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Next Generation
NCLEX-RN®

STUDENT WORKBOOK

CAT

CAT HORIZON: NCLEX FUTURE-READY PREP

S

ITEM 1 OF 6

Health History | Assessment | Vital Signs

The nurse is caring for a 31-year-old pregnant client.

A 31-year-old client who is 32 weeks pregnant and is a G3P2 is being seen in the office for a routine prenatal appointment. The client reports smoking during the pregnancy. She also reports continuous heartburn for the last week and a headache. The client reports a kick count of 10 in the first hour after waking this morning.

ITEM 1 OF 6

Health History | Assessment | Vital Signs

The nurse is caring for a 31-year-old pregnant client.

Body System	0900
Neurologic	Alert and oriented x 3; deep tendon patellar reflexes 3+
Respiratory	Clear breath sounds; respirations symmetric and unlabored
Cardiovascular	S1, S2 present; swelling in hands and face
Gastrointestinal	Bowel sounds normoactive x 4
Extremities	2+ pitting edema bilaterally in the lower extremities
Reproductive/Genitourinary	Fundal measurement is 32 centimeters; voiding without difficulty

NOTES:

Health History | Assessment | Vital Signs

The nurse is caring for a 31-year-old pregnant client.

	0900
T	98.2 F (36.7 C)
P	80
RR	18
BP	142/91
Pulse oximetry reading	98% on room air
Pain	5/10 headache

Select the top **6 findings** that would require **immediate follow-up.**

1. Kick count
2. Headache
3. Blood pressure
4. Smoking history
5. Deep tendon reflexes
6. Continuous heartburn
7. Lower extremity edema
8. Swelling in the hands and face

NOTES:

CLASIFICACIÓN DE LOS REFLEJOS TENDINOSOS PROFUNDOS (DTR)

Escala de DTR	Descripción	Significado
0	Arreflexia	**No hay respuesta del reflejo**. Puede indicar una disfunción neurológica grave, neuropatía periférica, o daño a la médula espinal.
1+	Hiporreflexia	**Respuesta disminuida.**
2+	Respuesta normal	Reflejo dentro de los **límites normales.** Indica que el sistema nervioso está funcionando adecuadamente.
3+	Hiperreflexia	**Respuesta más viva de lo normal.**
4+	Hiperreflexia con clonos	**Respuesta muy viva, a menudo con movimientos repetitivos (clonos).**

ITEM 2 OF 6

Vital Signs

The nurse is caring for a 31-year-old pregnant client.

Vital Signs	0900	1100
T	98.2 F (36.7 C)	98.2 F (36.7 C)
P	80	83
RR	18	18
BP	142/91	146/93
Pulse oximetry reading	98% on room air	99% on room air

The client is transferred to labor and delivery for further evaluation. The nurse reviews the updated Vital Signs from 1100.

Select whether each diagnostic study is anticipated or not anticipated to aid in the diagnosis of this client.

Diagnostic Study	Anticipated (A)	Not Anticipated (B)
1. Serial blood pressures		
2. Perform a nitrazine test.		
3. Obtain blood for culture.		
4. Obtain a urine protein dipstick.		
5. Obtain blood for a complete metabolic panel.		
6. Prepare the client for an abdominal ultrasound.		

ITEM 2 OF 6

NOTES:

ITEM 3 OF 6

Vital Signs | Assessment | Laboratory Results

The nurse is caring for a 31-year-old pregnant client.

Vital Signs	0900	1100	1300
T	98.2 F (36.7 C)	98.2 F (36.7 C)	98.2 F (36.7 C)
P	80	83	80
RR	18	18	18
BP	142/91	146/93	146/91
Pulse oximetry reading	98% on room air	99% on room air	98% on room air

The nurse is caring for a 31-year-old pregnant client.

ITEM 3 OF 6

Vital Signs | Assessment | Laboratory Results

Body System	0900	1300
Neurologic	Alert and oriented x 3; 5/10 headache; deep tendon patellar reflexes 3+	Alert and oriented x 3; 6/10 headache; deep tendon patellar reflexes 4+
Respiratory	Clear breath sounds; respirations symmetric and unlabored	Clear breath sounds; respirations symmetric and unlabored
Cardiovascular	S1, S2 present; swelling in hands and face	S1, S2 present; swelling in hands and face
Gastrointestinal	Bowel sounds normoactive x 4	Bowel sounds normoactive x 4
Extremities	2+ pitting edema bilaterally in the lower extremities	2+ pitting edema bilaterally in the lower extremities
Reproductive/Genitourinary	Fundal measurement is 32 centimeters; voiding without difficulty	Fundal measurement is 32 centimeters; voiding without difficulty

NOTES:

The nurse is caring for a 31-year-old pregnant client.

ITEM 3 OF 6

Vital Signs | **Assessment** | **Laboratory Results**

Laboratory Tests and Reference Range	1100
Hemoglobin Female: 12-16 g/dL (120-160 g/L)	12 g/dL (120 g/L)
Platelets 150-400 x 103/µL (150-400 x 109/L)	300 x 103/µL (300 x 109/L)
Urinary protein dipstick (0-trace)	3+

Total protein **6.4–8.3 g/dL** **(64–83 g/L)**	6.2 g/dL (62 g/L)
Alanine aminotransferase **4–36 U/L** **(4-36 U/L)**	17 U/L (17 U/L)
Aspartate aminotransferase **0–35 U/L** **(0–0.58 µkat/L)**	26 U/L (0.43 µKat/L)
Blood urea nitrogen **10–20 mg/dL** **(3.6–7.1 mmol/L)**	15 mg/dl (5.4 mmol/L)
Creatinine **Female: 0.5–1.1 mg/dL** **(44–97 µmol/L)**	1.3 mg/dL (99 µmol/L)

ITEM 3 OF 6

The nurse updates the client's Vital Signs and Assessment at 1300 and reviews the client's Laboratory Results from 1100.

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

The nurse recognizes that the client is experiencing [ ]

Select...
1. eclampsia
2. preeclampsia
3. hypercoagulability.

This places the client at greatest risk for developing [ ]

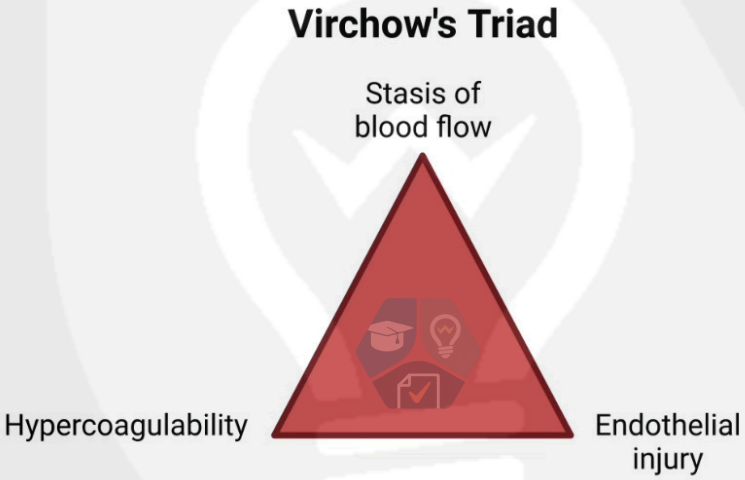
Select...
1. seizures
2. a pulmonary embolism
3. HELLP syndrome [hemolysis, elevated liver enzymes, low platelet syndrome].

NOTES:

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NOTES:



Hypertensive Disorder of Pregnancy	Characteristics
Chronic hypertension	Blood pressure ≥140/90 occurring <20 weeks gestation.
Gestational hypertension	New-onset blood pressure ≥140/90 in a client >20 weeks gestation.
Preeclampsia	Blood pressure ≥140/90 (x 2 taken at least 4 hours apart) plus new-onset proteinuria (>2+ urine dipstick).
Eclampsia	Presence of seizures in a preeclamptic client unrelated to any other cause.

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

Note: Each row must have 1 response option selected.

ITEM 4 OF 6

Potential Interventions	Indicated	Not Indicated
1. Adminiter ondansetron.		
2. Administer IV furosemide.		
3. Initiate seizure precautions.		
4. Prepare the client for an amniotomy.		
5. Place a tocodynamometer on the client.		
6. Prepare to administer IV magnesium sulfate.		
7. Neurological assessments every 15 minutes.		
8. Verify calcium gluconate is available in the medication dispense.		

ITEM 5 OF 6

The nurse initiates the prescribed magnesium sulfate bolus. Which of the following is the **priority** to monitor during the infusion?

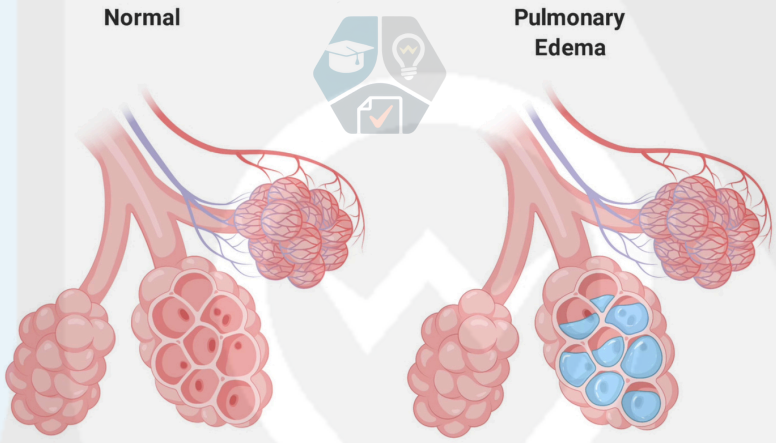
1. Edema
2. Respirations
3. Blood pressure
4. Serum creatinine

NOTES:

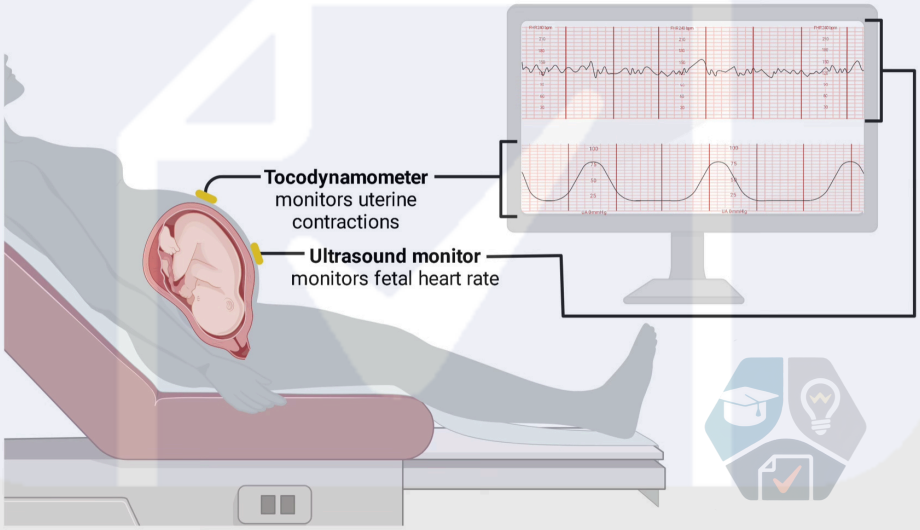
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NOTES:



Ultrasound and Tocodynamometer Placement and Tracing



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Magnesium Sulfate Toxicity

Blood pressure decreased ↓

Urine output decreased ↓

Respiratory rate decreased ↓

Patellar reflex absent 🚫

ITEM 6 OF 6

Vital Signs | **Assessment**

Vital Signs	0900	1100	1300	1315
T	98.2 F (36.7 C)	98.2 F (36.7 C)	98.2 F (36.7 C)	98.2 F (36.7 C)
P	80	83	80	80
RR	18	18	18	11
BP	142/91	146/93	146/91	141/97
Pulse oximetry reading	98% on room air	99% on room air	98% on room air	98% on room air

Body System	0900	1300	1315
Neurologic	Alert and oriented x 3; 5/10 headache; deep tendon patellar reflexes 3+	Alert and oriented x 3; 6/10 headache; deep tendon patellar reflexes 4+	Client reports feeling tired, hot, and flushed; Deep tendon patellar reflexes 2+
Respiratory	Clear breath sounds; respirations symmetric and unlabored	Clear breath sounds; respirations symmetric and unlabored	RR 11
Cardiovascular	S1, S2 present; swelling in hands and face	S1, S2 present; swelling in hands and face	BP 141/97
Gastrointestinal	Bowel sounds normoactive x 4	Bowel sounds normoactive x 4	-
Extremities	2+ pitting edema bilaterally in the lower extremities	2+ pitting edema bilaterally in the lower extremities	-
Reproductive/Genitourinary	Fundal measurement is 32 centimeters; voiding without difficulty	Fundal measurement is 32 centimeters; voiding without difficulty	Urine output of 90 mL in 4 hours

ITEM 6 OF 6

The nurse starts the client's magnesium sulfate infusion and updates the client's Vital Signs and performs a focused Assessment at 1315.

Which of the following findings indicate that the nurse should **notify** the healthcare provider and **slow the rate of the infusion**? Select all that apply.

1. Respiratory rate 11
2. Blood pressure 141/97
3. Deep tendon reflexes 2+
4. Client reports feeling tired
5. Urine output 90 ml over 4 hours
6. Client reports feeling hot and flushed

ITEM 1 OF 6

Vital Signs | Assessment | Laboratory Results

The nurse cares for a 46-year-old male in the emergency department.

1630: Client arrived at the emergency department via emergency medical services (EMS). EMS reports the client was picked up from a local park following a call made by bystanders for an unresponsive person. The client has shallow respirations and is not responsive to verbal stimulation. The client has pinpoint pupils. A non-rebreather mask is in place with 15 L/min of oxygen being administered. The client arrived at the emergency department with an 18-gauge IV catheter to the right antecubital area placed by EMS with no medication infusing at this time. The client appears unkempt and has small puncture wounds in various stages of healing to the left antecubital space. Erythema and swelling present to the left antecubital space, with a small amount of bleeding noted to a fresh puncture wound. The client smells of alcohol and has dried emesis on his clothes. Client placed in a left side-lying position.

ITEM 1 OF 6

Vital Signs | Assessment | Laboratory Results

The nurse cares for a 46-year-old male in the emergency department.

	1630:
T	98.6 F (37.0 C)
P	64
RR	9
BP	105/70
Pulse oximetry reading	93% on 100% non-rebreather mask

ITEM 1 OF 6

The nurse reviews the Nurses' Notes and Vitals Signs from 1630.

Drag the top 3 findings that are most concerning to the box on the right.

Client Findings

1. Smells of alcohol
2. Pulse oximetry reading
3. Level of consciousness
4. Respiratory assessment
5. Erythema to left antecubital area
6. Presence of multiple puncture wounds

Top 3 Findings

ITEM 2 OF 6

Which complication is the client at **greatest risk** for experiencing?

1. Sepsis
2. Aspiration
3. Respiratory arrest
4. Alcohol withdrawal

ITEM 3 OF 6

Nurses' Notes

The nurse cares for a 46-year-old male in the emergency department.

1645:

Client's family arrives at the emergency department and reports the client has struggled with chronic pain after he was in a motor vehicle collision last year. The client's family reports he had been struggling with pain control the past week and has a history of alcohol abuse and hypertension. The client has shallow respirations and is not responsive to verbal stimuli. Respiratory rate is 7.

ITEM 3 OF 6

Vitals

The nurse cares for a 46-year-old male in the emergency department.

	1630	**1645**
T	98.6 F (37.0 C)	98.6 F (37.0 C)
P	64	62
RR	9	7
BP	105/70	92/58
Pulse oximetry reading	93% on 100% non-rebreather mask	91% on 100% non-rebreather mask

ITEM 3 OF 6

The nurse reviews the Nurses' Notes and Vitals Signs from 1645. Complete the following sentence by choosing from the list of options.

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

Select...
1. opioid overdose
2. hemorrhagic stroke
3. acute alcohol toxicity
4. acute respiratory distress syndrome.

ITEM 4 OF 6

For each potential intervention below, click to select whether the intervention is anticipated or not anticipated in the care of the client.

Potential Interventions	Anticipated (a)	Not Anticipated (b)
1. Administer naloxone.		
2. Administer epinephrine.		
3. Stay at the client's bedside.		
4. Place suction equipment at the bedside.		
5. Assess blood pressure every 15 minutes.		
6. Initiate continuous pulse oximetry monitoring.		

NOTES:

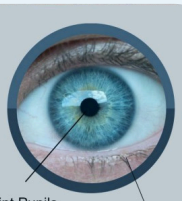
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OPIATES

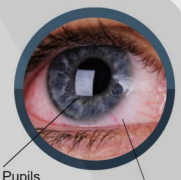
Including: Heroin, OxyContin, Methadone, Morphine

Other Signs of Opiate Use:
- Itching and/or Scratching
- Nodding Out
- Horse/Deepening Voice
- Change in Sleep Patterns
- Vomiting
- Intense Sugar Cravings



MARIJUANA

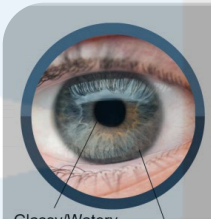
Other Signs of Marijuana Use:
- Change in Behavior
- Hunger/Eating
- Droopy Eyes
- Slowed Heart Rate
- Slowed Speech
- Laughing



ALCOHOL

Including: Beer, Hard Liquor, & Wine

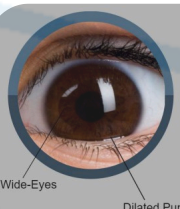
Other Signs of Alcohol Use:
- Loss of Inhibitions
- Unsteady Walking
- Droopy Eyes
- Slowed Heart Rate
- Slowed Speech
- Blackouts



AMPHETAMINES / MDMA

Including: Cocaine, Crystal Meth, Molly/Ecstasy, Adderall

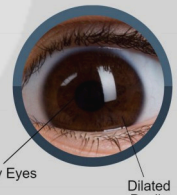
Other Signs of Amphetamines/MDMA Use:
- Change in Sleep Pattern
- Chewing/Grinding Teeth
- Constant Talking
- Increased Heart Rate
- Slowed Breathing



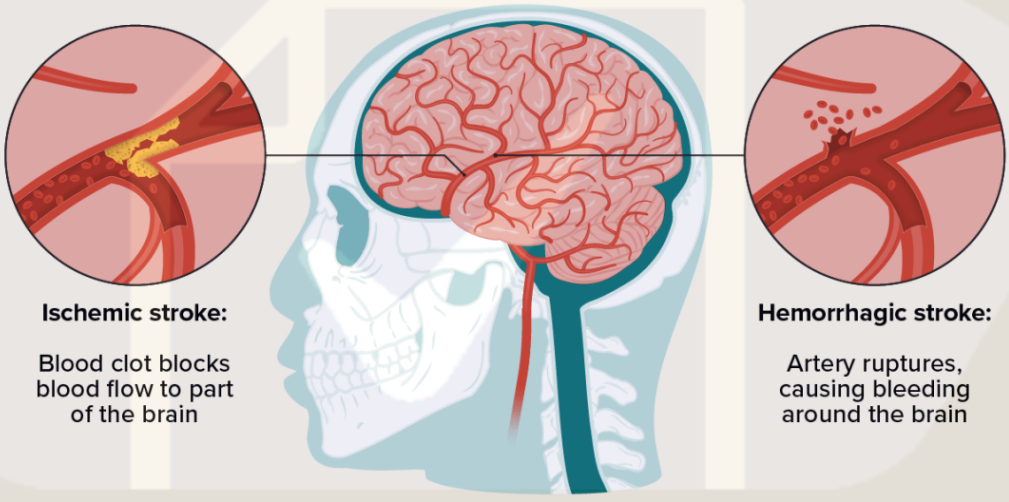
BENZODIAZEPINES

Including: Xanax, Valium, Ativan, & Klonopin

Other Signs of Benzo Use:
- Change in Behavior
- Drowsiness
- Droopy Eyes
- Slowed Heart Rate
- Slowed Speech
- Loss of Memory/Time
- Falling Asleep



Ischemic stroke vs. Hemorrhagic stroke



Ischemic stroke:

Blood clot blocks blood flow to part of the brain

Hemorrhagic stroke:

Artery ruptures, causing bleeding around the brain

ITEM 5 OF 6

Nurses' Notes

The nurse cares for a 46-year-old male in the emergency department.

1700:

One dose of naloxone 0.4 mg administered via IV push. Client is now responsive to verbal stimuli but is anxious and reports nausea. Breathing is even and unlabored. Client is awake, alert, and oriented x 1, to person.

1730:

The client appears drowsy and is no longer responsive to verbal or physical stimuli. Snoring respirations heard with decreased respiratory effort. Pulse oximetry reading is 92% on a non-rebreather mask with 100% oxygen administered. Respiratory rate is 5.

ITEM 5 OF 6

The nurse reviews the updated Nurses' Notes from 1700 and 1730.
Complete the following sentence by choosing from the lists of options.

The nurse should first [ ] and then [ ]

Select...
1. administer naloxone
2. prepare for endotracheal intubation
3. check the client's capillary blood glucose
4. provide respirations with a bag valve mask

Select...
1. administer naloxone
2. prepare for endotracheal intubation
3. check the client's capillary blood glucose
4. provide respirations with a bag valve mask

NOTES:

Nurses' Notes

The nurse cares for a 46-year-old male in the emergency department.

Emergency Department

1735:
Additional dose of naloxone 0.4 mg administered via IV push. Client is now alert and responsive with even and unlabored respirations. The client reports he self-administered fentanyl IV earlier in the day.

ITEM 6 OF 6

The client is requesting to leave the emergency department against medical advice. The nurse has provided home education to the client. Which client statements) indicate that the teaching was effective? **Select all that apply.**

1. "Taking methadone every day can reduce my drug cravings."
2. "Opioid withdrawal can make me have nausea, vomiting, and diarrhea."
3. "There are behavioral therapy programs that can help me manage drug cravings."
4. "If I stop using opioids, I should expect my withdrawal symptoms to peak in 3-4 weeks."
5. "I can use a fentanyl patch for a couple of weeks to reduce serious withdrawal symptoms."
6. "If my pain gets worse, I should ask my provider to prescribe me oxycodone since my tolerance is so high."
7. "| should always keep naloxone nasal spray at home in case of accidental overdoses."

NOTES:

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