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Leading Regulatory Excellence

Next Generation NCLEX®

Sample Pack

Next Generation NCLEX®

RN Case Study: Sepsis

The nurse in the emergency department (ED) is caring for a 78-year-old female client.

Nurses' Notes

1000: Client was brought to the ED by the client's adult child due to increased shortness of breath this morning. The adult child reports that the client has been running a fever for the past few days and has started to cough up greenish mucus and to complain of soreness throughout the body. Client was hospitalized for issues with atrial fibrillation 6 days ago. History of hypertension. Vital signs: T 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. On assessment, the client's breathing appears slightly labored, and coarse crackles (rales) are noted in the bilateral lung bases. Skin slightly cool to touch and pale pink in tone; pulses 3+ and irregular. Capillary refill is 3 seconds. Client is alert and oriented to person, place, and time. The adult child states, "Sometimes it seems like my parent is confused." Peripheral venous access device (VAD) placed in right forearm.

Select the 4 client findings that require **immediate** follow-up.

- [ ] 1. vital signs
- [ ] 2. lung sounds
- [ ] 3. capillary refill
- [ ] 4. client orientation
- [ ] 5. radial pulse characteristics
- [ ] 6. characteristics of the cough

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For each client finding below, click to specify if the finding is consistent with the disease process of pneumonia, a urinary tract infection (UTI), or influenza. Each finding may support more than 1 disease process.

Client Findings	Pneumonia	Urinary Tract Infection	Influenza
fever	☐	☐	☐
confusion	☐	☐	☐
body soreness	☐	☐	☐
cough and sputum	☐	☐	☐
shortness of breath	☐	☐	☐

Note: Each column must have at least 1 response option selected.

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

The client is at **highest** risk for developing Select… .

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

The client is at **highest** risk for developing Select… .

- Select…
- stroke
- hypoxia
- dysrhythmias
- a pulmonary embolism

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1200: Called to bedside by the adult child who states that the client "isn't acting right." On assessment, client is difficult to arouse, pale, and diaphoretic. Vital signs: P 112, RR 32, BP 90/62, pulse oximetry reading 91% on 2 L/min of oxygen via nasal cannula.

The nurse has reviewed the Nurses' Notes from 1200.

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

Potential Nursing Interventions	Indicated	Not Indicated
Prepare the client for defibrillation.	○	○
Place client in a semi-Fowler's position.	○	○
Request an order to increase the oxygen flow rate.	○	○
Request an order to insert an additional peripheral VAD.	○	○
Request an order to administer an intravenous fluid bolus.	○	○

Note: Each row must have 1 response option selected.

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The nurse has reviewed the Orders from 1215.

Click to highlight the orders that the nurse should consider a **priority**.

Orders

1215:

- insert an indwelling urethral catheter
- vancomycin 1 g, IV, every 12 hours
- computed tomography (CT) scan of the chest
- 0.9% sodium chloride (normal saline) 500 mL, IV, once
- laboratory tests: blood culture and sensitivity (C & S), complete blood count (CBC), arterial blood gas (ABG)

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Nurses' Notes | **Orders**

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For each assessment finding, click to specify if the finding indicates that the client's condition has improved, not changed, or worsened.

Assessment Findings	Improved	Not Changed	Worsened
pale skin tone	○	○	○
respirations, 36	○	○	○
blood pressure, 118/68	○	○	○
pulse oximetry reading 91%	○	○	○
client interacting with adult child at bedside	○	○	○

Note: Each row must have 1 response option selected.

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pale skin tone	○	○	○
respirations, 36	○	○	○
blood pressure, 118/68	○	○	○
pulse oximetry reading 91%	○	○	○
client interacting with adult child at bedside	○	○	○

Note: Each row must have 1 response option selected.

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RN Case Study: Splenic Laceration

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Pulmonary	denies shortness of breath; reports discomfort in the lower left side of chest when taking a deep breath
Gastrointestinal	reports feeling abdominal fullness and is occasionally nauseated
Musculoskeletal	sustained an injury to the left rib cage after being struck by a mechanically pitched baseball in a batting cage last week; reports intermittent pain in the left shoulder rated 6/10 on the Numerical Rating Scale and feels light-headed; significant bruising to the shoulder; history of an orthoscopic repair to the left shoulder for a torn rotator cuff last year
Psychosocial	client has not felt well enough to attend baseball practice since the injury

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

- [ ] 1. lung sounds
- [ ] 2. shoulder pain
- [ ] 3. laboratory results
- [ ] 4. productive cough
- [ ] 5. abdominal assessment findings
- [ ] 6. pulse, respirations, and blood pressure
- [ ] 7. temperature and pulse oximetry reading

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RN Case Study: Splenic Laceration

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Emergency Department

Day 1

0900: Client appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUQ) of the abdomen. Tenderness, guarding, and dullness to percussion noted on abdominal assessment. Slightly diminished breath sounds noted in the left lung fields on auscultation; client has a productive cough. Electrocardiogram (ECG) shows normal sinus rhythm.

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

1. lung sounds
2. shoulder pain
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4. productive cough
5. abdominal assessment findings
6. pulse, respirations, and blood pressure
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The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

	Emergency Department Day 1 0900
T	97.8° F (36.6° C)
P	116
RR	24
BP	90/50
Pulse oximetry reading	98% on room air

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

1. lung sounds
2. shoulder pain
3. laboratory results
4. productive cough
5. abdominal assessment findings
6. pulse, respirations, and blood pressure
7. temperature and pulse oximetry reading

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History and Physical | Nurses' Notes | Vital Signs | **Laboratory Results**

Laboratory Test and Reference Range	Emergency Department Day 1 0900
white blood cell (WBC) count Adult/child > 2 years: 5,000–10,000/mm^3 (5–10 x 10^9/L)	19,000/mm^3 (19 x 10^9/L)
hemoglobin (Hgb) Male: 14–18 g/dL (140–180 g/L) Female: 12–16 g/dL (120–160 g/L)	9 g/dL (90 g/L)
hematocrit (HCT) Male: 42%–52% (0.42–0.52) Female: 37%–47% (0.37–0.47)	27% (0.27)

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

1. lung sounds
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5. abdominal assessment findings
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Psychosocial	client has not felt well enough to attend baseball practice since the injury

Which of the following issues is the client at risk of developing? **Select all that apply.**

- [ ] 1. stroke
- [ ] 2. hemothorax
- [ ] 3. bowel perforation
- [ ] 4. splenic laceration
- [ ] 5. pulmonary embolism
- [ ] 6. abdominal aortic aneurysm

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History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

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Psychosocial	client has not felt well enough to attend baseball practice since the injury

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

The nurse should **first** address the client's Select… .

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History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

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Psychosocial	client has not felt well enough to attend baseball practice since the injury

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

The nurse should **first** address the client's Select… .

- Select…
- abdominal pain
- respiratory status
- laboratory results

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History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Emergency Department

Day 1

0900: Client appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUQ) of the abdomen. Tenderness, guarding, and dullness to percussion noted on abdominal assessment. Slightly diminished breath sounds noted in the left lung fields on auscultation; client has a productive cough. Electrocardiogram (ECG) shows normal sinus rhythm.

1000: Client diagnosed with a splenic laceration and a left-sided hemothorax per the physician.

The nurse has reviewed the Nurses' Notes from 1000.

For each potential order, click to specify whether the potential order is indicated or not indicated for the client.

Potential Orders	Indicated	Not Indicated
intravenous fluids	○	○
serum type and screen	○	○
chest percussion therapy	○	○
insertion of a nasogastric (NG) tube	○	○
administration of prescribed pain medication	○	○

Note: Each row must have 1 response option selected.

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RN Case Study: Splenic Laceration

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History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Emergency Department

Day 1

0900: Client appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUG) of the abdomen. Tenderness, guarding, and dullness to percussion noted on abdominal assessment. Slightly diminished breath sounds noted in the left lung fields on auscultation; client has a productive cough. Electrocardiogram (ECG) shows normal sinus rhythm.

1000: Client diagnosed with a splenic laceration and a left-sided hemothorax per the physician.

1030: Client referred for immediate surgery.

The nurse has reviewed the Nurses' Notes from 1030.

Which of the following actions should the nurse take?
Select all that apply.

- [ ] 1. Mark the surgical site.
- [ ] 2. Provide the client with ice chips.
- [ ] 3. Perform a medication reconciliation.
- [ ] 4. Obtain consent for surgery from the client.
- [ ] 5. Insert a peripheral venous access device (VAD).
- [ ] 6. Inform the client about the risks and benefits of the surgery.
- [ ] 7. Assess the client's previous experience with surgery and anesthesia.
- [ ] 8. Ask the client's parents to wait in the waiting room while the plan of care is discussed with the client.

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Psychosocial	client has not felt well enough to attend baseball practice since the injury

The nurse has reviewed the Progress Notes from 0800.

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

Progress Notes

Day 3

0800: Client is postoperative day 3 after a splenectomy and is able to ambulate in the corridor 3 or 4 times daily with minimal assistance. Client has clear breath sounds a left-sided chest tube in place attached to a closed-chest drainage system. Tidaling of the water chamber noted on deep inspiration. Client refuses to use the incentive spirometer, stating it causes left-sided chest pain. Client is using prescribed patient-controlled analgesia (PCA) device maximally every hour and continues to have intermittent nausea and vomiting. Adequate urine output. Abdominal surgical incision site with dressing is clean, dry, and intact with no erythema, edema, or drainage.

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RN Case Study: Splenic Laceration

The nurse in the emergency department (ED) is caring for a 17-year-old male client.

History and Physical | **Nurses' Notes** | **Vital Signs** | **Laboratory Results**

Body System	Findings
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The nurse has reviewed the Progress Notes from 0800.

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RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

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

Nurses' Notes

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

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RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

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

Nurses' Notes

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

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RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

For each assessment finding below, click to specify if the finding is consistent with the disease process of bowel obstruction, appendicitis, or ruptured spleen. Each finding may support more than 1 disease process.

Assessment Findings	Bowel Obstruction	Appendicitis	Ruptured Spleen
appetite	☐	☐	☐
pain level	☐	☐	☐
bowel pattern	☐	☐	☐
gastrointestinal symptoms	☐	☐	☐

Note: Each column must have at least 1 response option selected.

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RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes

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Select the 3 complications the client is at risk for developing.

1. anemia
2. peritonitis
3. septic shock
4. hypovolemia
5. dysrhythmias
6. cardiac arrest

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RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

1130: Notified primary health care provider about client status. Awaiting orders.

The nurse has reviewed the Nurses' Notes from 1130.

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

Potential Interventions	Indicated	Not Indicated
clear liquid diet	○	○
soapsuds enema	○	○
heating pad to abdomen	○	○
abdominal girth measurements	○	○
abdominal computed tomography (CT) scan	○	○

Note: Each row must have 1 response option selected.

Next Generation NCLEX®

RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

1130: Notified primary health care provider about client status. Awaiting orders.

1230: Client transported to radiology department for abdominal computed tomography (CT) scan.

1245: 20-gauge peripheral venous access device (VAD) inserted into the left hand. VAD site patent without signs of infiltration. 0.9% sodium chloride (normal saline) infusing at 75 mL/hr.

1400: Client reports sudden relief of abdominal pain. Vital signs: T 102.5° F (39.2° C), P 110, RR 20, BP 125/86.

1415: Primary health care provider notified about client status. Order received for an additional abdominal CT scan. Client transported to radiology department.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

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

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

The nurse should prepare the client for surgery within Select… .

Next Generation NCLEX®

RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

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

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

The nurse should prepare the client for surgery within Select… .

Next Generation NCLEX®

RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

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

The nurse should insert Select… .

Select…
a rectal tube
a nasogastric (NG) tube
an indwelling urethral catheter

It would be a **priority** for
prescription for an Selec

The nurse should prepare lect… .

Next Generation NCLEX®

RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

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

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

- Select…
- analgesic medication
- antipyretic medication
- anti-infective medication

The nurse should p…y within Select… .

Next Generation NCLEX®

RN Case Study: Ruptured Appendix

The nurse in the emergency department (ED) is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

1445: Free intraperitoneal fluid noted consistent with a ruptured appendix.

The nurse has reviewed the Nurses' Notes from 1230, 1245, 1400, and 1415 and the Diagnostic Results from 1230 and 1445.

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

The nurse should insert Select… .

It would be a **priority** for the nurse to request a prescription for an Select… .

The nurse should prepare the client for surgery within Select… .

Select…
6 hours
8 hours
24 hours

Next Generation NCLEX®

RN Case Study: Ruptured Appendix

The nurse in the medical-surgical unit is caring for a 41-year-old male client.

Nurses' Notes | **Diagnostic Results**

Emergency Department

1100: Client reports nausea, loss of appetite, vomiting, fever, and constipation for the past 2 weeks and abdominal pain rated 7/10 on the Numerical Rating Scale for 1 week. Client states, "The abdominal pain started after my 7-year-old child accidentally kicked me in the stomach." Client plays soccer with the child once a week. Vital signs: T 103.4° F (39.7° C), P 92, RR 22, BP 130/86, pulse oximetry reading 98% on room air. No significant past medical or surgical history. Body mass index (BMI) of 32. Drinks alcohol only during social occasions, usually 3 beverages. Smokes cigarettes during social occasions.

1130: Notified primary health care provider about client status. Awaiting orders.

1230: Client transported to radiology department for abdominal computed tomography (CT) scan.

1245: 20-gauge peripheral venous access device (VAD) inserted into the left hand. VAD site patent without signs of infiltration. 0.9% sodium chloride (normal saline) infusing at 75 mL/hr.

1400: Client reports sudden relief of abdominal pain. Vital signs: T 102.5° F (39.2° C), P 110, RR 20, BP 125/86.

1415: Primary health care provider notified about client status. Order received for an additional abdominal CT scan. Client transported to radiology department.

1800: Client transported to the operating room for an open appendectomy.

Medical-Surgical Unit

2030: Client transported back to the medical-surgical unit.

2230: Client performing coughing and deep-breathing exercises every hour while awake with the incentive spirometer. Performing postoperative leg exercises every hour while awake. Nasogastric (NG) tube removed. Drinking clear liquids. Abdomen boardlike with diminished bowel sounds in all quadrants. Rebound tenderness present.

The nurse has reviewed the Nurses' Notes from 1800, 2030, and 2230.

Which of the following findings would indicate the client is progressing as expected? **Select all that apply.**

- [ ] 1. clear liquid diet
- [ ] 2. boardlike abdomen
- [ ] 3. rebound tenderness
- [ ] 4. incentive spirometry use
- [ ] 5. diminished bowel sounds
- [ ] 6. performance of leg exercises

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the outpatient clinic is caring for a 38-year-old female client.

Progress Notes

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

Day 13

0900: Client returns to clinic reporting that left ear pain was reduced after completing azithromycin treatment, but it recurred 3 days ago. Yesterday, client observed drops of blood on pillow case. Reports bile-colored emesis last evening after eating dinner. Reports having no oral intake today. Client states, “I have not had an appetite for over a week.” Client is febrile and experiencing dizziness, vertigo, and tenderness over the left mastoid process. Purulent drainage observed in the left ear canal. Tympanic membrane is dull and bulging on otoscopic examination. Client reports decreased hearing in the left ear and onset of a headache. Abdomen soft with hypoactive bowel sounds. Last bowel movement was yesterday of formed, brown stool. Sinuses, chest, and throat clear without congestion. 12-lead electrocardiogram (ECG) reveals normal sinus rhythm.

The nurse has collected data from the client.

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

- [ ] 1. vertigo
- [ ] 2. appetite
- [ ] 3. vomiting
- [ ] 4. headache
- [ ] 5. bowel sounds
- [ ] 6. cardiac rhythm

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the outpatient clinic is caring for a 38-year-old female client.

Progress Notes

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

Day 13

0900: Client returns to clinic reporting that left ear pain was reduced after completing azithromycin treatment, but it recurred 3 days ago. Yesterday, client observed drops of blood on pillow case. Reports bile-colored emesis last evening after eating dinner. Reports having no oral intake today. Client states, “I have not had an appetite for over a week.” Client is febrile and experiencing dizziness, vertigo, and tenderness over the left mastoid process. Purulent drainage observed in the left ear canal. Tympanic membrane is dull and bulging on otoscopic examination. Client reports decreased hearing in the left ear and onset of a headache. Abdomen soft with hypoactive bowel sounds. Last bowel movement was yesterday of formed, brown stool. Sinuses, chest, and throat clear without congestion. 12-lead electrocardiogram (ECG) reveals normal sinus rhythm.

The nurse has reviewed the collected data with the registered nurse.

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

- [ ] 1. leukopenia
- [ ] 2. paralytic ileus
- [ ] 3. fluid imbalance
- [ ] 4. injury from falling
- [ ] 5. venous thrombosis

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the outpatient clinic is caring for a 38-year-old female client.

Progress Notes

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

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The nurse has collaborated with the registered nurse.

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

The client is at **highest** risk for developing Select… .

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the outpatient clinic is caring for a 38-year-old female client.

Progress Notes

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

Day 13

0900: Client returns to clinic reporting that left ear pain was reduced after completing azithromycin treatment, but it recurred 3 days ago. Yesterday, client observed drops of blood on pillow case. Reports bile-colored emesis last evening after eating dinner. Reports having no oral intake today. Client states, “I have not had an appetite for over a week.” Client is febrile and experiencing dizziness, vertigo, and tenderness over the left mastoid process. Purulent drainage observed in the left ear canal. Tympanic membrane is dull and bulging on otoscopic examination. Client reports decreased hearing in the left ear and onset of a headache. Abdomen soft with hypoactive bowel sounds. Last bowel movement was yesterday of formed, brown stool. Sinuses, chest, and throat clear without congestion. 12-lead electrocardiogram (ECG) reveals normal sinus rhythm.

The nurse has collaborated with the registered nurse.

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

The client is at **highest** risk for developing [Select…] .

- Select…
- meningitis
- otosclerosis
- Ménière disease

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the medical-surgical unit is caring for a 38-year-old female client.

Progress Notes | **History and Physical**

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

Day 13

0900: Client returns to clinic reporting that left ear pain was reduced after completing azithromycin treatment, but it recurred 3 days ago. Yesterday, client observed drops of blood on pillow case. Reports bile-colored emesis last evening after eating dinner. Reports having no oral intake today. Client states, "I have not had an appetite for over a week." Client is febrile and experiencing dizziness, vertigo, and tenderness over the left mastoid process. Purulent drainage observed in the left ear canal. Tympanic membrane is dull and bulging on otoscopic examination. Client reports decreased hearing in the left ear and onset of a headache. Abdomen soft with hypoactive bowel sounds. Last bowel movement was yesterday of formed, brown stool. Sinuses, chest, and throat clear without congestion. 12-lead electrocardiogram (ECG) reveals normal sinus rhythm.

0930: Client transferred to hospital for further evaluation and treatment.

Medical-Surgical Unit

1000: Client admitted for recurring otitis media and worsening of symptoms.

The nurse has reviewed the Progress Notes from 0930 and 1000 and the History and Physical findings and is contributing to the client's plan of care.

Which of the following health care orders should the nurse anticipate? **Select all that apply.**

- [ ] 1. lumbar puncture
- [ ] 2. indwelling urethral catheter
- [ ] 3. airborne isolation precautions
- [ ] 4. culture and sensitivity (C & S) testing of ear drainage
- [ ] 5. psychiatric consultation for evaluation of abnormal grief
- [ ] 6. computed tomography (CT) scan of the head and left ear

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the medical-surgical unit is caring for a 38-year-old female client.

Progress Notes | **History and Physical**

Body System	Findings
Neurological	alert and oriented to person, place, and time; uncomfortable and becoming irritable
Eye, Ear, Nose, and Throat (EENT)	admitted for recurring otitis media and worsening symptoms
Pulmonary	vital signs: RR 18, pulse oximetry reading 97% on room air; lung sounds clear bilaterally; quit smoking cigarettes 3 years ago after a bacterial pneumonia infection
Cardiovascular	vital signs: T 100.6° F (38.1° C), P 110, BP 107/72; first heart sound (S_1) and second heart sound (S_2) heard on auscultation; peripheral pulses 2+; experiencing vertigo and headache
Gastrointestinal	weight loss of 12 lb (5.5 kg) in 2 weeks; reported experiencing anorexia for the past week; nausea and vomiting once yesterday
Musculoskeletal	generalized weakness
Genitourinary	voided 450 mL of amber-colored urine
Immunological	past anaphylactic reactions to penicillin and cefotaxime
Pyschosocial	married, lives with spouse and children; states, “The last time I was in a hospital was when my 11-year-old child died 2 years ago”; reports that the oldest child of 3 was hit by a motor vehicle and died; states, “It was very sad. My faith got me through it.”

The nurse has reviewed the Progress Notes from 0930 and 1000 and the History and Physical findings and is contributing to the client’s plan of care.

Which of the following health care orders should the nurse anticipate? **Select all that apply.**

- [ ] 1. lumbar puncture
- [ ] 2. indwelling urethral catheter
- [ ] 3. airborne isolation precautions
- [ ] 4. culture and sensitivity (C & S) testing of ear drainage
- [ ] 5. psychiatric consultation for evaluation of abnormal grief
- [ ] 6. computed tomography (CT) scan of the head and left ear

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the medical-surgical unit is caring for a 38-year-old female client.

Progress Notes | **History and Physical** | **Diagnostic Results** | **Laboratory Results**

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

Day 13

0900: Client returns to clinic reporting that left ear pain was reduced after completing azithromycin treatment, but it recurred 3 days ago. Yesterday, client observed drops of blood on pillow case. Reports bile-colored emesis last evening after eating dinner. Reports having no oral intake today. Client states, "I have not had an appetite for over a week." Client is febrile and experiencing dizziness, vertigo, and tenderness over the left mastoid process. Purulent drainage observed in the left ear canal. Tympanic membrane is dull and bulging on otoscopic examination. Client reports decreased hearing in the left ear and onset of a headache. Abdomen soft with hypoactive bowel sounds. Last bowel movement was yesterday of formed, brown stool. Sinuses, chest, and throat clear without congestion. 12-lead electrocardiogram (ECG) reveals normal sinus rhythm.

0930: Client transferred to hospital for further evaluation and treatment.

Medical-Surgical Unit

1000: Client admitted for recurring otitis media and worsening symptoms.

Day 14

1000: Client transferred to preoperative suite for scheduled mastoidectomy.

1600: Client transferred from postanesthesia care unit (PACU). Tolerated surgery without complications. Returned to medical-surgical unit in stable condition.

The nurse has reviewed the Progress Notes from 1000 and 1600, the Diagnostic Results from 1100 and 1300, and the Laboratory Results from 0830, all from Day 14, and is implementing the client's plan of care.

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

Potential Nursing Interventions	Indicated	Not Indicated
Keep the client supine for 24 hours.	○	○
Assess for bleeding from the left ear.	○	○
Administer antiemetics to prevent vomiting.	○	○
Reinforce the importance of coughing to clear the airway.	○	○

Note: Each row must have at least 1 response option selected.

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the medical-surgical unit is caring for a 38-year-old female client.

Progress Notes | **History and Physical** | **Diagnostic Results** | **Laboratory Results**

Day 14

Lumbar puncture

1100: Cerebral spinal fluid negative for infection.

Computed tomography (CT) scan of the head and left ear

1300: Negative for lesions or abscess. Inflammation of left mastoid bone. Large fluid collection noted in inner ear and middle ear.

The nurse has reviewed the Progress Notes from 1000 and 1600, the Diagnostic Results from 1100 and 1300, and the Laboratory Results from 0830, all from Day 14, and is implementing the client's plan of care.

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

Potential Nursing Interventions	Indicated	Not Indicated
Keep the client supine for 24 hours.	○	○
Assess for bleeding from the left ear.	○	○
Administer antiemetics to prevent vomiting.	○	○
Reinforce the importance of coughing to clear the airway.	○	○

Note: Each row must have at least 1 response option selected.

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the medical-surgical unit is caring for a 38-year-old female client.

Progress Notes | History and Physical | Diagnostic Results | Laboratory Results

Laboratory Test and Reference Range	Day 14 0830
left ear drainage specimen for culture and sensitivity (C & S) negative	pending

The nurse has reviewed the Progress Notes from 1000 and 1600, the Diagnostic Results from 1100 and 1300, and the Laboratory Results from 0830, all from Day 14, and is implementing the client's plan of care.

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

Potential Nursing Interventions	Indicated	Not Indicated
Keep the client supine for 24 hours.	○	○
Assess for bleeding from the left ear.	○	○
Administer antiemetics to prevent vomiting.	○	○
Reinforce the importance of coughing to clear the airway.	○	○

Note: Each row must have at least 1 response option selected.

Next Generation NCLEX®

PN Case Study: Mastoiditis

The nurse in the medical-surgical unit is caring for a 38-year-old female client.

Progress Notes | **History and Physical** | **Diagnostic Results** | **Laboratory Results**

Clinic Visit

Day 1

1300: Client reports pain in left ear for the past 2 days. Experienced pain in the same ear last month but was able to tolerate the pain and self-treat with over-the counter (OTC) medications. Client is febrile with small amount of cerumen observed in left ear canal. Prescribed azithromycin 500 mg, p.o., today, then 250 mg, p.o., daily for 4 days.

Day 13

0900: Client returns to clinic reporting that left ear pain was reduced after completing azithromycin treatment, but it recurred 3 days ago. Yesterday, client observed drops of blood on pillow case. Reports bile-colored emesis last evening after eating dinner. Reports having no oral intake today. Client states, "I have not had an appetite for over a week." Client is febrile and experiencing dizziness, vertigo, and tenderness over the left mastoid process. Purulent drainage observed in the left ear canal. Tympanic membrane is dull and bulging on otoscopic examination. Client reports decreased hearing in the left ear and onset of a headache. Abdomen soft with hypoactive bowel sounds. Last bowel movement was yesterday of formed, brown stool. Sinuses, chest, and throat clear without congestion. 12-lead electrocardiogram (ECG) reveals normal sinus rhythm.

0930: Client transferred to hospital for further evaluation and treatment.

Medical-Surgical Unit

1000: Client admitted for recurring otitis media and worsening symptoms.

Day 14

1000: Client transferred to preoperative suite for scheduled mastoidectomy.

1600: Client transferred from postanesthesia care unit (PACU). Tolerated surgery without complications. Returned to medical-surgical unit in stable condition.

Day 15

1400: Discharged client to home with postsurgical instructions. Follow-up appointment scheduled in 1 week.

The nurse has reviewed the Progress Notes from 1400 and has reinforced teaching with the client.

For each of the statements made by the client, click to specify whether the statement indicates an understanding or no understanding of the discharge teaching provided.

Client Statements	Understanding	No Understanding
"I should avoid blowing my nose."	○	○
"I will experience some permanent hearing loss."	○	○
"I should check with my physician before I travel by air again."	○	○
"I will stop taking the anti-infective as soon as I no longer have ear pain."	○	○
"I should not shampoo my hair until my physician instructs me to do so."	○	○

Note: Each row must have 1 response option selected.

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

The nurse has collected data from the client.

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

1. pulse
2. respirations
3. diaphoresis
4. piloerection
5. blood pressure
6. serum blood glucose result
7. wearing low-top athletic shoes

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

Body System	Findings
Neurological	spinal cord injury at C4 from a gunshot injury 2 years ago; uses sip-and-puff wheelchair
Pulmonary	receiving pressure-controlled portable mechanical ventilation, tracheostomy
Endocrine	diabetes mellitus (type 1)
Psychosocial	family lives 3 hours away from the facility and sends the client designer clothing and gifts once a month; friends have not visited the client in 1.5 years; client prefers to sit in room alone rather than interact with other residents

The nurse has collected data from the client.

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

- [ ] 1. pulse
- [ ] 2. respirations
- [ ] 3. diaphoresis
- [ ] 4. piloerection
- [ ] 5. blood pressure
- [ ] 6. serum blood glucose result
- [ ] 7. wearing low-top athletic shoes

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

	1100
T	99.0° F (37.2° C)
P	56
RR	18
BP	192/102
Pulse oximetry reading	97% on mechanical ventilation

The nurse has collected data from the client.

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

1. pulse
2. respirations
3. diaphoresis
4. piloerection
5. blood pressure
6. serum blood glucose result
7. wearing low-top athletic shoes

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

Laboratory Test and Reference Range	0900
serum glucose, 2-hour postprandial 0–50 years: < 140 mg/dL (< 7.8 mmol/L)	140 mg/dL (7.8 mmol/L)

The nurse has collected data from the client.

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

1. pulse
2. respirations
3. diaphoresis
4. piloerection
5. blood pressure
6. serum blood glucose result
7. wearing low-top athletic shoes

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

1115: Intermittent urethral catheterization was performed, and 400 mL of clear yellow urine was obtained. Client has facial flushing and foul-smelling liquid stool leaking from the anus. Semi-firm mass is still present in the LLQ of the abdomen.

The nurse has reviewed the collected data from the Nurses' Notes at 1115 with the registered nurse.

Drag each word choice from below to fill in each blank in the following sentence.

The nurse should recognize that the client is potentially experiencing [Word Choice] and [Word Choice].

Word Choices
an infection
urinary retention
a fecal impaction
autonomic dysreflexia

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

1115: Intermittent urethral catheterization was performed, and 400 mL of clear yellow urine obtained. Client has facial flushing and foul-smelling liquid stool leaking from the anus. Semi-firm mass is still present in the LLQ of the abdomen.

1130: Client reports a headache rated 10/10 on the Numerical Rating Scale and blurred vision.

The nurse has reviewed the Nurses' Notes from 1130 and has collaborated with the registered nurse.

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

The nurse should recognize that the client is **most** likely experiencing Select… ▾ .

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

1115: Intermittent urethral catheterization was performed, and 400 mL of clear yellow urine obtained. Client has facial flushing and foul-smelling liquid stool leaking from the anus. Semi-firm mass is still present in the LLQ of the abdomen.

1130: Client reports a headache rated 10/10 on the Numerical Rating Scale and blurred vision.

The nurse has reviewed the Nurses' Notes from 1130 and has collaborated with the registered nurse.

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

The nurse should recognize that the client is **most** likely experiencing Select… .

- Select…
- an infection
- autonomic dysreflexia
- an abdominal aneurysm

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

1115: Intermittent urethral catheterization was performed, and 400 mL of clear yellow urine obtained. Client has facial flushing and foul-smelling liquid stool leaking from the anus. Semi-firm mass is still present in the LLQ of the abdomen.

1130: Client reports a headache rated 10/10 on the Numerical Rating Scale and blurred vision.

The nurse is contributing to the client's plan of care.

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

Potential Nursing Interventions	Indicated	Not Indicated
Place the client in the left lateral position.	○	○
Remove the client's low-top athletic shoes.	○	○
Inform the client that the Credé method will be performed.	○	○
Request a prescription for an over-the-counter (OTC) laxative.	○	○

Note: Each row must have 1 response option selected.

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

1115: Intermittent urethral catheterization was performed, and 400 mL of clear yellow urine obtained. Client has facial flushing and foul-smelling liquid stool leaking from the anus. Semi-firm mass is still present in the LLQ of the abdomen.

1130: Client reports a headache rated 10/10 on the Numerical Rating Scale and blurred vision.

The nurse is implementing the client's plan of care.

Select 2 actions the nurse should take.

1. Request a prescription for hydralazine.
2. Place the client in Trendelenburg's position.
3. Check the client's blood pressure every 30 minutes.
4. Apply lubricant to gloved fingers to remove fecal impaction.
5. Inform the client that a magnetic resonance imaging (MRI) scan will be performed.

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

1100: Client has piloerection on the arms and legs and diaphoresis on the forehead. Client is wearing new, low-top athletic shoes purchased by the client's parents instead of prescribed foot splints. During abdominal palpation, a semi-firm mass is noted in the left lower quadrant (LLQ). Bladder is nonpalpable.

1115: Intermittent urethral catheterization was performed, and 400 mL of clear yellow urine obtained. Client has facial flushing and foul-smelling liquid stool leaking from the anus. Semi-firm mass is still present in the LLQ of the abdomen.

1130: Client reports a headache rated 10/10 on the Numerical Rating Scale and blurred vision.

1145: Elevated the head of the client's bed and removed the client's low-top athletic shoes. Requested a prescription for digital fecal impaction removal and lidocaine lubricant.

1200: Client is having tonic-clonic seizures, so the client has been placed in side-lying position.

The nurse has reviewed the Nurses' Notes from 1145 and 1200 and the Vital Signs from 1145 and is assisting to evaluate the client's status.

For each data collection finding, click to specify whether the finding indicates that the client's status has worsened or is unchanged.

Data Collection Findings	Worsened	Unchanged
pulse	○	○
respirations	○	○
blood pressure	○	○
tonic-clonic seizures	○	○

Note: Each row must have 1 response option selected.

Next Generation NCLEX®

PN Case Study: Autonomic Dysreflexia

The nurse in the long-term care facility is caring for a 19-year-old client.

Nurses' Notes | **History and Physical** | **Vital Signs** | **Laboratory Results**

	1100	1145
T	99.0° F (37.2° C)	98.9° F (37.2° C)
P	56	47
RR	18	17
BP	192/102	223/115
Pulse oximetry reading	97% on mechanical ventilation	96% on mechanical ventilation

The nurse has reviewed the Nurses' Notes from 1145 and 1200 and the Vital Signs from 1145 and is assisting to evaluate the client's status.

For each data collection finding, click to specify whether the finding indicates that the client's status has worsened or is unchanged.

Data Collection Findings	Worsened	Unchanged
pulse	○	○
respirations	○	○
blood pressure	○	○
tonic-clonic seizures	○	○

Note: Each row must have 1 response option selected.

Next Generation NCLEX®

RN Stand-Alone Trend Examples

Example 1

The home-health nurse is caring for a 2-month-old client.

Nurses' Notes

Weekly Visit 1

1000: Client is sleepy. Parent reports that the client breast-feeds on demand approximately 8 times daily. Weight is below the 5th percentile at 7 lb (3.2 kg). Physician notified.

Weekly Visit 2

1030: Client is alert but irritable. Parent reports that the client breast-feeds on demand, fluctuating from 6 to 8 times daily. Weight is below the 5th percentile at 6 lb 9 oz (3.0 kg), with a 6.3% weight loss. Parent is visibly upset after viewing client's current weight. Physician notified.

Weekly Visit 3

0900: Client is lethargic. Parent reports that the client is still breast-feeding on demand, fluctuating from 6 to 8 times daily. Weight remains below the 5th percentile at 6 lb 2 oz (2.8 kg), with a 12.5% total weight loss. Physician contacted; awaiting orders.

Drag words from the choices below to fill in each blank in the following sentence.

The nurse should anticipate that the physician will instruct the parent to

Word Choice and Word Choice .

Word Choices
fortify the breast milk
complete a feeding log
feed the client formula for 2 weeks
increase the parent's caloric intake
consult a pediatric surgeon for placement of a gastrostomy tube

Next Generation NCLEX®

RN Stand-Alone Trend Examples

Example 2

The nurse in the emergency department (ED) is caring for a 10-day-old client.

Flow Sheet

	1000	1400	1800
Intake	480 mL (formula)	60 mL (formula)	60 mL (formula)
Output	3 small yellow stools	40 mL (emesis)	40 mL (emesis)

Nurses' Notes

1000: Parent reports that the client has been vomiting after drinking each bottle of formula. Parent estimates the client is vomiting half of each bottle with each feeding. Client triaged. Vital signs: T 97.7° F (36.5° C), P 124, RR 30.

1400: Client experienced projectile vomiting 30 minutes after drinking 60 mL of formula. Anterior fontanel is soft and flat. Bowel sounds are hyperactive.

1800: Client experienced projectile vomiting 30 minutes after drinking 60 mL of formula. Abdomen is distended. Client is crying and inconsolable.

Which of the following diagnostic procedures should the nurse anticipate the physician would order? **Select all that apply.**

1. barium enema
2. abdominal x-ray
3. abdominal ultrasound
4. complete metabolic panel
5. esophagogastroduodenoscopy (EGD)

Next Generation NCLEX®

RN Stand-Alone Bow-Tie Examples

Example 1

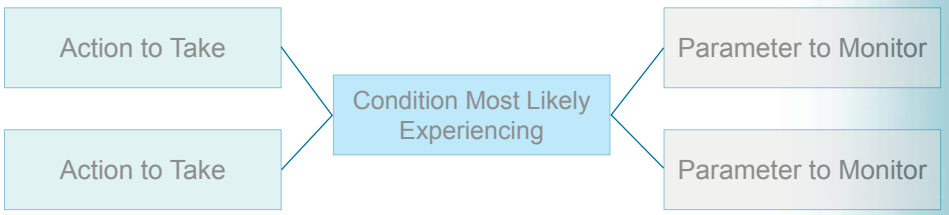
The nurse in the pediatric unit is caring for a 6-month-old client.

Nurses' Notes

0800: Client admitted with increased irritability and a leaking gastrostomy feeding tube, which was placed 2 weeks ago for failure to thrive. The feeding tube insertion site, which is on the left side of the abdomen, is covered with a dressing that is saturated with old formula. On removal of the dressing, the skin surrounding the feeding tube site is erythematous and flaking. At the insertion site, a small amount of thick, yellow drainage is noted, and the feeding tube is loose. Peripheral pulses are weak; capillary refill is 3 seconds. Extremities are cool to the touch. Client is intermittently pulling at the tube and scratching at the site. Parent reports giving the client acetaminophen last night before bedtime, but the client was still intermittently waking and irritable throughout the night. Parent attempted to feed the client through the feeding tube 8 hours ago. Vital signs: temporal T 100.6° F (38.1° C), P 171, RR 42, BP 74/62, pulse oximetry reading 97% on room air. Parent has a history of a penicillin allergy.

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
change the site dressing	refeeding syndrome	stool output
request a wound consultation	infection of the gastrostomy tube site	skin integrity
obtain an electrocardiogram (ECG).	normal gastrostomy tube site findings	feeding tolerance
request a bolus of intravenous 0.9% sodium chloride (normal saline)	intolerance to gastrostomy tube feedings	vital signs every 30 minutes
reassure the parent that the site findings are the normal progression of healing		parent's ability to administer a tube feeding

Next Generation NCLEX®

RN Stand-Alone Bow-Tie Examples

Example 2

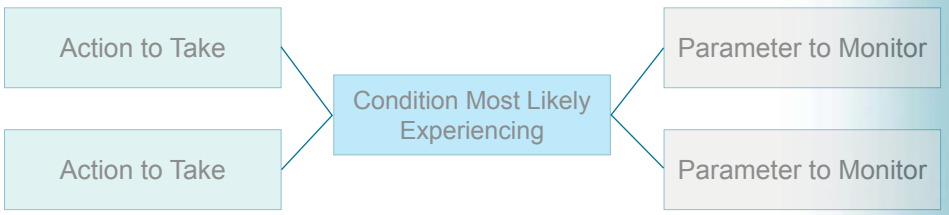
The nurse in the emergency department (ED) is caring for a 79-year-old female client.

Nurses' Notes | **History and Physical** | **Laboratory Results**

1215: Client presents with right-sided ptosis and facial drooping, right-sided hemiparesis, and expressive aphasia. Client's adult child reports that the client recently had influenza. On assessment, skin is warm and dry. Lung sounds are clear; apical pulse is irregular. Bowel sounds are active in all quadrants. Client is incontinent of urine 2 times in the ED; adult child reports that the client is typically continent of urine. Capillary refill of 3 seconds. Peripheral pulses palpable, 2+. Vital signs: T 97.5° F (36.4° C), P 126, RR 18, BP 188/90, pulse oximetry reading 90% on room air.

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
Administer oxygen at 2 L/min via nasal cannula.	Bell's palsy	urine output
Request a prescription for an oral corticosteroid.	hypoglycemia	temperature
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine specimen for urinalysis and culture and sensitivity (C & S).	urinary tract infection (UTI)	serum glucose level
Request an order for 50% dextrose in water to be administered intravenously.		electrocardiogram (ECG) rhythm

Next Generation NCLEX®

RN Stand-Alone Bow-Tie Examples

Example 2

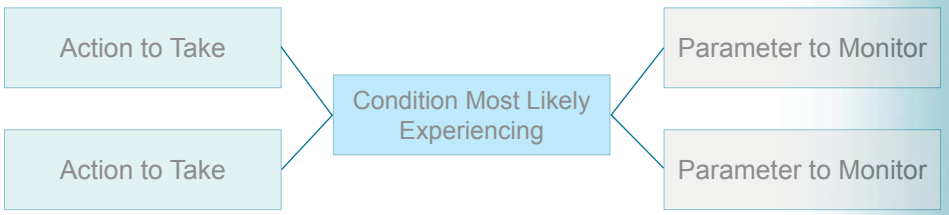
The nurse in the emergency department (ED) is caring for a 79-year-old female client.

Nurses' Notes | **History and Physical** | **Laboratory Results**

Body System	Findings
Neurological	history of a stroke 2 years ago
Cardiovascular	history of hypertension; atrial fibrillation; hyperlipidemia
Gastrointestinal	history of gastrointestinal bleeding 2 months ago
Endocrine	history of diabetes mellitus (type 2) for 30 years
Immunological	influenza 3 weeks ago

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
Administer oxygen at 2 L/min via nasal cannula.	Bell's palsy	urine output
Request a prescription for an oral corticosteroid.	hypoglycemia	temperature
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine specimen for urinalysis and culture and sensitivity (C & S).	urinary tract infection (UTI)	serum glucose level
Request an order for 50% dextrose in water to be administered intravenously.		electrocardiogram (ECG) rhythm

Next Generation NCLEX®

RN Stand-Alone Bow-Tie Examples

Example 2

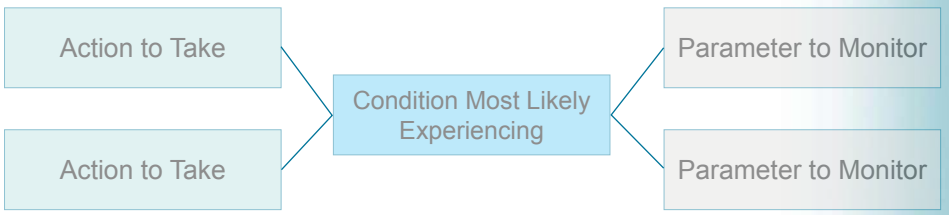
The nurse in the emergency department (ED) is caring for a 79-year-old female client.

Nurses' Notes | **History and Physical** | **Laboratory Results**

Laboratory Test and Reference Range	1215
random serum glucose Elderly 60–90 years: 82–115 mg/dL (4.6–6.4 mmol/L)	76 mg/dL (4.2 mmol/L)

The nurse is reviewing the client's assessment data to prepare the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
Administer oxygen at 2 L/min via nasal cannula.	Bell's palsy	urine output
Request a prescription for an oral corticosteroid.	hypoglycemia	temperature
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine specimen for urinalysis and culture and sensitivity (C & S).	urinary tract infection (UTI)	serum glucose level
Request an order for 50% dextrose in water to be administered intravenously.		electrocardiogram (ECG) rhythm

Next Generation NCLEX®

PN Stand-Alone Trend Example

Example 1

The nurse in the surgical unit is caring for a 50-year-old male client.

Nurses' Notes | **Vital Signs**

Preoperative Unit

0800: Awaiting thyroidectomy for thyroid cancer. No acute distress noted. Alert and oriented to person, place, time, and situation. Vital signs stable. Skin is warm and dry. Palpable thyroid gland noted. Lung sounds clear to auscultation bilaterally. Abdomen soft with diminished bowel sounds in all 4 quadrants. Peripheral venous access device (VAD) established with a 20-gauge cannula to client's right hand per the registered nurse. Client has been NPO since midnight. Denies having any allergies. History of hypertension and myopia.

Postanesthesia Care Unit

1130: Indwelling urethral catheter was inserted in the operating room; no complications during surgery. Client arouses readily. Appropriate when awake, follows commands. Surgical site pain rated 3/10 to 4/10 on the Numerical Rating Scale, and reports that the throat is sore. Lactated Ringer's solution infusing at 125 mL/hr. Preparing to transfer the client to the surgical unit, report given.

Surgical Unit

1200: Arouses easily and appropriately while alert. Taking ice chips for dry mouth without coughing. Neck dressing dry and intact. Head is supported by pillows. Indwelling urethral catheter draining yellow urine free from sediment. Client is requesting analgesia for incisional pain rated 6/10 on the Numerical Rating Scale. Informed the client that morphine may be administered intravenously. Intravenous fluids infusing at 125 mL/hr.

The nurse is contributing to the client's plan of care.

Select the 3 potential nursing interventions the nurse should anticipate for the care of the client.

- [ ] 1. Pad the client's side rails.
- [ ] 2. Place the client on telemetry.
- [ ] 3. Monitor serum calcium levels.
- [ ] 4. Remind the client to avoid flexion of the neck.
- [ ] 5. Keep a tracheostomy tray at the client's bedside.
- [ ] 6. Place several boxes of sterile dressings in the client's room.

Next Generation NCLEX®

PN Stand-Alone Trend Example

Example 1

The nurse in the surgical unit is caring for a 50-year-old male client.

Nurses' Notes | **Vital Signs**

	Preoperative Unit 0800	Postanesthesia Care Unit 1130	Surgical Unit 1200
T	98.7° F (37.1° C)	97.5° F (36.4° C)	98.7° F (37.1° C)
P	108	88	94
RR	16	18	16
BP	138/84	121/82	116/78
Pulse oximetry reading	99% on room air	97% on oxygen at 2 L/min via nasal cannula	96% on room air

The nurse is contributing to the client's plan of care.

Select the 3 potential nursing interventions the nurse should anticipate for the care of the client.

1. Pad the client's side rails.
2. Place the client on telemetry.
3. Monitor serum calcium levels.
4. Remind the client to avoid flexion of the neck.
5. Keep a tracheostomy tray at the client's bedside.
6. Place several boxes of sterile dressings in the client's room.

Next Generation NCLEX®

PN Stand-Alone Bow-Tie Example

Example 1

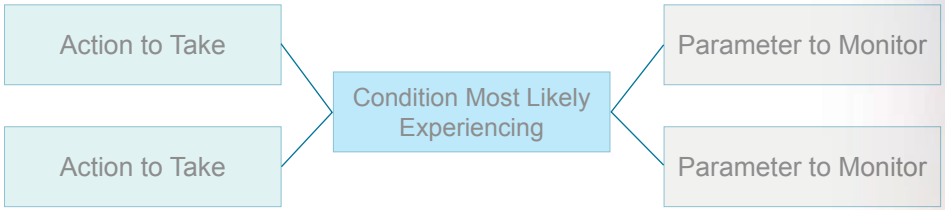
The nurse in the pediatric unit is caring for a 16-year-old client.

Nurses' Notes | **Vital Signs** | **History and Physical**

1600: Client is transferred from the emergency department (ED) to the pediatric unit via wheelchair, admitted, and accompanied by the parent. Client reports experiencing frequent nausea, vomiting, anorexia, periumbilical and right lower quadrant (RLQ) abdominal pain rated 8/10 on the Numerical Rating Scale. States, "The pain began around 4 o'clock this morning, and then I started to throw up." Respirations are shallow. Skin and mucous membranes are dry. Posture is stooped, mood and affect are irritable. Last meal was approximately 20 hours ago.

The nurse is reviewing the collected client data to assist with preparing the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
Request an order to administer corticosteroids.	appendicitis	rectal bleeding
Prepare to reinforce teaching about insulin administration.	ulcerative colitis	growth restriction
Prepare the client for a computed tomography (CT) scan of the abdomen.	new onset diabetes mellitus (type 1)	sudden pain relief
Reinforce teaching about the importance of folic acid supplementation.	regional enteritis (Crohn's disease)	complete blood count (CBC)
Ensure peripheral venous access device (VAD) for fluid and electrolyte correction.		glycosylated hemoglobin ($HgbA_1C$) every 3 months

Next Generation NCLEX®

PN Stand-Alone Bow-Tie Example

Example 1

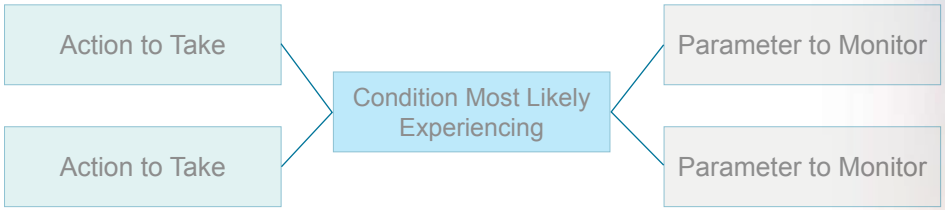
The nurse in the pediatric unit is caring for a 16-year-old client.

Nurses' Notes | **Vital Signs** | **History and Physical**

	1600
T	99.2° F (37.3° C)
P	102
RR	20
BP	100/58
Pulse oximetry reading	98% on room air

The nurse is reviewing the collected client data to assist with preparing the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
Request an order to administer corticosteroids.	appendicitis	rectal bleeding
Prepare to reinforce teaching about insulin administration.	ulcerative colitis	growth restriction
Prepare the client for a computed tomography (CT) scan of the abdomen.	new onset diabetes mellitus (type 1)	sudden pain relief
Reinforce teaching about the importance of folic acid supplementation.	regional enteritis (Crohn's disease)	complete blood count (CBC)
Ensure peripheral venous access device (VAD) for fluid and electrolyte correction.		glycosylated hemoglobin ($HgbA_1C$) every 3 months

Next Generation NCLEX®

PN Stand-Alone Bow-Tie Example

Example 1

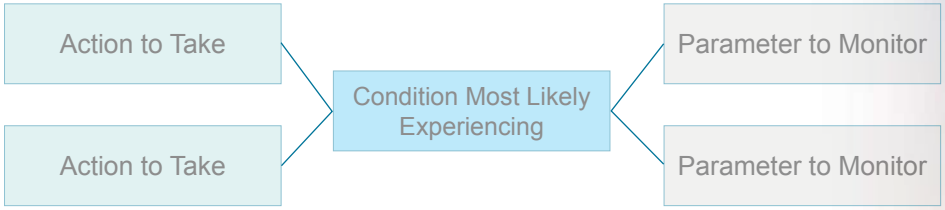
The nurse in the pediatric unit is caring for a 16-year-old client.

Nurses' Notes | **Vital Signs** | **History and Physical**

Body System	Findings
Eye, Ear, Nose, and Throat (EENT)	multiple episodes of streptococcal pharyngitis throughout school-age years; tonsillectomy at 8 years old
Reproductive	menarche at 12 years old; last menstrual period 3 weeks ago

The nurse is reviewing the collected client data to assist with preparing the client's plan of care.

- Complete the diagram by dragging from the choices below to specify what condition the client is **most** likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Actions to Take	Potential Conditions	Parameters to Monitor
Request an order to administer corticosteroids.	appendicitis	rectal bleeding
Prepare to reinforce teaching about insulin administration.	ulcerative colitis	growth restriction
Prepare the client for a computed tomography (CT) scan of the abdomen.	new onset diabetes mellitus (type 1)	sudden pain relief
Reinforce teaching about the importance of folic acid supplementation.	regional enteritis (Crohn's disease)	complete blood count (CBC)
Ensure peripheral venous access device (VAD) for fluid and electrolyte correction.		glycosylated hemoglobin ($HgbA_1C$) every 3 months