NurseAdemy
ESTUDIA ONLINE

Next Generation
NCLEX-RN®

STUDENT WORKBOOK

CAT

CAT HORIZON: NCLEX FUTURE-READY PREP

ITEM 1 OF 6

History and Physical | Vital Signs | Diagnostic Results

The nurse in the emergency department cares for a 68-year-old male client.

A 68-year-old male client presents to the emergency department with intermittent substernal chest pain during activity that began yesterday evening and has worsened this morning. The client describes the pain as heavy pressure that radiates to his neck and jaw. He rates chest pain as 7/10. He states that the pain was previously relieved by rest but is now more persistent. Client reports that he took three nitroglycerin tablets sublingually in the past hour, which partially relieved his pain. He denies fever or chills. Client has a history of chronic stable angina, hypertension, coronary artery disease, osteoarthritis, and type 2 diabetes mellitus. He is a former smoker and smoked one pack per day for 20 years. He appears anxious and diaphoretic. S1 and S2 present. Lung sounds clear. Capillary refill <3 seconds in all extremities.

ITEM 1 OF 6

History and Physical | Vital Signs | Diagnostic Results

The nurse in the emergency department cares for a 68-year-old male client.

1000	
T	98.2 F (36.8 C)
P	105
RR	21
BP	115/83
Pulse oximetry reading	96% on room air

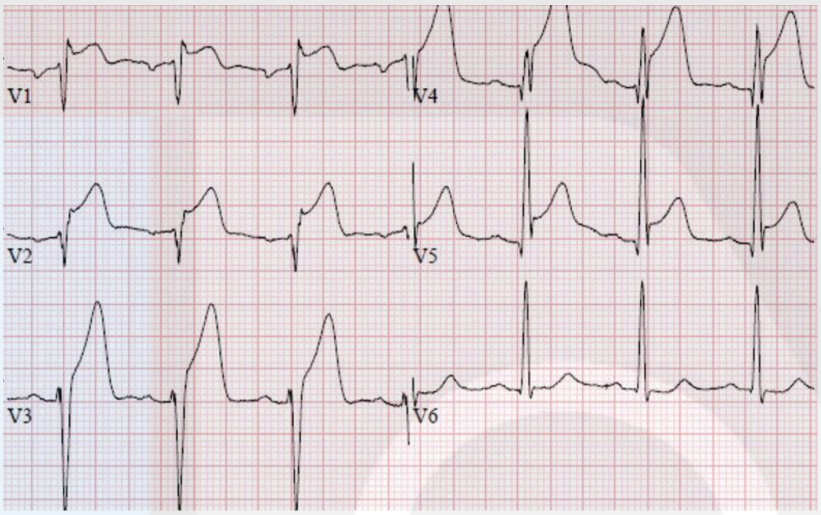
NOTES:

ITEM 1 OF 6

History and Physical | Vital Signs | Diagnostic Results

The nurse in the emergency department cares for a 68-year-old male client.

12-Lead ECG
1000:



ITEM 1 OF 6

History and Physical | Vital Signs | Diagnostic Results

The nurse in the emergency department cares for a 68-year-old male client.

Laboratory Results

Laboratory Test and Reference Range	1000
Sodium 136–145 mEq/L (136–145 mmol/L)	142 mEq/L (142 mmol/L)
Potassium 3.5–5.0 mEq/L (3.5–5.0 mmol/L)	4.5 mEq/L (4.5 mmol/L)
Blood urea nitrogen (BUN) 10–20 mg/dL (3.6–7.1 mmol/L)	15 mg/dL (5.4 mmol/L)

NOTES:

History and Physical | Vital Signs | Diagnostic Results

The nurse in the emergency department cares for a 68-year-old male client.

Laboratory Results

Laboratory Test and Reference Range	1000
Creatinine Male: 0.6–1.2 mg/dL (53–106 µmol/L); Female: 0.5–1.1 mg/dL (44–97 µmol/L)	1.2 mg/dL (92 µmol/L)
Glucose 74–106 mg/dL (4.1–5.9 mmol/L)	195 mg/dL (10.8 mmol/L)
Troponin I <0.03 ng/mL (<0.03 mcg/L)	2.5 ng/mL (2.5 mcg/L)

ITEM 1 OF 6

Which client findings require immediate follow-up by the nurse?

1. Pulse
2. Respirations
3. Troponin results
4. Pain characteristics
5. Past medical history
6. Response to nitroglycerin
7. Electrocardiogram findings

NOTES:

ITEM 2 OF 6

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

This client is potentially experiencing [ ]

Select...
1. chronic stable anginaan
2. ST-elevation myocardial infarction
3. a non-ST-elevation myocardial infarction.

This suspicion is best supported by the client's [ ]

Select...
1. serum troponin
2. 12-lead ECG results
3. evolving chest pain.

ITEM 3 OF 6

Select the 2 complications the nurse is most concerned about the client developing.

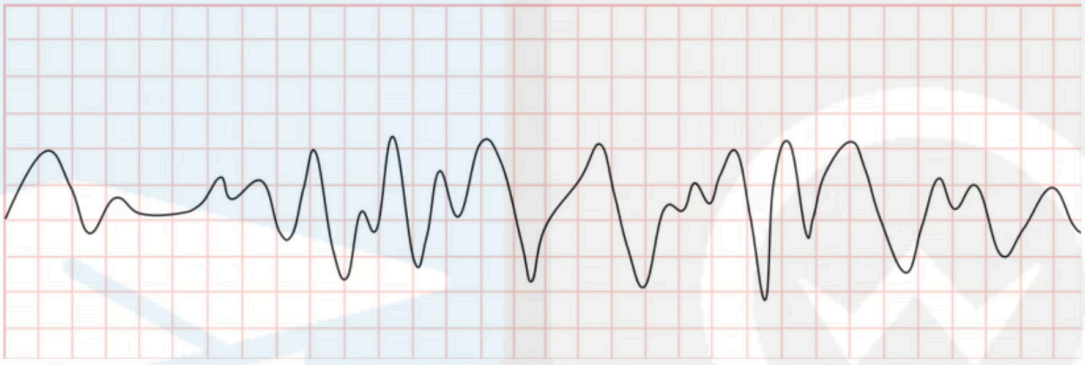
1. Pericarditis
2. Heart failure
3. Acute kidney injury
4. Ventricular arrhythmias
5. Abdominal aortic aneurysm

NOTES:

REMEMBER

Next Gen PASSERS NCLEX

Ventricular Fibrillation



- **Rate**: Not measurable, irregular
- **Rhythm**: Irregular
- **P waves**: Absent
- **PR interval**: Not measurable
- **QRS complex**: Fibrillatory waves in place of QRS complexes
- **Pulse activity**: Absent

Ventricular Tachycardia

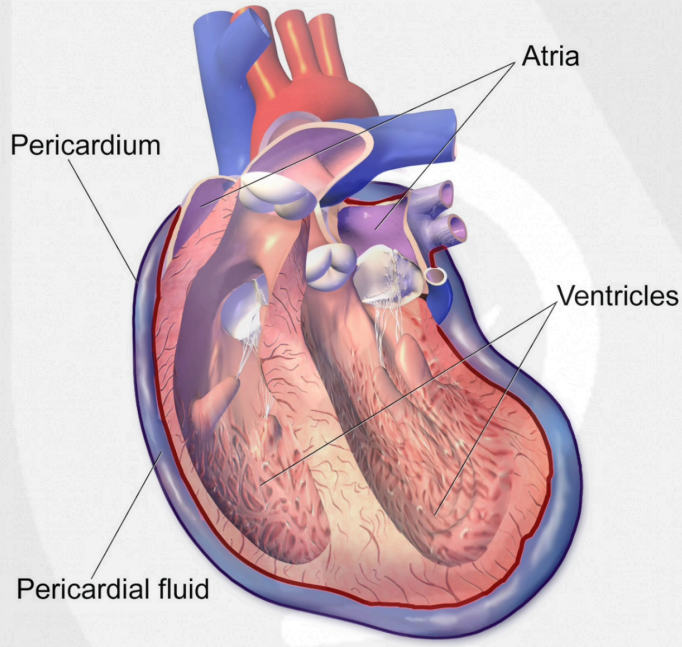


- **Rate**: 150-250 beats/min
- **Rhythm**: Regular or irregular
- **P waves**: Absent
- **PR interval**: Not measurable
- **QRS complex**: Wide, distorted
- **Pulse activity**: Present or absent

REMEMBER

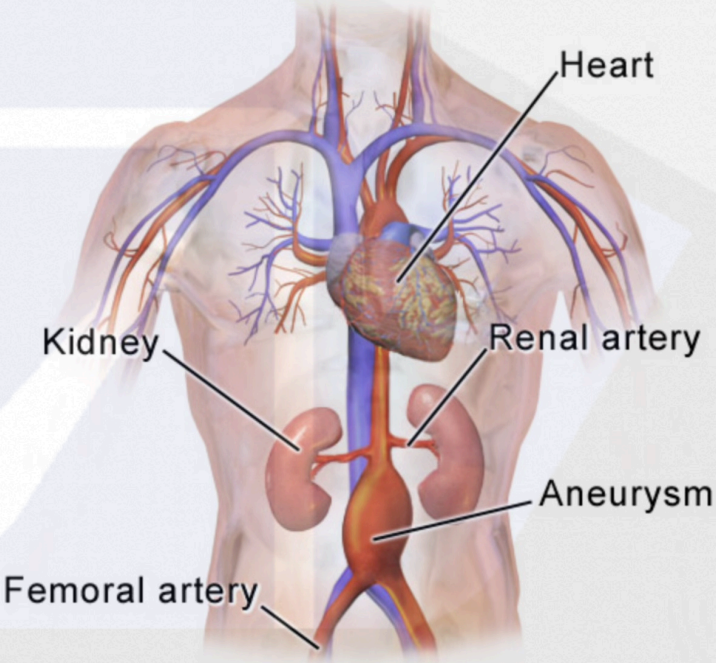
Next Gen PASSERS NCLEX

NOTES:



Inflammation of the Pericardium in the Heart

NOTES:



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

Potential intervention	Indicated	Not Indicated
1. Administer ticagrelor 180 mg PO.		
2. Initiate continuous cardiac monitoring.		
3. Administer aspirin 325 mg crushed PO.		
4. Initiate nitroglycerin 5 mcg/min continuous IV infusion.		
5. Regularly assess peripheral pulses and capillary refill.		
6. Assess the client's exercise tolerance with a walk test.		
7. Administer 2 L/min supplemental oxygen via nasal cannula.		

ITEM 4 OF 6

ITEM 5 OF 6

Vital Signs | Progress Notes

	1000	1200
T	98.2 F (36.8 C)	98.0 F (36.7 C)
P	105	93
RR	21	18
BP	115/83	110/75
Pulse oximetry reading	96% on room air	95% on room air

NOTES:

ITEM 5 OF 6

Vital Signs | Progress Notes

Day 1

1200:

Client received loading doses of aspirin and ticagrelor and was placed on IV nitroglycerin. Client was transferred to the cardiac catheterization lab where he underwent percutaneous coronary intervention via the femoral artery approach. A drug-eluting stent was placed in the left anterior descending coronary artery. The client was transferred to the coronary care unit in stable condition.

ITEM 5 OF 6

The nurse has reviewed the client's Progress Notes and updated Vital Signs from 1200. The nurse in the coronary care unit is caring for the client immediately after stent placement. Drag the potential interventions the nurse should take to the box on the right. Choose only the interventions that are appropriate.

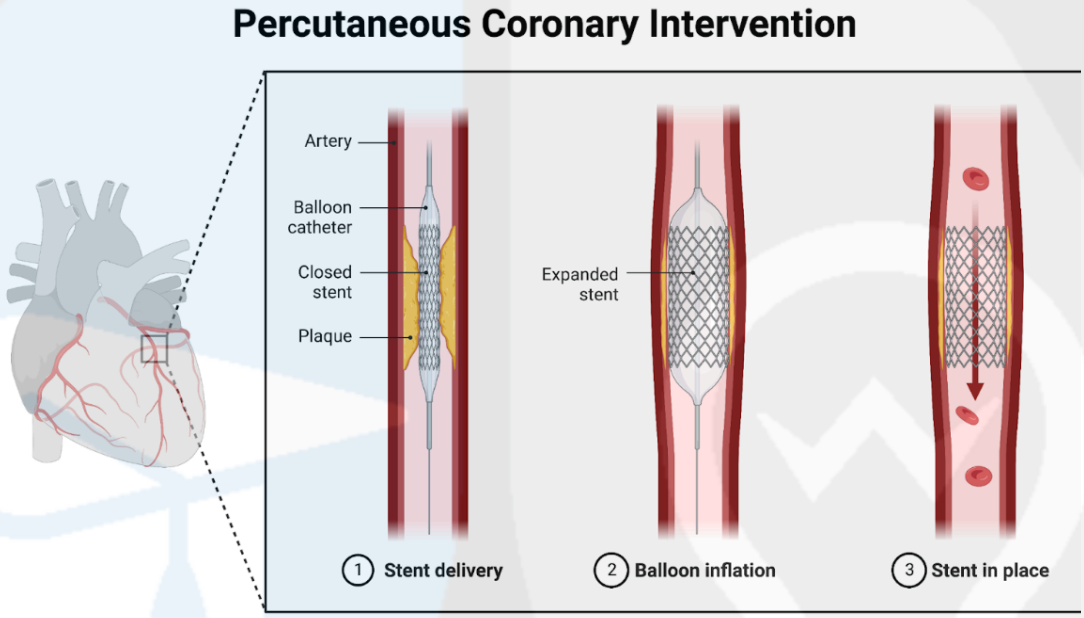
Potential Interventions

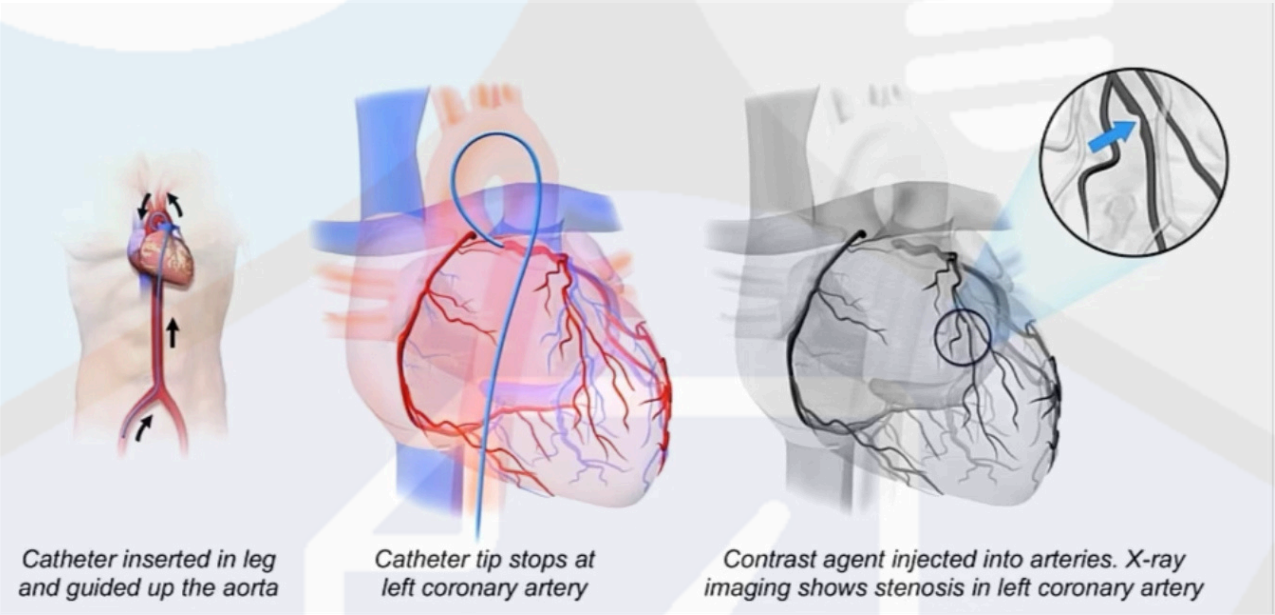
1. Encourage intake of oral fluids.
2. Administer metoprolol 25 mg PO.
3. Monitor insertion site for bleeding.
4. Keep the affected lower extremity extended.
5. Assess dorsalis pedis pulses every 15 minutes.
6. Apply pressure above puncture site if a swollen, indurated area develops.

Completed Interventions

NOTES:

REMEMBER





NOTES:

ITEM 6 OF 6

Progress Notes

Progress Notes
Day 2

0800:
Client vital signs remained stable overnight with no further chest pain and no arrhythmias noted on cardiac monitoring. He is now stable for discharge with plans to follow up with a visit to the cardiology clinic in one week.

ITEM 6 OF 6

The nurse reviews the Day 2 0800 Progress Notes.

The nurse in the coronary care unit has provided discharge teaching to the client. Which of the following client statements indicate that the teaching was effective? Select all that apply.

1. "I will continue taking both aspirin and ticagrelor after I am discharged from the hospital."
2. "I can take naproxen or ibuprofen if I have aches or pains in my joints from physical activity."
3. "If I fall and hurt myself or if I hit my head, I should contact my healthcare provider immediately."
4. "I should slowly increase my activity level to a goal of 30-60 minutes of brisk walking at least 5 days a week."
5. "I should keep a bottle of nitroglycerin tablets available in my house and my car in case I experience chest pain again."
6. "I can gradually resume sexual activity once I can climb two flights of stairs or walk a block without experiencing chest pain."

NOTES:

ITEM 1 OF 6

Nurses' Notes

Emergency Department
1330:
Client was brought to the emergency department by his mother. The mother states the client is a 6-month-old male and that they identify as "Hispanic or Latino." The child has had liquid diarrhea for the past day, and his last diaper change contained a small amount of blood and mucus. The mother reports that several times over the past hour, while the child was playing with his toys, he would "stop, curl up, and cry, then return to playing." Mom states the client also had "green, mucousy vomit" on the way to the hospital. His mother notes that she changed formula 3 weeks ago. The client has refused feeds since yesterday. The mother reports the client has a history of hip dysplasia and a ventricular septal defect diagnosed at 1 month of age, but she states the septal defect has since resolved on its own. Upon physical examination, the posterior fontanelle is firm, flat, and closed, and the anterior fontanelle is soft, flat, and open. S1 and S2 heart sounds auscultated; no murmurs detected. Abdominal auscultation reveals hyperactive bowel sounds. A 4 cm elongated mass palpated in right upper quadrant (RUQ). The child screamed and guarded his abdomen throughout the abdominal examination. The skin assessment reveals dry, erythematous patches behind the knees and an irregularly shaped blue mark on the sacrum. All other skin is pink and appropriate for ethnicity.

ITEM 1 OF 6

Nurses' Notes Vital Signs Laboratory Results

Day 1: 1330	
T	99.1 F (37.2 C) axillary
P	151
RR	41
BP	101/52
Pulse oximetry reading	98% on room air

NOTES:

Nurses' Notes | Vital Signs | Laboratory Results

Laboratory Test and Reference Range	Day 1: 1330
White blood cell count Child ≤2 years: 6,200-17,000/mm3 (6.2-17.0 x 109/L)	20,000/mm3 (20.0 x 109/L)
Hematocrit 6 months - 1 year: 29%-43% (0.29-0.43)	31% (0.31)
Hemoglobin 6 months - 1 year: 9.5-14 g/dL (95 g/L-140 g/L)	10 g/dL (100 g/L)

ITEM 1 OF 6

Click to highlight the findings below that require immediate follow-up.

Emergency Department

1330:

Client was brought to the emergency department by his mother. The mother states the client is a 6-month-old male and that they identify as "Hispanic or Latino." The child has had liquid diarrhea for the past day, and his last diaper change contained a small amount of blood and mucus. The mother reports that several times over the past hour, while the child was playing with his toys, he would "stop, curl up, and cry, then return to playing." Mom states the client also had "green, mucousy vomit" on the way to the hospital. His mother notes that she changed formula 3 weeks ago. The client has refused feeds since yesterday. The mother reports the client has a history of hip dysplasia and a ventricular septal defect diagnosed at 1 month of age, but she states the septal defect has since resolved on its own. Upon physical examination, the posterior fontanelle is firm, flat, and closed, and the anterior fontanelle is soft, flat, and open. S1 and S2 heart sounds auscultated; no murmurs detected. Abdominal auscultation reveals hyperactive bowel sounds. A 4 cm elongated mass palpated in right upper quadrant (RUQ). The child screamed and guarded his abdomen throughout the abdominal examination. The skin assessment reveals dry, erythematous patches behind the knees and an irregularly shaped blue mark on the sacrum. All other skin is pink and appropriate for ethnicity.

NOTES:

For each client finding below, click to specify if the finding is consistent with the disease process of appendicitis, intussusception, or hypertrophic pyloric stenosis. Each finding may support more than 1 disease process.

ITEM 2 OF 6

Assessment Findings	Appendicitis	Intussusception	Hypertrophic Pyloric Stenosis
Diarrhea			
Abdominal pain			
Green, mucousy vomit			
Stool with blood and mucus			
Increased white blood cell count			
Right upper quadrant abdominal mass			

ITEM 3 OF 6

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

The nurse should be most concerned about [ ]

Select...
1. failure to thrive
2. bowel perforation
3. fluid and electrolyte imbalance

due to [ ]

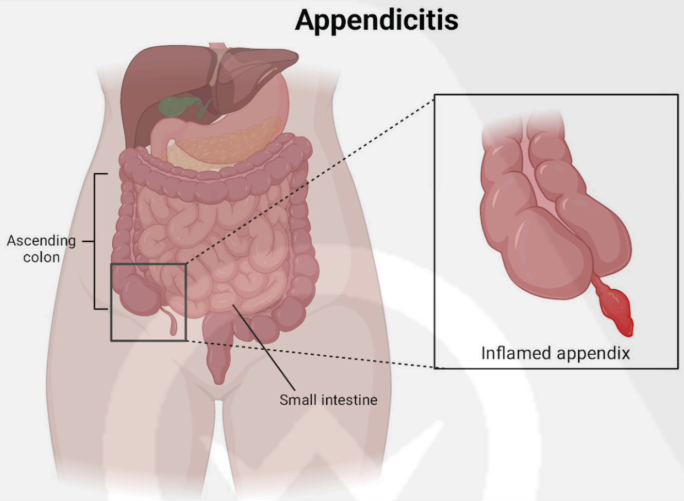
Select...
1. ischemia
2. poor intake
3. vomiting and diarrhea.

NOTES:

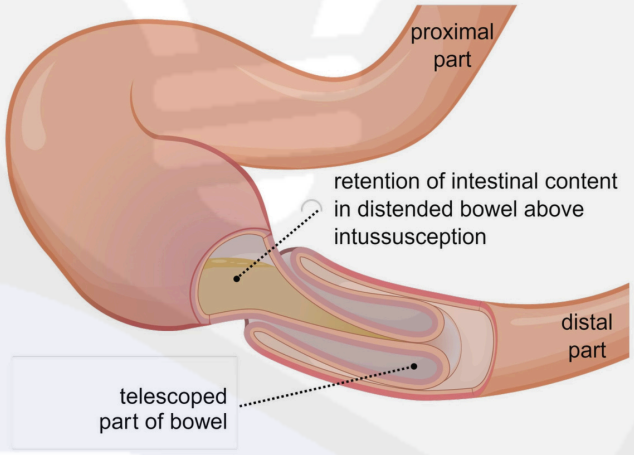
REMEMBER

Next Gen PASSERS NCLEX

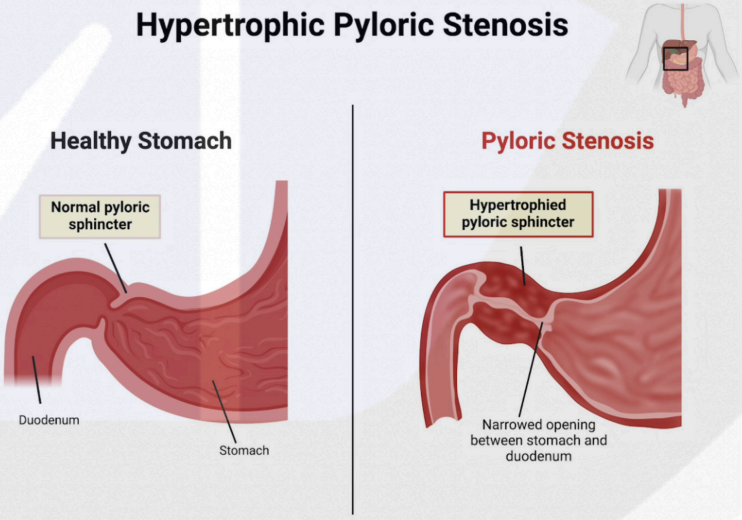
NOTES:



NOTES:



NOTES:



REMEMBER

Next Gen PASSERS NCLEX

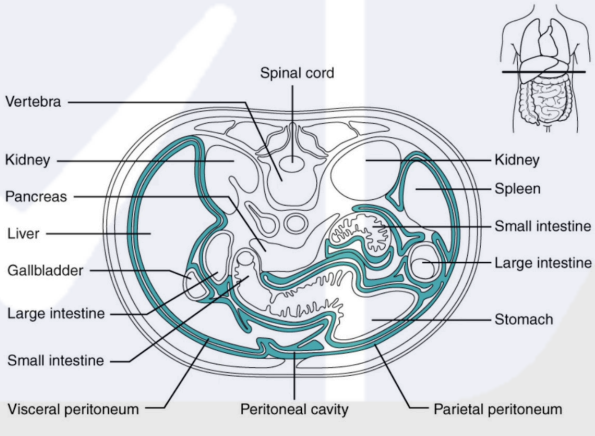
NOTES:



Intussusception of the Bowel

NOTES:

Anatomy of the Peritoneum



Transverse Sectional View



Sagittal View

For each potential intervention, click to specify whether the potential intervention is indicated or contraindicated for the care of the client.

Potential Interventions	Indicated	Contraindicated
1. Maintain NPO status.		
2. Administer loperamide.		
3. Prepare for a barium swallow.		
4. Prepare for abdominal ultrasound.		
5. Collect blood for a basic metabolic panel.		
6. Prepare for reduction of telescoped bowel.		

ITEM 4 OF 6

Nurses' Notes | Vital Signs

1415:
Ultrasonography results confirmed the presence of intussusception. Hydrostatic enema for reduction planned for 1500.

1430:
Called to the bedside by the client's mother. The client is tense, guarding his abdomen, diaphoretic, and crying. The client's mother reports emesis x 1 and states that the client has become increasingly irritable in the last 10 minutes. Upon physical examination of the client's abdomen, it has become more distended and firm.

NOTES:

Nurses' Notes | **Vital Signs**

	Day 1: 1330	Day 1: 1430
T	99.1 F (37.2 C)	101.6 F (38.7 C)
P	151	197
RR	41	55
BP	101/52	75/43
Pulse oximetry reading	99% on room air	92% on room air

ITEM 5 OF 6

The nurse reviews the Nurses' Notes from 1415 and 1430 and the Vital Signs from 1430.

What are the **4 most important interventions** to perform at this time?

1. Insert nasogastric tube.
2. Administer IV ampicillin.
3. Administer IV ondansetron.
4. Obtain an arterial blood gas.
5. Provide supplemental oxygen.
6. Administer IV normal saline bolus.
7. Insert an indwelling urinary catheter.
8. Obtain signed consent for surgery from the client's mother.

NOTES:

ITEM 6 OF 6

Nurses' Notes

Pediatric Intensive Care Unit
1500:

Client is postoperative on day 3 following an intussusception and bowel perforation repair. Upon entering the room, the client is lying in his crib, sucking on his thumb and drooling onto his gown. Client's breath sounds are clear and equal. S1 and S2 heart sounds auscultated. The child is guarding his abdomen during the abdominal assessment. Abdomen is rigid. Shiny, taut, and erythematous skin present at the surgical incision site, and the abdominal girth has increased by 2 cm from the last measurement. Auscultation reveals normoactive bowel sounds. Client voided and stooled in his diaper; the bowel movement is brown and soft. Mom states the client drank his entire bottle of formula an hour ago but feels "warmer than usual" and then leaves the room to take a phone call. The client cries immediately after his mother leaves the room.

ITEM 6 OF 6

The client underwent immediate surgery for intussusception and bowel perforation repair. The nurse reviews the Nurses' Notes from Day 4 at 1500.

Findings	Require Follow-up
1. Bowel movement is brown and soft. 2. Client cries when his mother leaves the room. 3. Mother states the client feels "warmer than usual." 4. Client is sucking his thumb and drooling onto his gown. 5. Shiny and taut erythematous skin at the surgical incision. 6. Abdominal girth has increased 2 cm since the last measurement.	

NOTES:

NurseAdemy
ESTUDIA ONLINE

"Every day it's a new opportunity!"

NEXT GENERATION
NCLEX®
Bilingual Review





Jeinis De Jesús Hernández
RN|MSN|CNS
RN License | US:209364
MSN License | PR:003381

Mizraim Marcano Meléndez
RN|MSN|CNS
RN License | US:9654014
MSN License | PR:003387

www.NurseAdemy.com
305-768-1038
info@nurseademy.com