars with my mind."
3. Client is unable to provide her address or name of a relative.
4. Client states, "The prophets speak to me and tell me what to do next."
5. Client looks around the room and states, "Spies are everywhere, so I can't talk here."
6. Client is wearing tattered clothing and does not appear to have showered in several days.
7. Client requests multiple blankets because she is feeling cold.
8. Client smiles and nods when greeted by the healthcare staff.

NOTES:

ITEM 1 OF 6

Nurses' Notes | Vital Signs

The nurse is caring for a 14-year old male client.

Emergency Department
Day 1

1100: Client was brought to the emergency department by his mother due to progressive aching pain in his hips and lower back, unrelieved by acetaminophen at home. Diagnosed with sickle cell disease at 8 months of age. Last hospitalization was 3 months ago. Currently rating pain 10 out of 10 on the numerical rating scale. Client states that he was playing volleyball on the beach yesterday and forgot his water bottle. Upon assessment, the client is withdrawn and lethargic. Sclera appear yellow. Oral mucosa is dry and pale. Lungs clear to auscultation bilaterally. Pulses 2+ and regular. Last bowel movement was three days ago. Voiding amber urine without difficulty.

ITEM 1 OF 6

Nurses' Notes | Vital Signs

The nurse is caring for a 14-year old male client.

	Day 1: 1100
T	99.0 F (37.2 C)
P	125
RR	22
BP	100/60
Pulse oximetry reading	94% on room air
Weight	110 lb (50 kg)

NOTES:

ITEM 1 OF 6

Drag the top 4 client findings that would require follow-up to the box on the right.

Client Finding	Findings Requiring Follow-up
1. Pulse 2. Yellow sclera 3. Pulse oximetry 4. Respiratory rate 5. Pain assessment 6. Pale, dry oral mucosa 7. Neurological assessment	



NOTES:

ITEM 2 OF 6

Click below to highlight the findings that could have precipitated the client's pain.

Emergency Department

Day 1

1100:	Client was brought to the emergency department by his mother due to progressive aching pain in his hips and lower back, unrelieved by acetaminophen at home. Diagnosed with sickle cell disease at 8 months of age. Last hospitalization was 3 months ago. Currently rating pain 10 out of 10 on the numerical rating scale. Client states that he was playing volleyball on the beach yesterday and forgot his water bottle. Upon assessment, the client is withdrawn and lethargic. Sclera appear yellow. Oral mucosa is dry and pale. Lungs clear to auscultation bilaterally. Pulses 2+ and regular. Last bowel movement was three days ago. Voiding amber urine without difficulty.

ITEM 3 OF 6

Complete the following sentence by choosing from the lists of options.

The nurse recognizes that the client is **most likely** experiencing [ ]

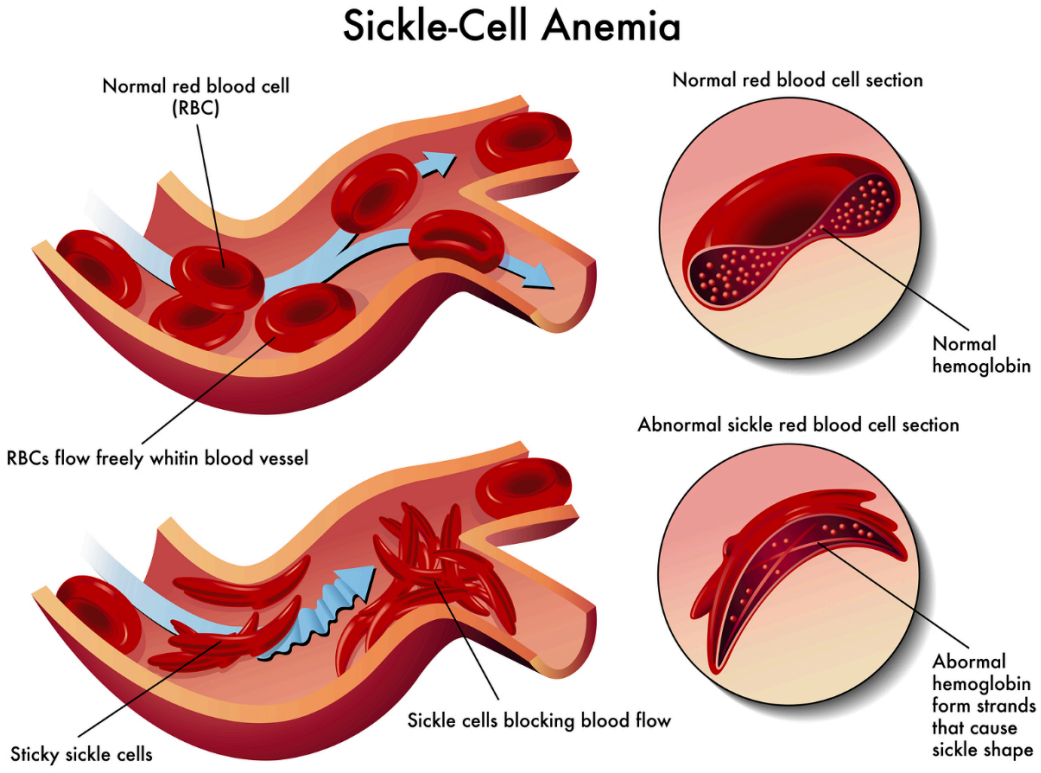
Select...
1. lethargy
2. rhabdomyolysis
3. vaso-occlusive crisis

associated with [ ]

Select...
1. iron deficiency anemia
2. ischemic injury
3. musculoskeletal injury

NOTES:

REMEMBER



NOTES:

The nurse is caring for a 14-year old male client.

ITEM 4 OF 6

Laboratory Test

Day 1: 1200

White blood cell count (WBC) Adult/Child: 5,000-10,000/mm3 (5.0-10.0 x 109/L)	9,400/mm3 (9.4 x 109/L)
Hemoglobin 6-18 years old: 10-15.5 g/dL (100-155 g/L)	5.2 g/dL (52 g/L)
Platelet count Adult/Child > 2 years old: 150,000-400,000/mm3 (150-400 x 109/L)	375,000/mm3 x 103/µL (375 x 109/L)
Total bilirubin Adult/Child: 0.3-1.0 mg/dL (5.1-17 µmol/L)	4.2 mg/dL (71.8 µmol/L)

For each potential intervention, click to specify whether the intervention is anticipated or not anticipated in the care of the client at this time.

Note: Each row must have 1 response option selected

Potential Intervention	Anticipated	Not Anticipated
1. Obtain blood cultures.		
2. Consult physical therapy.		
3. Administer iron dextrose IV.		
4. Administer IV morphine.		
5. Perform incentive spirometry 10 times per hour.		
6. Administer IV bolus of dextrose 5% in 0.45% saline.		
7. Prepare client for endoscopic retrograde cholangiopancreatography (ERCP).		

ITEM 4 OF 6

NOTES:

ITEM 5 OF 6

Nurses' Notes | Vital Signs

1530:

Client admitted to medical/surgical unit accompanied by mother. Dextrose 5% in 0.45% saline IV bolus complete; 18 gauge vascular access device saline locked. Client crying out with "100" out of 10 pain in hips and tightness in his chest. Non-productive cough noted. Bilateral diffuse wheezing on auscultation. Provider notified and chest x-ray performed at bedside.

ITEM 5 OF 6

Nurses' Notes | Vital Signs

	Day 1: 1100	Day 1: 1530
T	99. F (37.2 C)	101.4 F (38.6 C)
P	115	90
RR	22	26
BP	100/60	110/65
Pulse oximetry reading	94% on room air	89% on room air

NOTES:

The nurse updates the client's Vital Signs at 1530 and performs a re-assessment recorded in the Nurses' Notes at 1530.

For each body system below, click to specify the potential intervention that would be appropriate for the care of the client. Each body system may support more than 1 potential intervention. Note: Each category must have at least 1 response option selected.

ITEM 5 OF 6

Body System	Potential Healthcare Intervention
Respiratory	1. Prepare client for intubation. 2. Administer guaifenesin now and every 6 hours. 3. Administer oxygen at 4 L/min via nasal cannula.
Cardiovascular	1. Obtain blood for type and cross. 2. Prepare client for exchange transfusion 3. Administer continuous IV infusion of 5% dextrose in 0.45% saline.
Systemic	1. Administer broad-spectrum IV antibiotics. 2. Administer polyethylene glycol and docusate sodium. 3. Start IV hydromorphone via patient-controlled analgesia (PCA) pump.

ITEM 6 OF 6

Nurses' Notes | Vital Signs

Day 5
0900:

Client alert and oriented x 3, playing a video game this morning. Received exchange transfusion two days ago. Complaints of aching pain of bilateral hips at 6/10. Weaned from hydromorphone patient-controlled analgesia (PCA) pump . Prescription provided for hydroxyurea 500 mg PO daily and oxycodone 5 mg PO every 4 hours for pain greater than 4 out of 10 on the numerical rating scale. Denies cough and shortness of breath. Last bowel movement yesterday. Voiding without difficulty. Plan for discharge to home this morning. Client asked for a note about missing school.

NOTES:

Nurses' Notes | Vital Signs

	Day 1: 1100	Day 1: 1530	Day 5: 0900
T	99. F (37.2 C)	101.4 F (38.6 C)	98.6 F (37.0 C)
P	115	90	85
RR	22	26	16
BP	100/60	110/65	118/68
Pulse oximetry reading	94% on room air	89% on room air	99% on room air

The nurse reviews the Nurses' Notes and Vital Signs from Day 5 at 0900.

The nurse is performing discharge teaching for the client and his mother. For each of the statements made by the client's mother, click to specify whether the statement indicates an understanding or no understanding of the teaching provided.

ITEM 6 OF 6

Client Statements	Understanding	No Understanding
1. "He shouldn't get a yearly influenza vaccination."		
2. "We can't be discharged until his pain is at least a 2/10."		
3. "We will call the on-call hematologist if he has a fever."		
4. "I will buy him a backup water bottle to keep in his locker."		
5. "He should take the stool softener even if he had a bowel movement that day."		
6. "He should focus on staying active with sports and avoid playing his video games."		
7. "If he keeps taking the hydroxyurea as prescribed, we can prevent more painful crises."		

NOTES:

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