

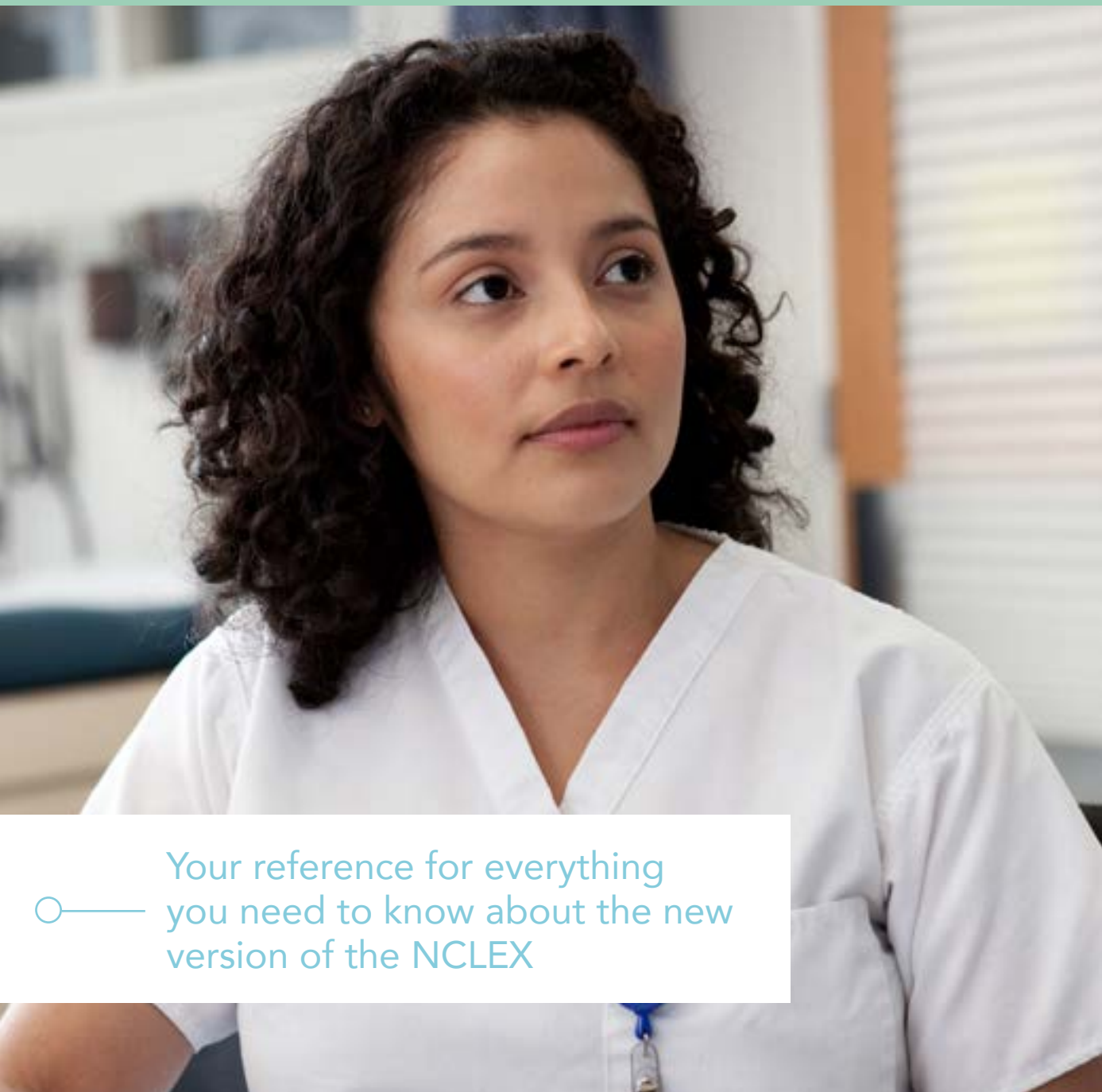
Next Generation

NCLEX Guidebook **2023**

for Students



PREPARED AND PRESENTED BY:
ATI Nursing Education



Your reference for everything
you need to know about the new
version of the NCLEX

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Note: The information in this guide was current at the time of publication, but the NCSBN regularly releases new details on the NGN.

The new version of the NCLEX:

The Next Generation NCLEX

We've gathered everything you need to know so you are prepared for the Next Generation NCLEX.

The National Council of State Boards of Nursing (NCSBN) is the organization that oversees the National Council Licensure Examination, more commonly referred to as the NCLEX.

On April 1, 2023, the NCSBN launched a new version of the exam, which it refers to as the Next Generation NCLEX (or the

NGN). If you haven't taken your board exam yet or will be retaking it, then you will be tested using this new version of the exam.

To help you understand what the test includes, we've gathered all you need to know in this guide created specifically for students. It provides the most up-to-date and clearly explained information currently available.

Why a new NCLEX was needed

Nurses face more complex client needs in a rapidly changing healthcare environment.

Healthcare is very dynamic today compared to years past. It moves at a rapid pace. And nurses

today care for people with more acute, complex, and chronic illnesses that require completely new technology.

The NCSBN confirmed this reality by viewing new nurses at work. This *observational practice analysis* verified how often new nurses use clinical judgment in their daily tasks in today's practice settings.

Upon reviewing this research, the NCSBN realized it was critical to change the NCLEX so that the exam could accurately assess candidates' clinical judgment skills to ensure public safety.



Clinical judgment

& its impact on public safety

Clinical judgment is necessary when caring for the complex needs of clients.

The NCSBN's observational practice analysis showed that the linking factor in almost any task that an entry-level nurse performed was the ability to make judgments on the spot based on the evidence presented.

What was especially concerning to the NCSBN was the data that new nurses were regularly making errors, and 60 percent of them were directly related

to clinical judgment. About half of the errors led to remediation or disciplinary action. This knowledge is important because clinical errors quite often affect client safety and lead to client harm.

It was clear to the NCSBN that assessing clinical judgment in nursing candidates was imperative.

How do you define clinical judgment?

The NCSBN defines clinical judgment for the nursing profession as "the observed outcome of critical thinking and decision-making."

Further, clinical judgment is an iterative decision-making process that uses nursing knowledge to:

- Observe and assess presenting situations
- Identify a prioritized client concern
- Generate the best possible evidence-based solutions to deliver safe client care.

On the following pages, we'll dive into the concept of clinical judgment so you can better understand why you must possess this skill (and not simply be able to memorize thousands of facts about the human body, diseases, and medications).

How is priority setting related to clinical judgment?

Priority setting is *directly* related to clinical decision-making and clinical judgment. You can improve your clinical judgment skills by strengthening your ability to prioritize the care of clients. How? By having a good understanding of the various priority-setting frameworks you use in the clinical setting. In doing so, you will inherently improve your clinical judgment skills.

On the following pages, we illustrate each. Then, after each explanation, you'll find some questions, answers, and rationales. Take some time to read through these and determine why the answers in red are correct. You'll soon start to get a feel for why you should make certain decisions based on the factors of the situation.

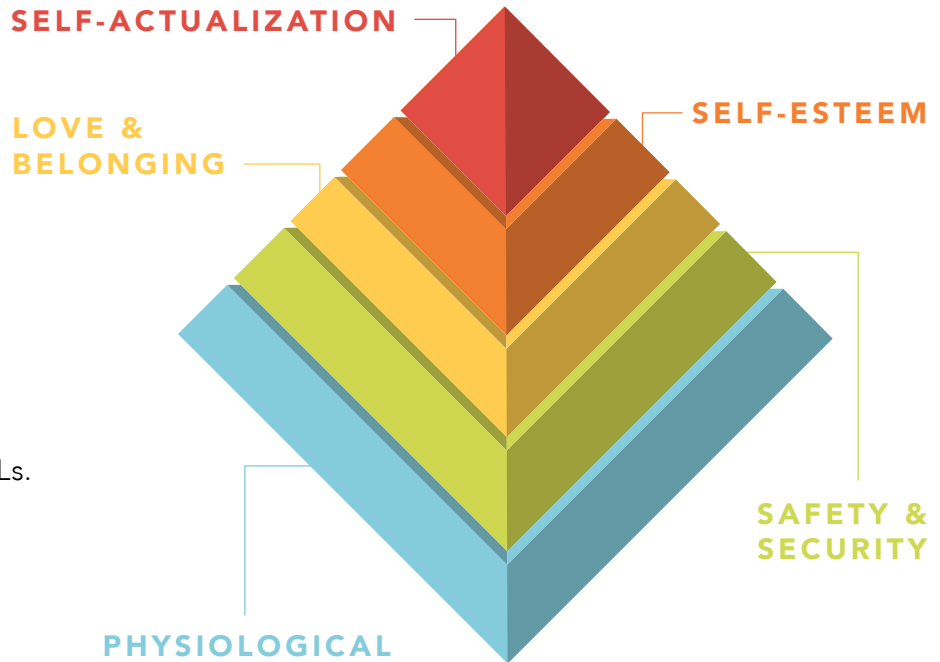
Maslow's hierarchy of needs

This framework contains five levels of prioritized needs. (See diagram below.) Physiological needs take priority over the others in most circumstances. However, you should consider all client factors before determining need order.

ITEM EXAMPLE

A nurse is planning care for a client who has bipolar disorder and is experiencing an acute manic episode. Which of the following is the highest priority intervention the nurse should include in the plan of care?

- A. Give the client simple directions for completing ADLs.
- B. Offer the client high-calorie fluids frequently.
- C. Provide the client with structured solitary activities.
- D. Keep the client's valuables in a locked area.



RATIONALES

- A. Clients who are having an acute manic episode are likely to have poor concentration and difficulty completing routine tasks. Providing simple directions for completing ADLs helps the client focus; however, the nurse should take another action first.
- B. The priority action for a client who is experiencing an acute manic episode is to meet the client's physiological need for food and water. Therefore, the priority intervention is to offer the client high-calorie fluids frequently to prevent calorie deprivation and dehydration.
- C. Clients who are having an acute manic episode are likely to have difficulty focusing on any one activity. Providing the client with structured solitary activities helps provide focus and feelings of security; however, the nurse should take another action first.
- D. Clients who are having an acute manic episode are likely to give away their valuables. Keeping the client's valuables in a locked area prevents the client from doing so; however, the nurse should take another action first.

Airway – breathing – circulation

Often called the ABCs, this framework is always the priority for initial assessments when the client's life is at stake as all three attributes are essential for survival.

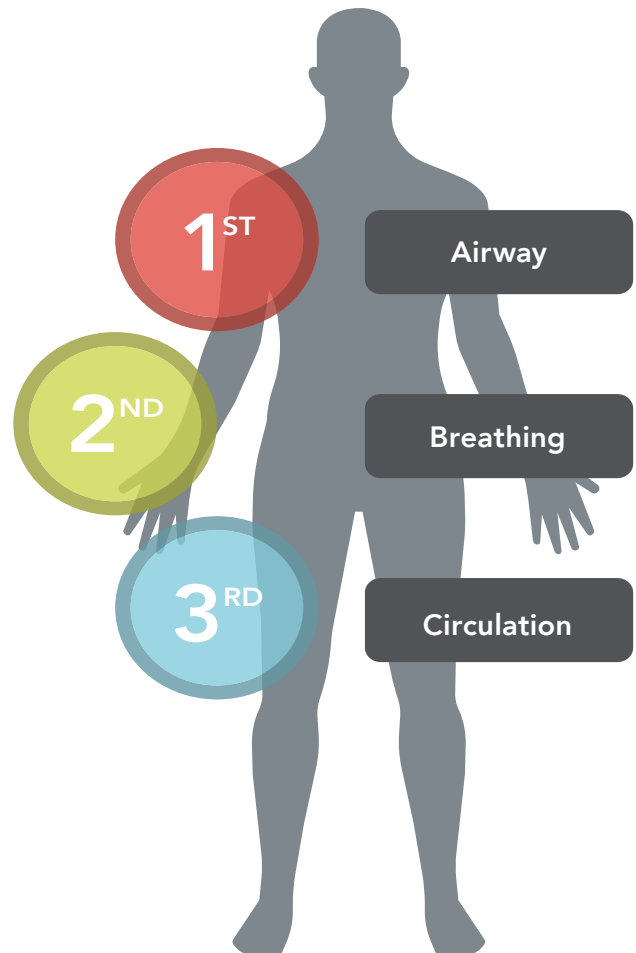
ITEM EXAMPLE

A nurse is caring for a client who is wheezing and gasping for breath just after receiving a dose of amoxicillin. Which of the following actions is the nurse's priority?

- A. Administer epinephrine parenteral injection.
- B. Provide reassurance to the client.
- C. Initiate an IV infusion of 0.9% sodium chloride.
- D. Place client on a cardiac monitor.

RATIONALES

- A. Using the airway, breathing, circulation priority framework, the nurse's priority is to give the client an injection of epinephrine, which will counteract the bronchoconstriction.
- B. The nurse should reduce the client's anxiety by providing reassurance; however, the nurse should perform another action first.
- C. Starting an IV infusion of 0.9% sodium chloride is important to maintain fluid balance and provide venous access; however, the nurse should perform another action first.
- D. Attaching the client to a cardiac monitor is important, because medications used to treat anaphylaxis can cause tachycardia and dysrhythmias; however, the nurse should perform another action first.



Safety & risk reduction

This framework establishes priority based on which situation poses the greatest threat to the client at that time. When multiple risks are present, you may need to use another priority-setting framework, like the ABCs, to identify the highest priority.

ITEM EXAMPLE

A nurse is planning care for a client who is experiencing acute alcohol withdrawal. Which of the following medications should the nurse plan to administer first?

- A. Disulfiram
- B. Lorazepam
- C. Clonidine
- D. Atenolol.

RATIONALES

A. Disulfiram is given to support abstinence from alcohol and prevent relapse; however, this is not the greatest risk to the client at this time.

B. The greatest risk to the client during acute alcohol withdrawal is seizures. Therefore, the nurse should first administer lorazepam to control or minimize seizures.

C. Clonidine can help minimize the autonomic symptoms that occur with acute alcohol withdrawal; however, these are not the greatest risks to the client at this time.

D. Atenolol can help minimize the autonomic symptoms that occur with acute alcohol withdrawal; however, these are not the greatest risks to the client at this time.



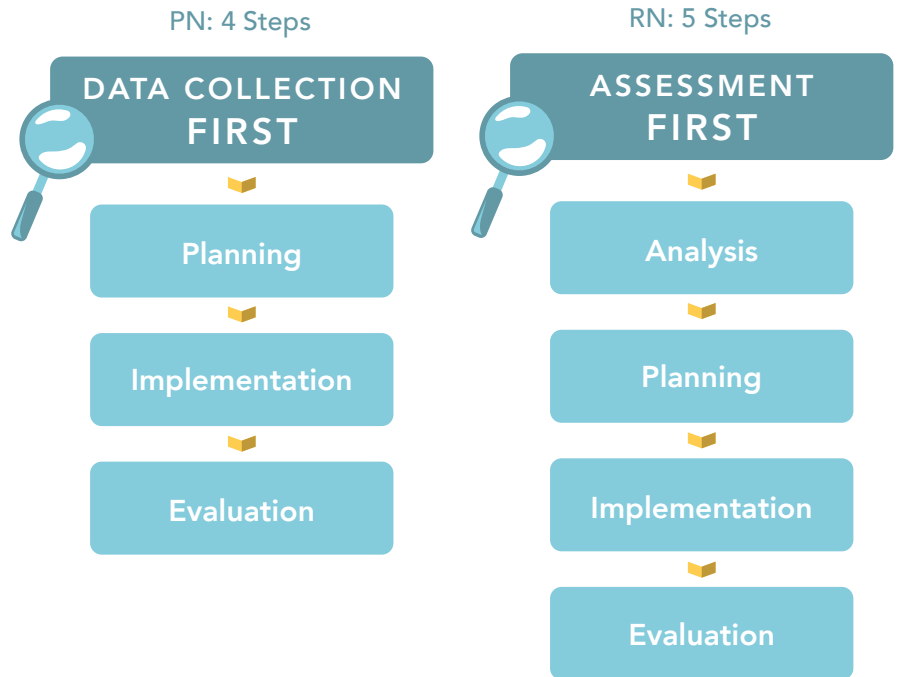
The nursing process

This framework is a four- or five-step process (differing between PNs and RNs) that nurses use for decision-making. It helps determine priority nursing actions based on the steps below and always starts with data collection/assessment.

ITEM EXAMPLE

A nurse is caring for an adolescent who is to undergo an open reduction and internal fixation of the ankle following a sports injury. The client is extremely anxious and having difficulty sleeping. Which of the following is the priority intervention?

- A. Provide dim lighting in the client's room.
- B. Allow the client's family to spend the night with him.
- C. Offer music as a distraction.
- D. Ask the client to tell you what he knows about the procedure.



RATIONALES

A. Providing dim lighting in the client's room can promote sleep for some clients; however, the nurse should take a different action to address the client's anxiety.

B. Allowing the client's family to stay with him can help reduce his anxiety; however, the nurse should take a different action to address the client's anxiety.

C. Offering music as a distraction can help reduce his anxiety; however, the nurse should take a different action to address the client's anxiety.

D. The first action the nurse should take is to assess the client. By determining the client's understanding of the procedure, the nurse can provide information needed to help decrease the client's anxiety.

Least restrictive/Least invasive

This framework sets priorities based on the interventions that are the least restrictive or invasive to the client to minimize the risk for harm.

ITEM EXAMPLE

A nurse is caring for a client who gave birth vaginally 8 hours ago. The client reports feeling weak and dizzy. The nurse notes that the client's perineal pad is soaked with blood. Which of the following actions should the nurse take first?

- A. Administer oxygen at 10 L/minute via face mask.
- B. Insert an indwelling urinary catheter.
- C. Massage the fundus of the uterus.
- D. Administer oxytocin 20 units in 1000 mL of lactated ringers.

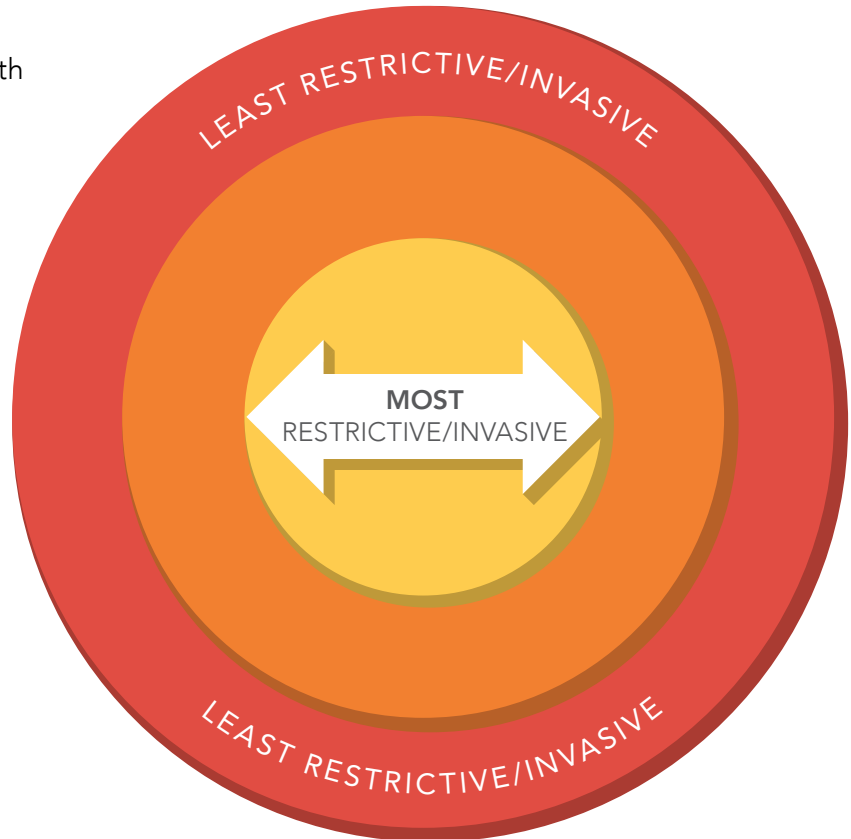
RATIONALES

A. Manifestations of postpartum hemorrhage include saturation of the perineal pad, as well as dizziness and weakness. The nurse may need to administer oxygen; however, the nurse should perform a less-invasive intervention first.

B. Manifestations of postpartum hemorrhage include saturation of the perineal pad, as well as dizziness and weakness. The nurse may need to insert an indwelling urinary catheter; however, the nurse should perform a less-invasive intervention first.

C. Manifestations of postpartum hemorrhage include saturation of the perineal pad, as well as dizziness and weakness. When providing client care, the nurse should first use the least-invasive intervention; therefore, the first action the nurse should take is to massage the client's fundus.

D. Manifestations of postpartum hemorrhage include saturation of the perineal pad, as well as dizziness and weakness. The nurse may need to administer oxytocin; however, the nurse should perform a less-invasive intervention first.



Acute vs. chronic/Unstable vs. stable/ Urgent vs. nonurgent

These three frameworks establish the priority need based on the client condition. You may use them when the other frameworks do not apply to the client-care situation.

ACUTE VS. CHRONIC

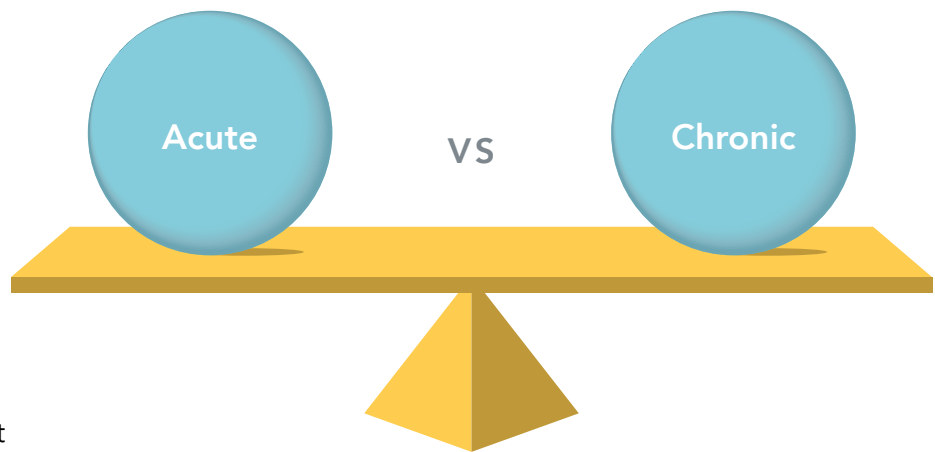
Addressing acute problems before chronic problems is important because there is a great risk posed for acute problems.

UNSTABLE VS. STABLE

Unstable clients pose a greater threat than stable clients and need to receive care first.

URGENT VS. NONURGENT

Urgent needs pose a greater threat to a client than a nonurgent need.



ACUTE VS. NONACUTE

ITEM EXAMPLE

A nurse is receiving a hand-off report at the beginning of the shift for four clients. Which of the following clients should the nurse assess first?

- A. A client who has macular degeneration and does not want to take his medication.
- B. A client who is taking insulin and has an HbA1c of 7%.
- C. A client who has Graves' disease and has exophthalmos.
- D. A client who is taking digoxin and is experiencing anorexia.

RATIONALES

- A. Macular degeneration is a chronic condition that responds to medication; although the nurse should assess the client to determine why he does not want to take his medication, the nurse should assess another client first.
- B. An HbA1c reflects a client's blood glucose over the past three months; therefore, the nurse should assess another client first.
- C. Exophthalmos is an expected finding for a client who has Graves' disease; therefore, the nurse should assess another client first.
- D. The nurse should recognize that anorexia is a possible indication of digoxin toxicity. Therefore, the nurse should assess this client first.

UNSTABLE VS. STABLE ITEM EXAMPLE

A nurse is reviewing laboratory data for four clients. Which of the following clients should the nurse assess first?

- A. A client who has atherosclerosis with a total cholesterol level of 250 mg/dL.
- B. A client who has chronic kidney disease with a BUN of 80 mg/dL
- C. A client who is receiving warfarin with an INR of 4.0.
- D. A client who is receiving furosemide and has a serum potassium of 3.8 mEq/L.

RATIONALES

A. The nurse should continue to monitor the client who has atherosclerosis and an elevated total cholesterol level; however this client is stable and does not need to be assessed first.

B. The nurse should continue to monitor the client who has chronic kidney disease and an elevated BUN; however this client is stable and does not need to be assessed first.

C. A client who is receiving warfarin and has an INR of 4.0 is at risk for hemorrhage. The nurse should assess this client first.

D. The nurse should continue to monitor the client who is receiving furosemide and has a potassium level within the expected reference range; however this client is stable and does not need to be assessed first.

URGENT VS. NONURGENT ITEM EXAMPLE

A nurse is caring for a client who has peripheral arterial disease. Which of the following findings should the nurse report to the provider immediately?

- A. Report of intermittent claudication
- B. Shiny, hairless lower extremities
- C. Absent dorsalis pedis pulse
- D. Dependent rubor.

RATIONALES

A. Report of intermittent claudication is an important finding; however, it is common for clients with peripheral arterial disease to have this type of pain.

B. Shiny, hairless lower extremities is an important finding; however, clients with peripheral arterial disease usually develop this from long-term impaired circulation.

C. The nurse should recognize that an absent dorsalis pedis pulse can indicate acute arterial occlusion, which requires immediate intervention.

D. Dependent rubor is an important finding; however, clients with peripheral arterial vascular disease usually develop this from long-term impaired circulation.

Survival potential

This is a triage system used during mass-casualty events to determine priorities of care for all injured clients.

Triage classes

**EMERGENT/
IMMEDIATE**

Emergent or immediate category (class I):

Highest priority is given to clients who have life-threatening injuries but also have a high possibility of survival once they are stabilized.

**URGENT/
DELAYED**

Urgent or delayed category (class II):

Second-highest priority is given to clients who have major injuries that are not yet life-threatening and can usually wait 30 minutes to 2 hours for treatment.

**NONURGENT/
MINIMAL**

Nonurgent or minimal category (class III):

The next-highest priority is given to clients who have minor injuries that are not life-threatening and do not need immediate attention.

EXPECTANT

Expectant category (class IV):

The lowest priority is given to clients who are not expected to live and are allowed to die naturally. Comfort measures can be provided, but restorative care is not.

ITEM EXAMPLE

A nurse is assessing clients at a mass-casualty event and placing the appropriate triage tag on each client. Which of the following tags should the nurse assign to a client with an abdominal wound that has eviscerated?

- A. Class I "emergent" tag
- B. Class II "urgent" tag
- C. Class III "nonurgent" tag
- D. Class IV "expectant" tag

RATIONALES

A. A class I emergent tag indicates the client has injuries that are life-threatening and need immediate attention; therefore, the nurse should issue an emergent tag to this client.

B. A class II urgent tag indicates the client has injuries that need attention but are not life-threatening; therefore, the nurse should not issue an urgent tag to a client who has an abdominal wound that has eviscerated.

C. A class III nonurgent tag indicates the client has minor injuries that do not need immediate treatment; therefore, the nurse should not issue a nonurgent tag to a client who has an abdominal wound that has eviscerated.

D. A class IV expectant tag indicates the client has injuries that are not consistent with life; therefore, the nurse should not issue an expectant tag to a client who has an abdominal wound that has eviscerated.



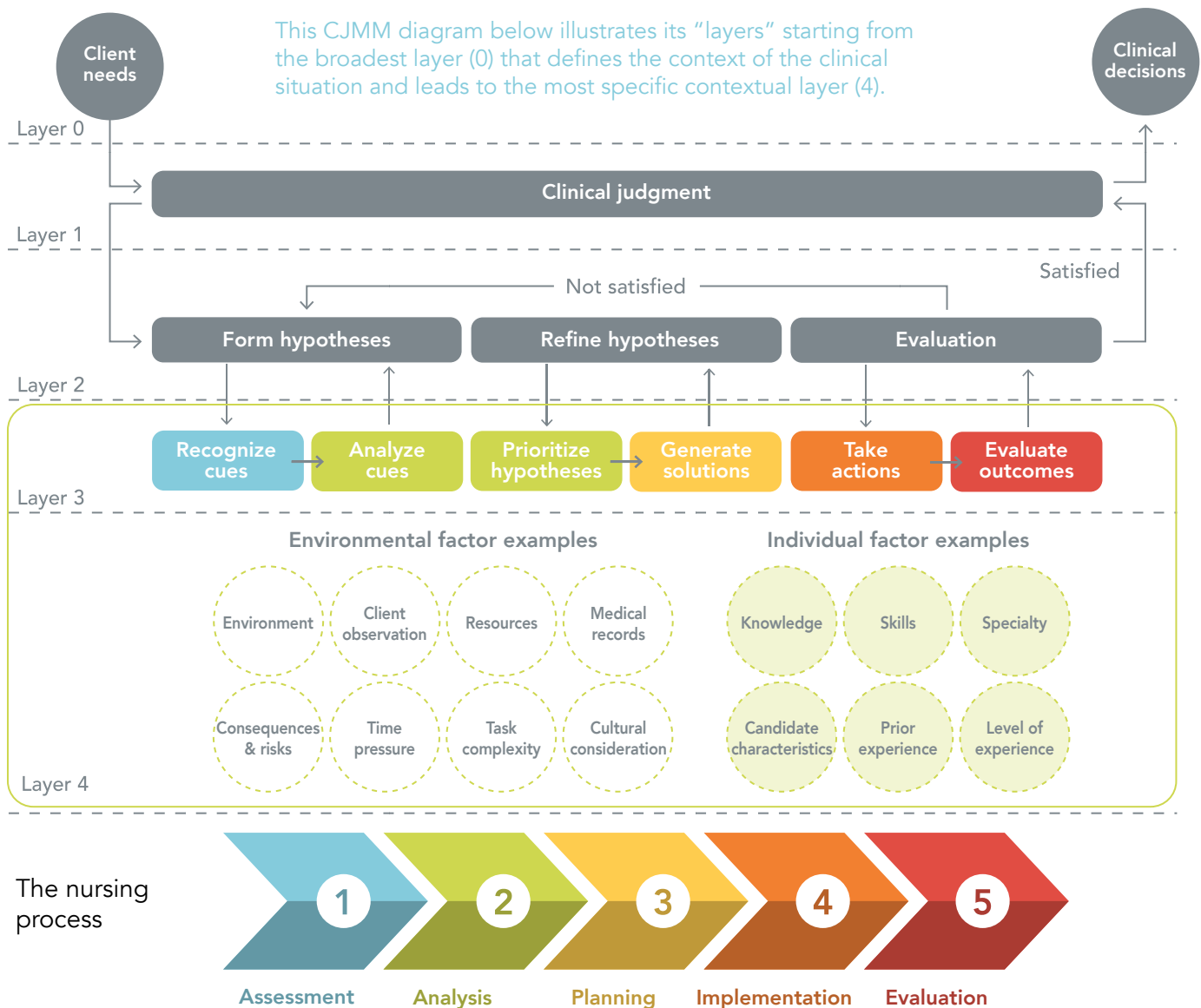
Tips to prepare

for the new NCLEX

Step 1: Understand the NCSBN's Clinical Judgment Measurement Model.

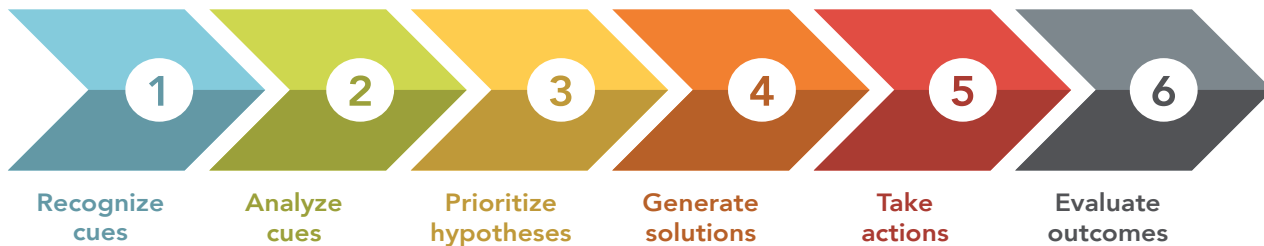
The NCSBN created its clinical judgment measurement model (CJMM) to evaluate candidates' clinical judgment and develop new item types for the exam. Layers 3 and 4 delineate the cognitive process of how a nurse makes decisions for Layer 2. Based on the client's response from

Layer 2, either satisfactory or unsatisfactory, the nurse can move through the entire cognitive processes of Layers 3 and 4 again. The entirety of nursing clinical judgment in Layer 1 subsequently impacts the clinical decision for the client's needs at Layer 0.



Step 2a: Review the six functions of clinical judgment in Layer 3.

In considering the education and testing the skills and knowledge of entry-level nurses, the NCSBN believes it is essential to focus on Layer 3 of the CJMM.



The six steps in this layer involve a repetitious process the nurse moves through with each client. This process is iterative, meaning the nurse can gain new information or cues while assessing or treating a client. This new information can cause the nurse to return to a previous function and then move through the process again, continuously re-evaluating.

The NCSBN emphasizes: "Any evidence-based curriculum that teaches clinical judgment effectively will provide students with preparation necessary for the new components of the exam."



Step 2b: Review the environmental and individual factors in Layer 4.

To further help you understand the aspects of your job that affect your clinical judgment, the NCSBN developed Layer 4. This layer identifies additional factors that impact the clinical situation.

Considering these environmental and individual factors is crucial to ensuring you make an appropriate clinical decision as a nurse.

Some examples of these factors are:

ENVIRONMENTAL

- Setting, situation, and environment (i.e., safety considerations, equipment, surroundings)
- Client observation (i.e., age, symptoms of health alteration)
- Resources (i.e., staffing, supplies, beds, care partners)
- Health records (i.e., history, labs, diagnostic tests, I&O, medications, treatments)
- Time pressure (i.e., pager, STAT medication, change in client condition).
- Cultural considerations (i.e., language, literacy, religion, diet)
- Task complexity (i.e., level of difficulty, complicated versus simple action, number of people involved, sound delegation)

- Risk assessment (i.e., identifying and finding ways to remove or minimize harm to promote safety and health).

INDIVIDUAL

- Nursing factors (i.e., knowledge, skills, specialty)
- Nurse characteristics (i.e., attitudes, prior experience, level of experience)
- Cognitive load (i.e., demands on the nurse, stress, problem solving, memory).

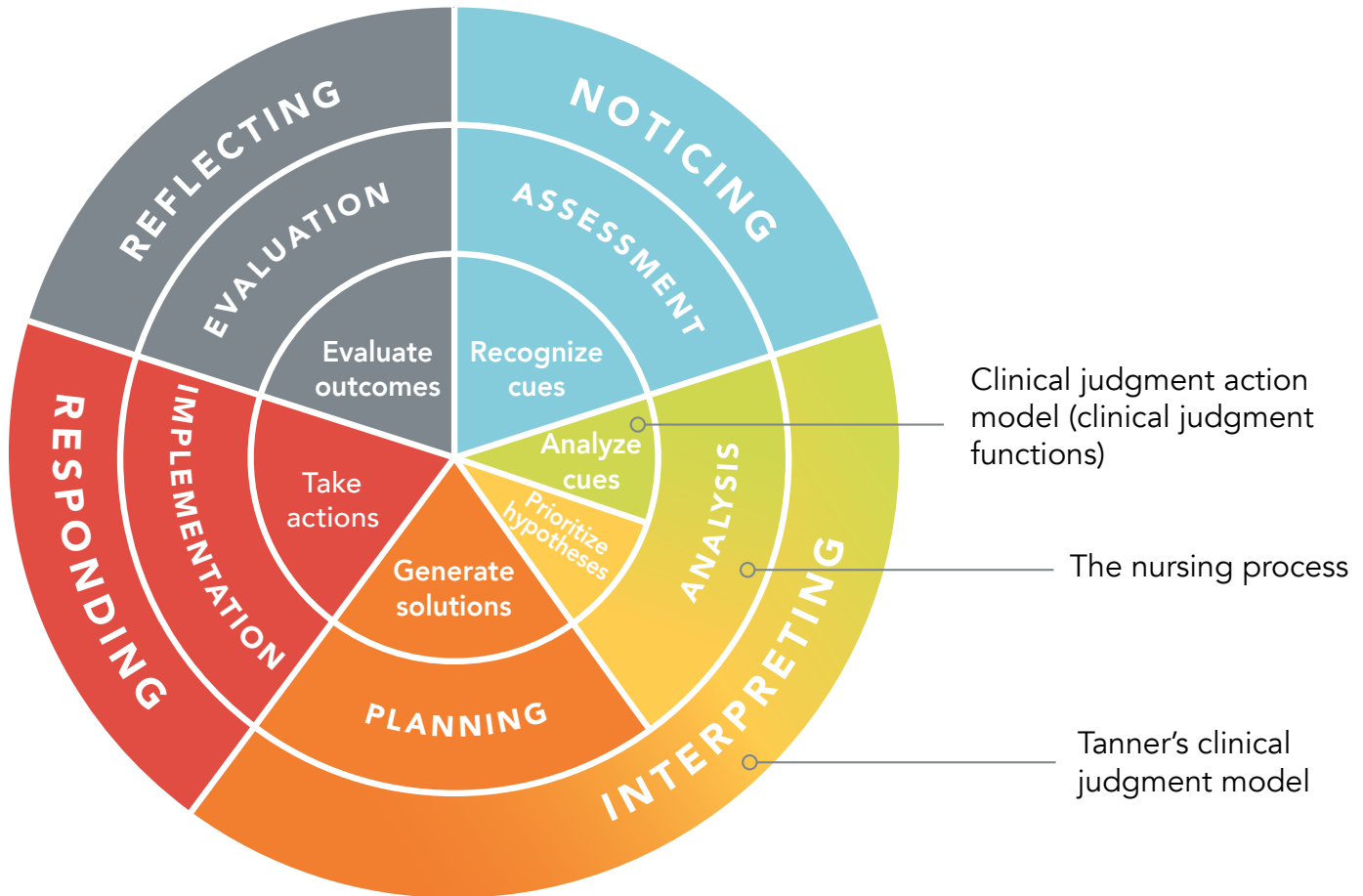
Environmental factor examples



Individual factor examples



Compare “The relationship of approaches fostering clinical judgment” (graphic below) to understand how the nursing frameworks overlap with the CJMM.



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Your nursing program may teach using the nursing process, Tanner’s clinical judgment model, or some other type of nursing framework. Any of them can work in helping you understand the NCSBN’s clinical judgment measurement model. The diagram above shows their similarities and breaks out the functions of clinical judgment.

The following pages provide detail on each of these functions.

Function 1: Recognize cues (assessment)

Definition: The filtering of information from different sources (i.e., signs, symptoms, health history, environment)



EXPECTED RESPONSES AND BEHAVIORS

- Identify relevant information related to the client's condition.
- Use knowledge, experience, and evidence to assess clients.
- Use verbal, nonverbal, written, and electronic modes of communication.
- Recognize relevant subjective/objective client data.
- Identify subtle and apparent changes in client condition and related factors.

Function 2: Analyze cues (analysis)

Definition: The linking of recognized cues to the client's clinical presentation and establishing probable client needs, concerns, and problems

EXPECTED RESPONSES AND BEHAVIORS

- Compare client findings to evidence-based resources.
- Analyze expected and unexpected findings in health data.
- Anticipate illness/injury and wellness progression.
- Identify client problems and related health alterations.
- Analyze client needs.
- Identify potential complications.
- Identify how pathophysiology relates to clinical presentation.
- Identify data that are of immediate concern.

Function 3: Prioritize hypotheses (analysis)

Definition: Establishing priorities of care based on the client's health problems (i.e., environmental factors, risk assessment, urgency, signs/symptoms, diagnostic tests, lab values)

EXPECTED RESPONSES AND BEHAVIORS

- Organize client assessment information according to changes, patterns, and trends.
- Use standards of care and empirical frameworks for priority setting.
- Establish and prioritize client problems/needs based on the analysis of information and factors.

Function 4: Generate solutions (planning)

Definition: Identifying expected outcomes and related nursing interventions to ensure a client's needs are met

EXPECTED RESPONSES AND BEHAVIORS

- Collaborate with members of the interprofessional healthcare team to establish client outcomes and the plan of care.
- Collaborate with the client and care partners to establish client outcomes and the plan of care.
- Identify optimal client outcomes and the plan of care.
- Identify evidence-based nursing actions to effectively address the clinical situation of the client's health problem.
- Prioritize the plan of care to achieve optimal client outcomes.
- Prioritize nursing care when caring for multiple clients.
- Reprioritize nursing actions as the client's condition changes.
- Modify a plan of care to assure achievement of optimal client outcomes when indicated.
- Determine the potential impact of selected interventions.

Function 5: Take actions (implementation)

Definition: To implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client's health

EXPECTED RESPONSES AND BEHAVIORS

- Promptly and accurately perform nursing actions based on prioritized client problems.
- Implement a plan of care in collaboration with members of the interprofessional healthcare team.
- Implement a plan of care in collaboration with the client and care partners.
- Accurately document client care data and information.
- Incorporate client preferences and needs when performing nursing actions.
- Provide education to the client and/or care partner(s) regarding the client's health condition and care management.
- Participate in coordination of care with the client and the healthcare team.
- Monitor the client's response to interventions.

Function 6: Evaluate outcomes (evaluation)

Definition: To evaluate a client's response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met

EXPECTED RESPONSES AND BEHAVIORS

- Reassess the client's condition to determine achievement of expected outcomes.
- Evaluate efficacy of nursing actions to determine if client outcomes were met.
- Modify client outcomes and/or nursing actions based on the client's response and clinical findings when indicated.
- Update and revise the plan of care.



Details

about the new exam

The Next Gen NCLEX covers more than just clinical judgment.

When you read or hear about the NGN, the emphasis is typically on the measurement of clinical judgment, because that's what's changed. But the NGN doesn't focus solely on assessing that skill. It continues to include questions that require your application of knowledge.

Assessing knowledge is still important, because clinical judgment — in and of itself — is not nursing; nursing is a *combination* of having the knowledge *and* the clinical judgment to care for clients safely and effectively.

Keep in mind that the new test is not designed to trick you or measure whether you are a master nurse. Its purpose is to evaluate your clinical

judgment ability and measure your nursing knowledge. That being said, you are probably nevertheless wondering how many NGN-style items you will encounter. Here's a summary:

- A minimum-length exam includes 70 scored items, including three case studies and possibly some standalone items. (About 25% of the exam of the minimum-length exam, then, is NGN items.)
- A maximum-length exam includes 135 scored items, including three case studies and about 10 standalone items. (About 20% of the maximum-length exam, then, is NGN items.)

The length of the NGN is slightly different from the previous NCLEX.

The NGN presents 70-135 scored items (plus 15 pretest items) based on your ability. The unscored items don't contribute to your test score but are used for future exam development. In all, the total exam length is 85-150 items. Among the scored items on a minimum length test, you can expect three case studies with 18 of the 85 items (21%) being NGN.

CASE STUDIES MEASURING CLINICAL JUDGMENT

You can expect to answer three case studies that count toward your score, along with the possibility of standalone NGN items. Each case study comprises six clinical judgment items.

KNOWLEDGE

You will answer up to 52 nursing knowledge items. Don't be misled; being a knowledge item doesn't mean the question is easy. You still must apply nursing knowledge to answer it. Nursing knowledge is critical to your passing the test and practicing as a safe, competent nurse.

After answering the initial 85 items (70 scored + 15 pretest), if you are close to the cut score (see page 24), you will be asked additional questions. Most of these will be knowledge-based, but up to 10 will focus on clinical judgment in the form of stand-alone items. The maximum number of questions, then, is 150 (135 scored + 15 pretest).

How much time is required to answer the new item types?

Initially, the NCSBN theorized that test-takers would spend double the time answering an NGN-style item compared to a standard NCLEX item. It turned out that expectation was incorrect.

Instead, candidates take only about 15 seconds more to answer an NGN item compared to a regular item on the current NCLEX.

The lower time required is likely due to test-takers "carrying knowledge" from one case study question to the next, continually gathering information as the case study unfolds. As a result, they answer items more quickly.

What hasn't changed from the previous version of the NCLEX?

THE CUT SCORE

This is the "cut point" along an ability range that marks the minimum aptitude required to safely and effectively practice nursing at the entry-level. Because the NGN is computer-adaptive, the computer stops administering items when it is 95 percent certain that your ability is either clearly above or clearly below the passing standard.

ACCOMMODATIONS

The NGN offers the same accommodations available to test-takers as the previous exam. For example, if you request a paper-pencil accommodation, your state board will deny it because the test is adaptive. But you can request extra time, a separate room, reader, or recorder. If you are visually impaired, you can use JAWS software. (If you need accommodations, you must request them from your state-specific regulatory body.)

COMPUTER ADAPTIVE TESTING (CAT)

This method of administering the NGN combines computer technology with measurement theory to conduct exams more efficiently.

- When you answer an item, the computer re-estimates your ability based on each individual item and the difficulty of those items.
- The computer selects the next item that it believes you will have a 50 percent chance of answering correctly.
- The computer's estimate of your ability becomes more precise as you answer more items.
- When the computer finally establishes your ability, after you have answered the minimum number of items, the examination ends.
- Note: Items within case studies are not computer-adaptive.

New item types on the NGN

The most significant change to the test will be unique new item types

The NCSBN researched a variety of item types to determine which ones best measure clinical judgment. The organization settled on 12 for use with case studies and two for the use of stand-alone items. (A standard multiple-choice item can also be used in a case study.)

WHAT ARE THE NEW ITEM TYPES?

- Matrix multiple-choice
- Matrix multiple-response
- Multiple-response: Select all that apply
- Multiple-response: Select N
- Multiple-response: Grouping
- Drag-and-drop: Cloze
- Drag-and-drop: Rationale
- Drop-down: Cloze
- Drop-down: Rationale
- Drop-down: Table
- Highlight: Text
- Highlight: Table.

WHAT IS A CASE STUDY ITEM TYPE?

- May use a variety of NGN item types
- Consists of six items
- Includes one item for each of the six functions of clinical judgment (recognize cues, analyze cues, prioritize hypotheses, generate solutions, take actions, and evaluate outcomes) in Layer 3 of the CJMM.

WHAT ARE STAND-ALONE ITEM TYPES?

They are broken into two types:

- **Bow-tie:** Incorporates all six functions of clinical judgment in one item.
- **Trend:** May use any one of the NGN item types; includes data that trend over time; target one or more of the six Layer 3 clinical judgment functions.



An introduction to the case study

Case studies are an effective way to measure clinical judgment.

Case studies are real-world nursing scenarios that focus on the six clinical judgment functions of Layer 3 of the Clinical Judgment Measurement Model.

TIP: To simplify these functions, define them using the questions in parentheses:

- 1) Recognize cues. (What matters most?)
- 2) Analyze cues. (What does it mean?)
- 3) Prioritize hypotheses. (Where do I start?)
- 4) Generate solutions. (What can I do?)
- 5) Take actions. (What will I do?)
- 6) Evaluate outcomes. (Did it help?)



The format of case studies

Case studies are displayed on a split-screen format

LEFT SIDE

Describes the scenario and includes a rendition of a client-care record with tabs for nursing notes, laboratory results, provider orders, vital signs, and history and physical.

Tabs are offered throughout the case study and may include additional information as the case progresses — just like in real life, where a client's condition changes or more information becomes available.

RIGHT SIDE

Includes the questions to be answered. These questions will be in the form of new item types specially designed to assess clinical judgment.

Nurses' notes

1000: Client was brought to the ED by her daughter due to increased shortness of breath this morning. The daughter reports that the client has been running a fever for the past few days and has started to cough up greenish-colored mucous and reports "soreness" throughout her body. The client was recently hospitalized for issues with atrial fibrillation 6 days ago. The client has a history of hypertension. Vital signs: T 101.1 F (38.4 C), heart rate 92/min., respiratory rate 22/min., BP 152/86 mmHg, pulse oximetry reading 94% on oxygen at 2 L/min. via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale in tone; pulse +3 and irregular. Capillary refill is 3 seconds. Client is alert and oriented to person, place, and time. The client's daughter states, "Sometimes it seems like my mother is confused."

Select the 4 findings that require immediate follow-up:

- vital signs
- lung sounds
- capillary refill
- client orientation
- radial pulse characteristics
- characteristics of the cough

Once the candidate answers an item, the screen will update and present a new item on the right.


The client information on the left side may remain the same, or new information may be added, such as in the close-up view of nurses' notes below.

(See the red arrow pointing to the new note added at noon in the example below. Note: The red arrow will *not* appear when you take the test. It is shown here for illustrative purposes only.)

Items within a case study are static and are not computer-adaptive. But the NCSBN has indicated that there will be an estimate at the end of each case study.

Nurses' notes

1000: Client was brought to the ED by her daughter due to increased shortness of breath this morning. The daughter reports that the client has been running a fever for the past few days and has started to cough up greenish-colored mucous and to report "soreness" throughout her body. The client was hospitalized for issues with atrial fibrillation 6 days ago. The client has a history of hypertension. Vital signs: temperature 101.1 F (38.4 C), heart rate 92/min., respiratory rate 22/min., B/P 152/86 mmHg, pulse oximetry reading 94% on oxygen at 2 L/min. via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale in tone; pulse +3 and irregular. Capillary refill is 3 seconds. Client is alert and oriented to person, place, and time. The client's daughter states, "Sometimes it seems like my mother is confused."



1200: Called to bedside by the daughter who states that her mother "isn't acting right." Upon assessment, client is difficult to arouse, pale, and diaphoretic in appearance. Vital signs: temperature 101.5 F (38.6 C), heart rate 112/min., respiratory rate 32/min., B/P 90/62 mmHg, pulse oximetry reading 91% on oxygen at 2 L/min. via nasal cannula.

An introduction to stand-alone items

These item types also will assess clinical judgment.

Stand-alone items are individual questions that are not part of a case study but have a similar format. They are introduced after the minimum number of items.

Stand-alone items target one or more of the clinical judgment functions in Layer 3 of the CJMM.

Stand-alone items will consist of two item types:

A BOW-TIE ITEM

Bow-tie items address all six steps of the CJMM in one item. You read a scenario to recognize whether findings are normal or abnormal (recognize cues), understand the possible complications or medical conditions the client may be experiencing (analyze cues), and identify possible solutions to address the client's needs and issues (generate solutions). You then answer the question to determine the most likely cause of the client's issues (prioritize hypotheses), the appropriate actions to take (take action), and the parameters to monitor once you have implemented interventions (evaluate outcomes).

TREND ITEM

Trend items are individual items in a scenario in which you review information in the medical record that trends over time (from minutes to hours, days, or more). Trend items address one to all of Layer 3 of the CJMM. Trend items can feature any item-response type. Possible tabs include "Nurses' notes," "History and physical," "Laboratory results," "Vital signs," "Admission notes," "Intake and output," "Progress notes," "Medications," "Diagnostic results," and "Flow sheet."

NOTE: Candidates who answer more than the minimum number of items will be presented with additional questions of which about 6-7 will be NGN stand-alone items.



Sample of a bow-tie stand-alone item

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, two actions the nurse should take to address the condition, and two parameters the nurse should monitor to assess the client's progress.



Actions to take	Potential conditions	Parameters to monitor
Request a prescription for an oral steroid.	Bell's palsy	temperature
Administer oxygen at 2 L/min via nasal cannula.	hypoglycemia	urinary output
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine sample 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

The different formats

of case study and trend item types



The matrix item type: multiple-choice & multiple-response

A matrix item type is presented in a table-like format.

A matrix multiple-choice item will have 4-10 rows and 2-3 columns. Each row must have only one answer.

A matrix multiple-response will have 4-7 rows and 2-10 columns. Each column must have at least one response. A row can have zero to all answers.

A clue as to how many answers you can or should choose? Look at whether the grid contains circles or boxes. Circles (also known as radio buttons) only allow you to choose one option.

Matrix multiple-response example

Assessment finding	Bowel obstruction	Appendicitis	Ruptured spleen
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bowel pattern	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastrointestinal symptoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Matrix multiple-choice example

Assessment finding	Improved	No change	Declined
RR 36	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BP 118/68	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pale skin tone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulse oximetry reading 91%	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interacting with daughter at bedside	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The highlight item type: text & table

On this item type, you are instructed to “click to highlight” the appropriate answers to the question.

This item type can be presented in a table format or in a chart tab where you click to highlight a token that answers the question. You will read a portion of a client medical record (e.g., a nursing note, medical history, lab values, medication record) and then

select the words or phrases that answer the question. The answer can also be part of a sentence.

The answer options will be shown when the candidate hovers over a section that is tokenized. You will then click to choose it as an answer.

Example of a highlight item text

- Click to highlight the findings below that would indicate the client is not progressing as expected.

Progress notes

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

Example of a highlight item table

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

History and physical

Body system	Findings
Neurological	pupils equal and reactive to light and accommodation; anterior and posterior fontanel sunken; moves all extremities weakly
Pulmonary	crackles (rales) noted in bilateral bases upon auscultation; mild grunting and head bobbing; tachypneic
Cardiovascular	pulses 2+ in all extremities; capillary refill 3 seconds; hands and feet slightly cool to touch; mediastinal chest tube in place, serosanguineous drainage noted
Gastrointestinal	hypoactive bowel sounds; abdomen soft and round

The multiple-response item type: select all that apply, select "N," & grouping

MULTIPLE-RESPONSE SELECT ALL THAT APPLY

In this item type, there are 5-10 options. Select one to all options to answer the item.

Example of multiple-response select all that apply

> The nurse has been asked to prepare the patient for immediate surgery. Which of the following actions should the nurse take? Select all that apply.

- Mark the surgical site.
- Provide the client with ice chips.
- Obtain surgical consent from the client.
- Perform a medication reconciliation.
- Insert a peripheral venous access device (VAD).
- Inform the client about the risks and benefits of the surgery.
- Assess the client's previous experience with surgery and anesthesia.
- Ask the client's parents to wait in the waiting room while you discuss the plan of care with the client.

Example of multiple-response select "N" item

> Select 4 findings that require **immediate** follow-up.

- vital signs
- lung sounds
- capillary refill
- client orientation
- radial pulse characteristic
- characteristics of the cough

MULTIPLE-RESPONSE SELECT "N"

Presents information in a sentence format with a list of 5-10 options. The number of correct answers is indicated in the stem of the item. You select the appropriate number of options to answer the item.

MULTIPLE-RESPONSE GROUPING

Presents information in a sentence format with 2-5 small groups of options. Each group contains 2-4 options with 1-4 correct answers. Select one to all options in each group to answer the item. The number of correct answers in each group might not be the same.

NOTE: See page 37 for scoring this item type.

Example of a multiple-response grouping

> For each body system below, click to specify the potential nursing intervention that would be appropriate for the care of the client. Each body system may support more than 1 potential nursing intervention.

Body system	Potential nursing interventions
Neurologic	<input type="checkbox"/> neurologic check every 2 hours <input type="checkbox"/> computed tomography (CT) scan <input type="checkbox"/> morphine 1 mg, IV, every hour p.r.n. pain <input type="checkbox"/> electroencephalogram (EEG)
Cardiovascular	<input type="checkbox"/> chest x-ray every morning <input type="checkbox"/> oxygen at 2 L/min. via nasal cannula <input type="checkbox"/> arterial blood gas (ABG) every 4 hours <input type="checkbox"/> incentive spirometry every 1 hour
Respiratory	<input type="checkbox"/> aspirin 81 mg, p.o., every morning <input type="checkbox"/> echocardiogram <input type="checkbox"/> continuous telemetry <input type="checkbox"/> defibrillator at bedside

The drop-down item type: cloze, rationale, & table

DROP-DOWN CLOZE

- Presents information in sentence format.
- Contains 2-5 drop downs that represent missing information in the form of a word or short phrase; each drop down has 3-5 options, and you select an option from each drop down to complete the sentence.

Example of a drop-down cloze

> Complete the following sentence by using the list of options

The nurse should first address the client's followed by the client's

Select ▼

Abdominal pain

Respiratory status

Laboratory test results

Example of a drop-down rationale

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

The client is at highest risk for developing as evidenced by the client's

Select

Select...

vital signs

neurologic assessment

respiratory assessment

cardiovascular assessment

Select ▼

Select...

hypoxia

stroke

dysrhythmias

a pulmonary embolism

DROP-DOWN RATIONALE

- Presents information as a single sentence containing two drop downs (dyad) or three drop downs (triad) that represent missing information in the form of a word or short phrase. You select the option from each drop down to complete the sentence.

DROP-DOWN TABLE

- Presents information in a table containing at least one column and three rows.
- Each row has one drop down that you must answer.
- You select an option from each drop down.

Example of a drop-down table

> For each body system below, click to specify the potential nursing intervention that would be appropriate for the care of the client. Each body system may support more than 1 potential nursing intervention.

Body system	Findings
Neurologic	<input type="text" value="Select"/>
Respiratory	<input type="text" value="Select"/>
Cardiovascular	<input type="text" value="Select"/>

Differences in scoring the Next Generation NCLEX

How new item types will be scored

With traditional NCLEX items, answers are either right or wrong. Responses may receive zero or one point. This is referred to as dichotomous scoring.

For NGN-style items, however, the NCSBN decided to add two different scoring methods to allow for partial credit.

All of the new items will be correct or incorrect. Some will have partial scoring to give you partial credit. This is referred to as polytomous scoring.

Partial credit scoring can be assigned in different ways:

- **+/- scoring:** You earn one point for each correct response and lose one point for each incorrect response. Scores are summed together to get the item total score. If the summed value is negative, the final score will be truncated to zero.
- **0/1 scoring:** You earn one point for each correct response, but points are not deleted for incorrect responses. Points are summed together to get the item total score.
- **Rationale scoring:** In a dyad, you earn one point when you correctly answer both responses in a paired set. In a triad, you get one point if you get the cause and one effect correct. You get two points if you get all correct.

NOTE: Standard items (Fill-in-the-blank numeric, Multiple choice, Multiple-response select all that apply, Hot spot, and Ordered response) continue to be worth one point. (The Multiple-choice item can be text or a graphic. Multiple-response items will receive partial scoring.)



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