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STUDENT WORKBOOK

CAT

"PRECISION TESTING: TARGETED NCLEX APPROACHES"

ITEM 1 OF 1

Nurses' Note | **Vital Signs** | **Medical History**

The emergency department (ED) nurse is caring for a client with liver cirrhosis
Item 1 of 1

57-year-old male reporting increasing dyspnea and abdominal pressure after missing his previously scheduled paracentesis. The client reports he feels 'uncomfortable.' He is alert and oriented x 4; sclera is yellow along with jaundice skin appearance. Respirations were labored, tachypnea, and clear breath sounds. Abdominal distention noted, hypoactive bowel sounds in all four quadrants. Ascites and dependent edema were noted. Peripheral pulses were intact.

ITEM 1 OF 1

Nurses' Note | **Vital Signs** | **Medical History**

- Oral Temperature 101 o F (38.3C)
- Heart rate 94/minute
- Respirations 24/minute
- Blood pressure 104/68 mm Hg
- Oxygen saturation 95% on room air

- Hepatitis C
- Liver cirrhosis
- Substance use disorder
- Hyperlipidemia

ITEM 1 OF 1

Which assessment findings require follow-up? Select all that apply.

1. Jaundice
2. Labored breathing
3. Hypoactive bowel sounds
4. Respiratory rate
5. Oral temperature
6. Yellow sclera

ITEM 1 OF 1

Nurses' Note | Vital Signs | Intake and Output

The nurse cares for a client recovering from a transurethral resection of the prostate (TURP)

The client arrived at the medical-surgical unit six hours post-operative from a TURP. The client was alert, oriented to person, place, time, and situation. The client has a three-way indwelling urinary catheter and is continuously irrigated with isotonic saline. Urine output is ketchup-like with medium to large clots. The client reports the need to urinate and reported pressure in the pelvic region described as spasms.

ITEM 1 OF 1

Nurses' Note | Vital Signs | Intake and Output

The nurse cares for a client recovering from a transurethral resection of the prostate (TURP)

- Blood Pressure 100/60 mm Hg
- Temperature 98° F (36.7° C)
- Heart rate 106/min
- Respiratory rate 19 breaths per minute
- Oxygen saturation 95% on room air

The nurse cares for a client recovering from a transurethral resection of the prostate (TURP)

Intake - Continuous bladder irrigation: 550 mL
Output - Indwelling catheter: 975 mL

ITEM 1 OF 1

Drag words from the choices below to fill in the blank in the following sentence
Click the answer box to view the correct answer.

The client is demonstrating signs and symptoms of [ ]

Select...
1. urinary catheter obstruction
2. hyponatremia
3. shock
4. urinary tract infection

ITEM 1 OF 1

Nurses' Note

The nurse in the emergency department (ED) is caring for 3 year old

0100: The client was brought to the ED by his parents because they were awakened by the child crying and because 'his throat hurt.' The parents indicated that he was sick the night before, but the symptoms were not severe, and this change was sudden. The child was drooling, hot to the touch, and their voice was muffled. On assessment, the child is alert and restless. Pain was endorsed in the throat. Voice is muffled and excessive secretions were noted in his mouth. Visualization of the throat was difficult because of the excessive secretions but the throat was significantly erythemic. The child was resistant to lying supine and maintained a tripod position. Low-pitch inspiratory stridor was heard in upper lung fields, and the client had tachypnea. Peripheral pulses were 2+. Skin was hot and dry. Vital signs: T 103.4° F (39.7° C), P 141, RR 34, pulse oximetry reading 89% on room air. No significant past medical or surgical history.

ITEM 1 OF 1

The nurse in the emergency department (ED) is caring for 3 year old

Assessment Findings	Streptococcal pharyngitis	Epiglottitis	Laryngotracheobronchitis
Throat Pain			
Inspiratory Stridor			
Sudden Onset of Symptoms			
Restlessness			
Tripod Position with Drooling			
Muffled Voice			

Nurses' Note

ITEM 1 OF 1

A client arrives at the clinic with his daughter, reporting memory impairments

A 71-year-old male arrives with his daughter with concerns about memory loss. The client's daughter reports that he has forgotten key dates, such as birthdays and his wedding anniversary, over the past six months. She emphasized that he would never forget these dates. Further, the client's daughter also reports that driving has become more difficult and that the client has been involved in two minor accidents over the past six months. He has also misplaced three sets of keys. The daughter describes her father's judgment as “declining” along with his memory. The client's daughter is concerned that her father may have dementia.

The client is alert and fully oriented. The client had difficulty with remote memory questioning. Immediate and recent memory was intact. The client denied any pain or physical symptoms, stating, "I'm here because my daughter insisted."

Each finding may support more than 1 disease process. Note: Each column must have at least 1 response option selected

Clinical Feature	Delirium	Dementia
The onset of symptoms is months to years		
May be caused by uncontrolled hypertension and diabetes		
Progressively worsens		
Memory impairments		
May be caused by fluid and electrolyte imbalances or infection		
May cause impairments in judgment		
Altered level of consciousness		

ED Triage Note **History And Physical**

The nurse in the emergency department (ED) is caring for a 20-year-old female client

0912: Client was brought to the ED by her two college roommates 'because she was not acting right.' The roommate reports that she went to bed the night before reporting stiffness in her neck and a headache. She attributed it to being under pressure with final exams and having poor sleep the previous several days. The client apparently took non-prescribed lorazepam from another roommate to assist her with sleep. The roommate reported recently having influenza and is unsure if she became infected. It is reported that she declined the influenza vaccination when it was offered on campus. The roommate reports waking her with physical stimuli and found her diaphoretic, hot to touch, and mumbling, saying she did not feel well. Vital signs: T 103.4° F (39.7° C), P 112, RR 12, BP 116/86, pulse oximetry 95% on room air.

ED Triage Note **History And Physical**

The nurse in the emergency department (ED) is caring for a 20-year-old female client

Assessment	Findings
Neurological	where she mumbles a few incoherent words; pupils equal, round, and reactive to light; limited purposeful movements; Glasgow coma scale 13
Cardiovascular	peripheral edema
Respiratory	(no findings extracted)
Gastrointestinal	(no findings extracted)
Integumentary	on the torso
Past Medical History	condition; it is reported that she is a daily smoker

Which of the following assessment findings require **immediate** follow-up? **Select all that apply.**

1. neurological assessment findings
2. pulse and temperature
3. gastrointestinal assessment findings
4. influenza vaccination status
5. daily smoking habit
6. blood pressure and pulse oximetry reading

ITEM 2 OF 6

For each client finding below, click to specify if the finding is consistent with the disease process of benzodiazepine toxicity, bacterial meningitis, or influenza. Each finding may support more than 1 disease process

Client Findings	Benzodiazepine Toxicity	Bacterial Meningitis	Influenza
Altered Mental Status			
Fever			
Petechial Rash			
Altered Speech Pattern			
Neck Stiffness			

ITEM 3 OF 6

Drag words from the choices below to fill in the blank in the following sentence
Click the answer box to view the correct answer.

The client is at highest risk for developing [ ]

Select...
1. bacterial meningitis.
2. influenza.
3. benzodiazepine toxicity.

ITEM 4 OF 6

The nurse in the emergency department (ED) is caring for a 20-year-old female client

The nurse develops a plan of care for this client. For each potential 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

Potential Intervention	Indicated	Not Indicated
Keep the door to the client's room closed		
Provide visitors with face shields upon entering the client's room		
Provide a quiet environment		
Perform frequent neurological assessments		
Obtain an order to start a peripheral vascular access device		
Prepare the client for an immediate electroencephalography (EEG)		

ITEM 5 OF 6

Physician Orders

The nurse in the emergency department (ED) is caring for a 20-year-old female client

- Prepare the client for lumbar puncture
- Blood cultures
- Complete blood count (CBC), complete metabolic panel (CMP), PT/INR level, and serum ammonia level
- Urine drug screen
- Urine analysis
- Computed tomography (CT) scan of the head without contrast
- Start two peripheral vascular access devices
- ketorolac 15 mg intravenous (IV) push x 1 dose
- ceftriaxone 2 grams intravenous (IV) x 1 dose
- 1000 mL of 0.9% saline bolus over one hour
- Infectious disease consultation dx meningitis
- Admit to critical care

The nurse reviews the physician's orders

For each physician order, click to specify the appropriate nursing intervention

ITEM 5 OF 6

Physician Order	Potential Intervention
Lumbar Puncture	1.
Ketorolac	2.
Ceftriaxone	3.
Seizure Precautions	4.

Select... (1)
1. assess the client for an allergy to contrast dye
2. obtain laboratory work prior to the procedure
3. position the client flat before the procedure

Select... (2)
1. monitor the client's temperature for efficacy
2. place an incontinence pad under the client for increased urinary output
3. assess the client's blood glucose for a hypoglycemic reaction

Select... (3)
1. monitor the client's temperature for efficacy
2. administer immediately after lumbar puncture
3. assess the client's blood glucose for a hypoglycemic reaction

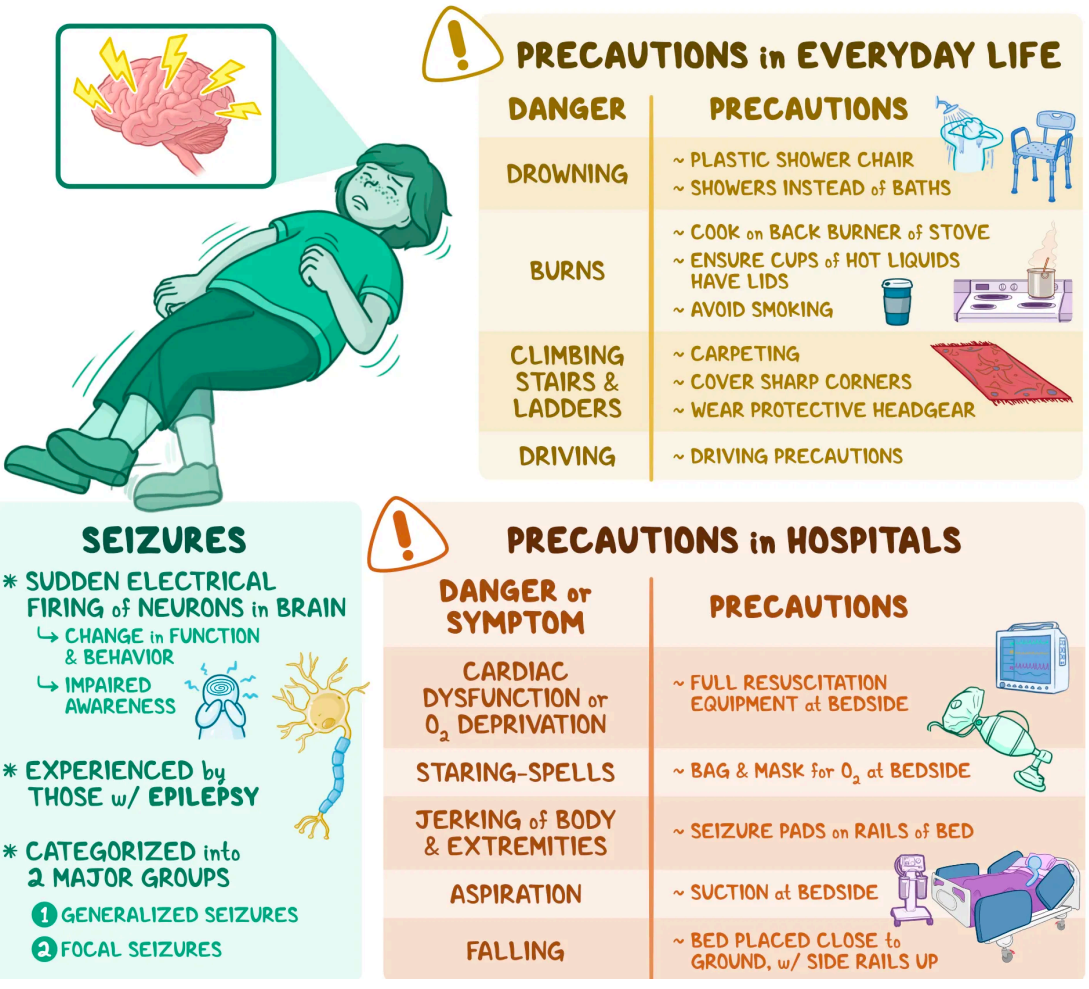
Select... (4)
1. pad the frame of the bed
2. establish a patent vascular access device
3. provide additional lighting in the room

The nurse implements the physician's orders and documents a follow-up nursing note **ITEM 6 OF 6**

Click to highlight the findings below that indicate a worsening of the client's status

Client's status

1100 - The client is lethargic and makes no purposeful movements. Does not respond to physical stimuli. Glasgow coma scale 10. Peripheral pulses 2+. The client's skin is pale and dry. Petechial rash on the torso. Vital signs: T 100.4° F (38° C), P 101, RR 12, BP 117/88, pulse oximetry reading 95%.



ITEM 1 OF 1

Nurses' Notes

The labor and delivery nurse is caring for a neonate immediately following vaginal delivery

1105: 37-week neonate born at 1105. Weight at birth was 7 pounds 3 ounces (3316 grams). Head circumference 33 cm; chest circumference 31 cm. The umbilical cord was clamped and cut, revealing two arteries and one vein. Vigorous cry and movement in all extremities were noted. Gluteal folds were symmetrical. Breath sounds clear, and no grunting; pink body and cyanotic extremities. Apical pulse was 119/minute; axillary temperature 96.5°F (35.8°C); respiratory rate was 50/minute. Pulse oximetry 95% on room air. APGAR at one minute was 9.

ITEM 1 OF 1

Drag one (1) condition and two (2) client findings to fill in each blank of the following sentence

The neonate is at greatest risk for _____

due to the neonates _____ and _____

Condition	Clinical Finding
1. developmental dysplasia of the hips (DDH) 2. hypoglycemia 3. neonatal abstinence syndrome 4. microcephaly 5. macrocephaly 6. respiratory distress	1. axillary temperature 2. head circumference 3. cry characteristics 4. gluteal fold symmetry 5. cyanotic extremities 6. APGAR score

NOTES:

History and Physical | **Orders**

A 22-year-old is evaluated in the emergency department for recurrent seizure activity

A 22-year-old female client was with friends at a restaurant and reportedly started acting odd and then had uncontrollable and uncoordinated movements. This lasted three minutes. Once this terminated, EMS was called, and this occurred again and lasted four minutes.
EMS administered lorazepam.
The client does not have any medical history or take any medications. On exam, she did not recall the seizure, nor did she remember how she felt leading up to the seizure. She denied any drug use. She is drowsy following the administration of lorazepam but can sustain attention and is fully oriented. Glasgow Coma Scale 14. Will admit the client for observation.

ITEM 1 OF 1

History and Physical | **Orders**

A 22-year-old is evaluated in the emergency department for recurrent seizure activity

- CT Scan of head
- Electroencephalogram (EEG)
- Magnetic Resonance Imaging (MRI) of brain
- Complete blood count
- Complete metabolic panel
- Loading dose of intravenous (IV) phenytoin
- Urine drug screen

NOTES:

For each physician order, click to specify the appropriate nursing intervention

ITEM 1 OF 1

Order	Nursing Intervention
Magnetic Resonance Imaging (MRI) of brain	
Loading dose of intravenous (IV) phenytoin	
Electroencephalogram (EEG)	

1. Ensure the client has a negative pregnancy test prior to the exam
2. Assess if the client has claustrophobia prior to the exam
3. Have the client nothing by mouth (NPO) eight hours prior to the exam

1. Monitor, the client's lung, sounds for pulmonary edema
2. Establish continuous cardiac monitoring during the infusion
3. Insert an indwelling urinary catheter to monitor intake and output

1. Position the client side-lying with their knees to their chest
2. Instruct the client how to remove the adhesive after the test
3. Assess the client for an allergy to intravenous (IV) contrast dye

NOTES:

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