Next Generation
NCLEX Guidebook 2022

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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Coming in April 2023:
a new version of the NCLEX

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

The National Council of State Boards of Nursing (NCSBN) has announced a definitive date for the launch of the Next Generation NCLEX: April 2023. With just that date nearing, the organization also has been actively sharing more detailed information about the exam.

This guide provides the most up-to-date and clearly explained information currently available.

Share it with colleagues to help them prepare for this momentous change.

Note: The information in this guide was current at the time of publication, but the NCSBN regularly releases new details on the NGN. For the most current info, visit ATItesting.com/educator/next-gen-nclex or NCSBN.org.

You can also download the most current version of this publication by scanning the QR code on the cover.

Quick refresher:

why a new NCLEX is needed now

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

When you were in nursing school, your instructors probably didn't talk about clinical judgment — at least not using that term. So why is it important to assess this skill today?

Because healthcare is now much more dynamic. It moves at a rapid pace. And nurses now care for people with more acute, complex, 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. The organization realized it was critical to change the NCLEX so that the exam can accurately assess candidates' clinical judgment skills to ensure public safety.

NCSBN research
& reasons for creating a new test

The plan for the Next Generation NCLEX has been in the works for many years.

In 2009, the NCSBN held conversations with professionals in clinical practice and nursing experts. They determined that the current level of decision-making in nursing had led to a large number of practice errors by entry-level nurses.

Since then, the problem has only gotten worse. An article by Kavanagh and Sharpnack (2021) said that 2016-2020 data showed only 14 percent of new graduate RNs demonstrated entry-level competencies. Worse, 2020 year-to-date graduate data from 200 unique schools of nursing displayed an even more disturbing decline: Only 9 percent of new RN grads ranked in the acceptable competency range for a novice nurse.

The NCSBN's studies underscored that recent data. Its research showed clinical judgment is one of the top five skills required to enter nursing practice. Two other high-priority skills were problem-solving and critical thinking, which are both vital to clinical judgment. (The other two required skills were active listening and professional communication.)

The RN Nursing Knowledge Survey from 2017 offered more evidence of the need for clinical judgment. Newly licensed RNs, RN supervisors, and RN educators unanimously agreed on the importance of clinical judgment. PN experts shared the same concerns.

As a result of these findings, the NCSBN determined it was vital to move forward with the Next Generation NCLEX (NGN) Project.

The NCSBN's steps

to create a new exam

Research is the backbone of the NCSBN's plan.

The NCSBN's team of researchers and psychometricians have followed eight evidence-based steps to prepare for the new version of the exam:

1) DEVELOP A CLINICAL JUDGMENT MODEL

The NCSBN developed a model of five interacting layers that illustrate the complex process of clinical judgment, including the context in which decisions are made. (See page 38.)

2) CREATE ITEM PROTOTYPES

Measuring clinical judgment requires more unique item types than simple multiple-choice questions, as well as different scoring methodologies, including one that deducts points for incorrect responses.

3) TEST ITEM USABILITY

Students, nurses, and educators have reviewed item prototypes to ensure they represent real-life clinical judgment scenarios.

4) COLLECT ITEM DATA

The NCSBN added a "Special Research Section" with new item types for some students to voluntarily answer after completion of the current NCLEX. Their responses didn't impact their scores but did provide valuable insight on question validity.

5) RESEARCH MEASUREMENT

Psychometricians have received millions of data points from the responses to the "Special Research Section." Ongoing analysis has been determining which item types accurately measure clinical judgment and nursing competence.

6) BUILD TECHNOLOGY

The NCSBN is now developing the complex technology needed to support the new item types.

7) PERFORM ALPHA/BETA TESTS

Multiple evaluations are necessary to assess test items. The NCSBN is scrutinizing every item type for those providing the highest accuracy.

8) LAUNCH NEW NCLEX

After the operational phase of testing and building item types, the Next Generation NCLEX is scheduled to launch in April 2023.

The purpose
of the Special Research Section

This section of the current NCLEX is a crucial factor in developing the NGN.

Starting in July 2017, the NCSBN began including a Special Research Section (SRS) as part of the NCLEX-RN exam for select candidates. In October 2020, it began offering an SRS to select PN candidates.

The SRS presents unique item types that are specially designed to evaluate the candidate's clinical judgment skills.

Candidates receive 30 minutes to complete the SRS after their standard NCLEX exam with no impact on their NCLEX score.

Candidates' answers provide data to the NCSBN for use in testing and analyzing the new item types.

The NCSBN says, "This research helps identify Next Generation NCLEX (NGN) items that are at the appropriate difficulty level for entry-level nurses — items that are neither too difficult nor too easy. The research section also helps gather data related to the time required to respond to the new NGN items. Validating both the content and the measurement properties of items is essential to developing a standard-leading assessment of clinical judgment."

Timeline
for NGN's launch

DECEMBER 2022

"Live" beta testing takes place. Actual candidates who are expected to graduate in April 2023 will take a fully functioning exam, but scoring and results will not count. Resulting data will be for internal NCSBN quality control purposes to ensure validity and reliability of the exam.

APRIL 1, 2023

The new test plan launches.

There will not be a separate test plan for the NGN. It is all-encompassing within the RN or PN Test Plan.

APRIL 2023
(To be determined)

The Next Generation NCLEX launches.

The NCSBN plans to launch the NGN for RNs and PNs simultaneously.

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.

Phil Dickison, PhD, RN, the NCSBN's Chief Officer of Operations & Examinations, explained, "Many of these judgments … have the biggest impact in urgent or emergent situations."

What was especially worrisome 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.

DR. PHIL DICKISON

NCSBN Chief Officer
of Operations & Examinations

"A decade of performance-based development system assessments representing more than 10,000 new graduate RNs reveals an alarming year-over-year decline in initial competency."

Kavanagh, Sharpnack, 2021

Clinical judgment:
NCSBN's official definition

Help students understand what it means.

The NCSBN has defined 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 in order to deliver safe client care.

Clinical judgment:
evidence-based advice

Research provides insights on how to incorporate clinical judgment in lessons.

- In cases where students face limitations in credit hours and clinical sites, use unfolding case studies to develop clinical judgment given the established link between dynamic case studies and clinical practice experience. Simulation can also play a role in developing sound clinical judgment. Shatto et al (2017) demonstrated that at least three simulation experiences can contribute to significant clinical judgment development in nursing students. (Hussein et al, 2021)

- Have students review encounters in an unfolding clinical scenario. Ask students to provide evidence-based responses and behaviors based on the associated clinical judgment functions. (See page 41.) This strategy allows educators to promote deep learning, foster the development of clinical judgment, and evaluate student learning. (Sommer et al. 2021)

- Show students why tasks require problem solving, critical thinking, and clinical judgment. (NCSBN, 2018)

- Focus on six instruments that measure clinical judgment: simulation-based experience exposures, specific nursing specialty simulations, debriefing and its effect on clinical judgment, assessment, clinical decision-making, and reflection. (Klenke-Borgmann, et al, 2020)

- Use concept-based strategies that engage students in deliberate practice with concepts as they manifest in a variety of contexts. This technique will increase the number of experiences upon which students can draw to reason through patient situations. (Jessee, 2021)

Learn more:

Sommer, S.K., Johnson, J.D., Clark, C,M,, Mills, C.M. Assisting learners to understand and incorporate functions of clinical judgment into nursing practice. *Nurse Educator.* 2021;46(6):372-375. doi: 10.1097/NNE.0000000000001020

Jessee, MA. (2021). An update on clinical judgment in nursing and implications for education, practice, and regulation. *Journal of Nursing Regulation*, 12(3), 50-60. DOI:https://doi.org/10.1016/S2155-8256(21)00116-2

Dickison, P., Haerling, K.A., & Lasater, K. (2019). Integrating the National Council of State Boards of Nursing clinical judgment model into nursing educational frameworks. *Journal of Nursing Education*, 58(2), 72-78. https://doi.org/10.392801484834-20190122-03.

NCSBN (2018). Strategic practice analysis. NCSBN Research Brief, 7,11-15.

Manetti, W. (2018). Sound clinical judgment in nursing: A concept analysis. *Nursing Forum*, 54(1), 102-110. https://doi.org/10.1111/nuf.12303

Hussein, M., Olfert, M. & Hakkola, J. (2022). Clinical judgment conceptualization scoping review protocol. *Teaching and Learning in Nursing*, 17, 84-101. https://doi.org/10.1016/j.teln.2021.10.003.

Jessee, M. A. (2021). An update on clinical judgment in nursing and implications for education, practice, and regulation. *Journal of Nursing Regulation*. 12(3), 50-57.

Klenke-Borgmann, L., Cantrell, M. & Mariani, B. (2020). Nurse educators' guide to clinical judgment: A review of conceptualization, measurement, and development. *Nursing Education Perspectives*, 41(4), 215-221. https://doi.10/1097/01.NEP0000000000000669.

Using effective techniques

Adopt teaching techniques based on research.

Based on the research noted on the previous page, use these techniques to help students develop their clinical judgment:

- Emphasize what is most important.

- Use cognitive and experiential strategies — active learning — that promote higher-level thinking, such as thinking aloud and reflection.

- Make assignments that are appropriate yet realistic for the students' level.

- Deliver one-on-one interaction and coaching.

- Encourage interaction with other healthcare team members.

- Incorporate quality feedback that:
  - Is timely and specific
  - Identifies strengths/deficits
  - Shares alternative perspectives
  - Recommends ways to improve.

Notes

Clinical judgment:
practical teaching tips

Help students develop clinical judgment skills in three primary ways.

1) USE ACTIVE-LEARNING STRATEGIES.

The use of a variety of active-learning strategies promotes the necessary deep-thinking skills required for developing clinical judgment. Incorporate case studies, video scenarios, and simulation to help students better grasp the concepts being addressed in the classroom.

2) THOROUGHLY ASSESS ALL ASSIGNMENTS.

Make sure any assignment you give students is relevant and challenging yet realistic for the level of your learners. Your goal should be to increase their curiosity and motivation so they thoughtfully complete the work.

3) QUESTION USING THE SOCRATIC METHOD.

This back-and-forth question-and-answer technique is recognized for promoting deep thinking. Require students to examine collected data, compare and contrast findings, provide rationales for their responses, and explain interrelationships.

Notes

Tips on the Socratic Method

Ask insightful questions to elicit deeper thinking about a topic

Socratic questioning is a technique that is especially useful in helping students develop their clinical judgment skills. In essence, you ask a question specifically designed to elicit discussion that clarifies information, justifies a student's response, or probes further.

CLARIFICATION
- "Tell me what you found during the client assessment."
- "What is the client's priority health problem?"

JUSTIFICATION
- "What prompted you to collect that data during your assessment?"
- "What evidence supports this as the client's priority problem?"

PROBING
- "Describe implications of the assessment findings."
- "Explain your thinking about selecting this as the priority problem."

Notes

Clinical judgment:

focus on priority setting

Priority setting is directly related to clinical decision-making and clinical judgment.

Students can improve their skills for prioritizing care by understanding priority-setting frameworks. In doing so, they will inherently improve their clinical judgment skills.

Priority-setting frameworks include (see following pages for details):

- Maslow's Hierarchy of Needs
- The Nursing Process
- Airway-Breathing-Circulation
- Safety & Risk Reduction
- Least Restrictive/ Least Invasive
- Acute vs. Chronic / Unstable vs. Stable / Urgent vs. Nonurgent

Strategies to help students improve their skills in prioritizing care include:

- Use of priority-setting NCLEX items as tools in the classroom or clinical post conference
- Screen-based simulations or videos with clinical scenarios that require students to respond based on a particular priority-setting framework
- Use of priority-setting frameworks in classroom activities such as case studies.

Some priority-settings questions you can use are:

- Which of the following actions should the nurse initiate first?
- Which of the following assessment findings should the nurse report to the provider immediately?
- Which of the following clients should the nurse assess first?
- Which of the following is the next action the nurse should take?

Maslow's Hierarchy of Needs

This framework contains five levels of prioritized needs. (See diagram below.) Physiological needs supersede the others in most circumstances. However, all client factors should be considered 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.

SELF-ACTUALIZATION

LOVE & BELONGING

SELF-ESTEEM

SAFETY & SECURITY

PHYSIOLOGICAL
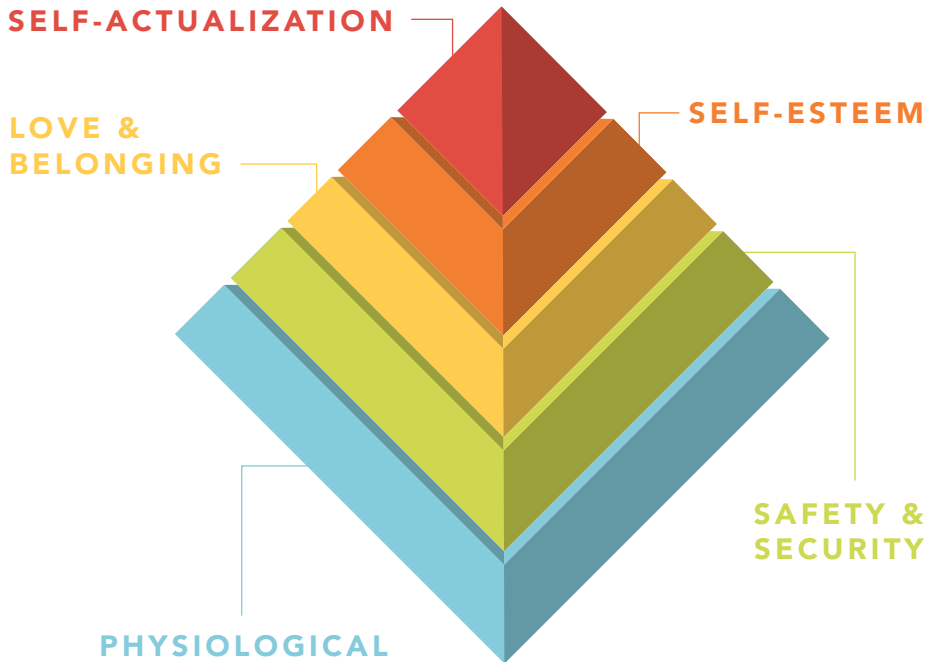
RATIONALES

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.

1ST   Airway

2ND   Breathing
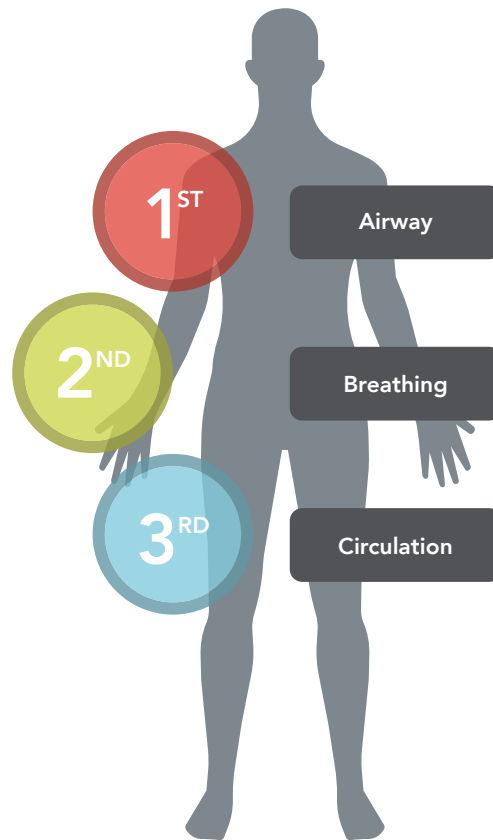
3RD   Circulation

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, another priority-setting framework, like the ABCs, may need to be used 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. Disulfuram
    B. Lorazepam
    C. Clonidine
    D. Atenolol.

RISK ASSESSMENT

Safety risk to client

Greatest risk to client

Significance of risk compared to other risks

RATIONALES

A. Disulfuram 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.

PN: 4 Steps

RN: 5 Steps

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.

DATA COLLECTION FIRST
↓
Planning
↓
Implementation
↓
Evaluation

ASSESSMENT FIRST
↓
Analysis
↓
Planning
↓
Implementation
↓
Evaluation
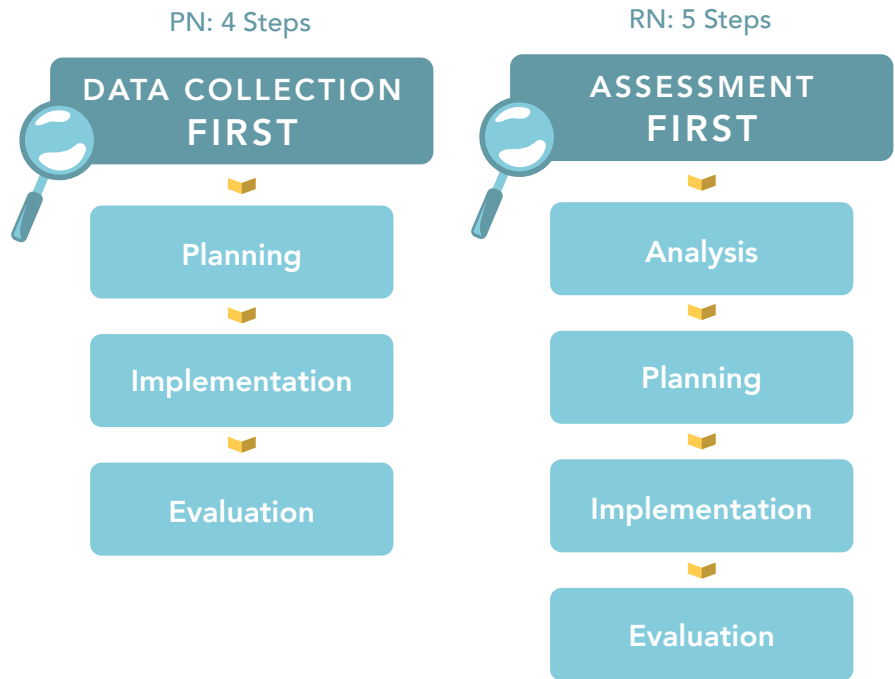
RATIONALES

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.

Notes

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 to the client.

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 and may be used 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.
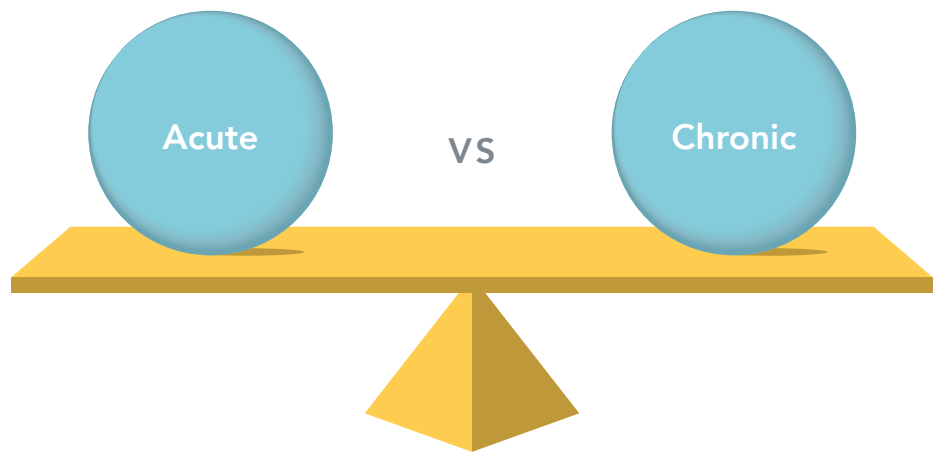
ACUTE VS. NONACUTE ITEM EXAMPLE

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 categories

EXPECTANT/ URGENT

Gray triage tag color

- Victim unlikely to survive given severity of injuries, level of available care, or both.
- Palliative care and pain relief should be provided.

URGENT/ IMMEDIATE

Red triage tag color

- Victim can be helped by immediate intervention and transport.
- Requires medical attention within minutes for survival (up to 60).
- Includes compromises to patient's Airway, Breathing, Circulation.

EMERGENT/ DELAYED

Yellow triage tag color

- Victim's transport can be delayed.
- Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours.

NONURGENT/ MINOR

Green triage tag color

- Victim with relatively minor injuries.
- Status unlikely to deteriorate over days.
- May be able to assist in own care: "walking wounded."

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.

Preparing for
the new version of the exam

Step 1: Don't automatically change the current curriculum you use.

The introduction of a new version of the NCLEX does not mean you need to change your core curriculum. The new version of the NCLEX is simply a measurement tool designed to assess the way students think. Thus, you do not need to completely revise your curriculum, whether it is traditional or concept-based.

How does the NCSBN know your current curriculum will be sufficient in preparing students for the new exam? The organization explained in the following statement from Dr. Dickison:

From July 2017 through December 2018, NCSBN had more than 340,000 individuals interact with new item types designed to measure clinical judgment, he explained.

All of those students had been educated using a variety of nursing curricula. And, no matter which curricula from which the student had learned, the impact was the same: Students who performed well on the regular NCLEX also performed well on the NGN-style items and vice versa.

Step 2: Ensure clinical judgment is part of your lessons.

This information was touched on previously, but it can't be emphasized too much.

To encourage the development of clinical judgment, make it a critical curriculum component.

Incorporate it into:

STUDENT LEARNING OUTCOMES

STUDENT ASSIGNMENTS

Provide multiple opportunities to develop clinical judgment skills. Give students experience with real-life scenarios/case studies.

CURRICULUM EVALUATIONS

Review student acquisition of clinical judgment skills.

TEACHING RESOURCES AND TOOLS

Incorporate learning activities that require clinical judgment.

STUDENT ASSESSMENTS

Incorporate iteration into assessments by adding new information to unfold the clinical situation forcing re-evaluation throughout the process rather than waiting until the end. Students need to know what gaps exist in their understanding even if they ultimately reach the correct decision. Understanding why the other choices in a question were wrong is also a helpful learning tool for students.

The NCSBN's Clinical Judgment Measurement Model is a crucial part of understanding the NGN. Read more about it on the next page and in the NCSBN's "Next Generation NCLEX News" publication.

Step 3: Understand the NCSBN's Clinical Judgment Measurement Model.

The NCSBN's Clinical Judgment Measurement Model (NCJMM) was created to help evaluate candidates' clinical judgment. The NCSBN has been using the NCJMM to develop the new item types that will appear on the Next Generation NCLEX. (If you've used a contextual unfolding case study before, then you may see similarities in the new item types.)

Here's how the NCSBN describes the NCJMM's relationship to the nursing profession:

"Layers 3 and 4 of the NCJMM 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."

The diagram illustrates the "layers" of the NCJMM starting from the broadest layer (0) defining the context of the clinical situation and leading to the most specific contextual layer (4).
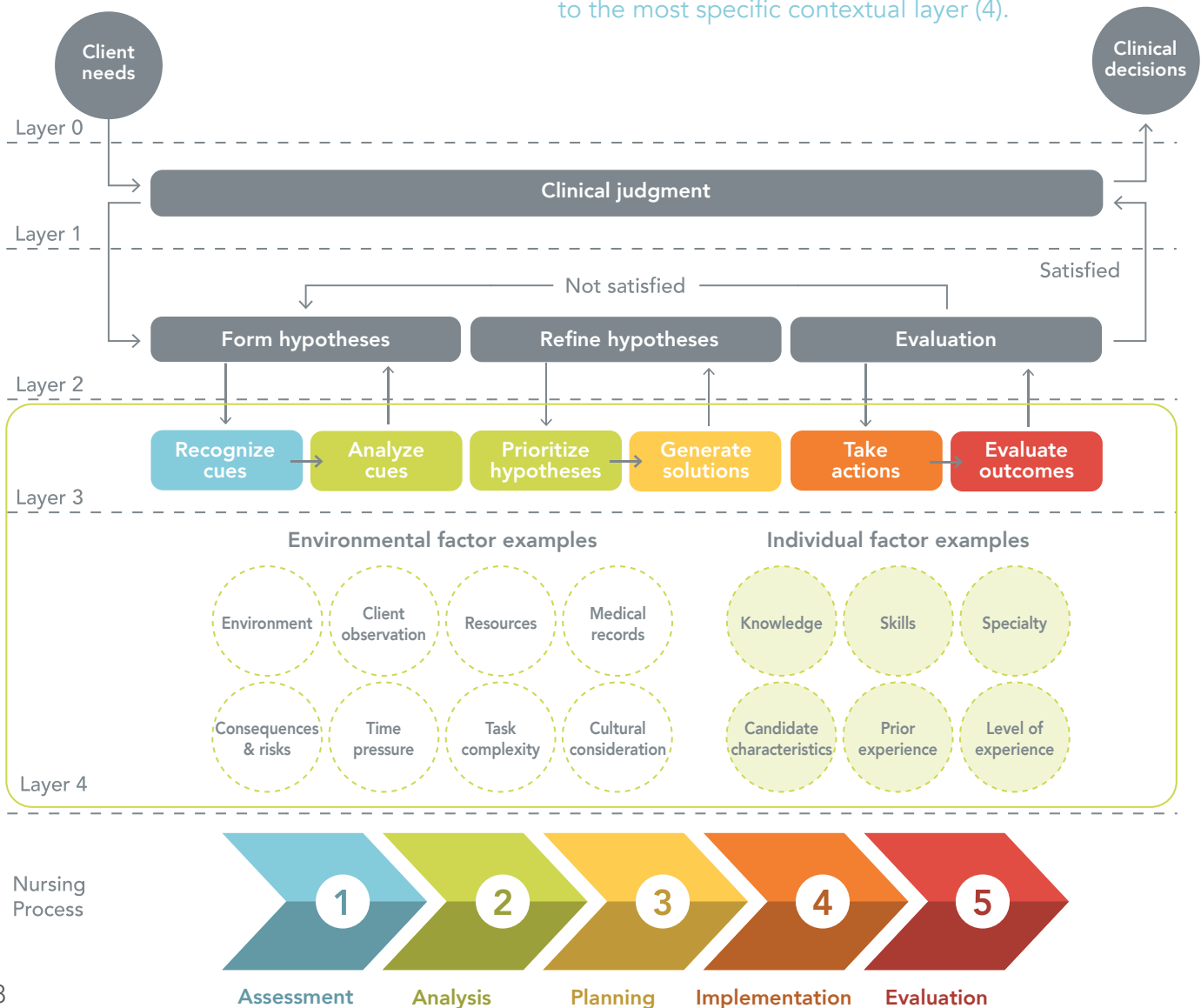
Step 3a: Review the six functions of clinical judgment in Layer 3

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 NCJMM.

1	2	3	4	5	6
Recognize cues	Analyze cues	Prioritize hypotheses	Generate solutions	Take actions	Evaluate outcomes
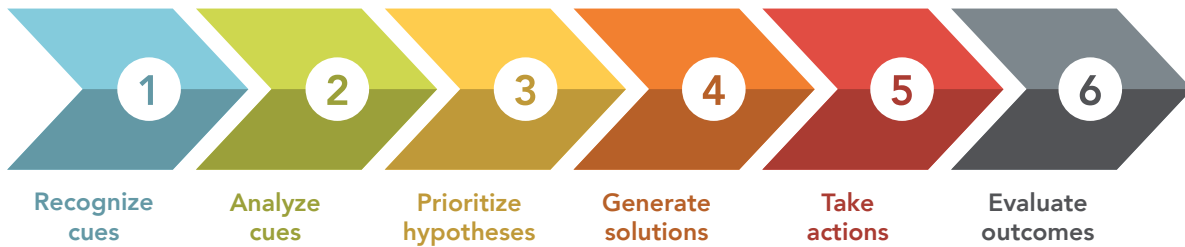
The six steps in this layer involve a repetitious process the nurse moves through with each client. This process is iterative, meaning the nurse can gain new information or cues while assessing or treating a client. This new information can cause the nurse to return to a previous function and then move 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 3b: Review the environmental and individual factors in Layer 4

To further help nursing students understand the aspects of their job that affect their 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 a nurse makes an appropriate clinical decision.

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

Environment

Client observation

Resources

Medical records

Consequences & risks

Time pressure

Task complexity

Cultural consideration

Individual factor examples

Knowledge

Skills

Specialty

Candidate characteristics

Prior experience

Level of experience

Step 4: Focus on creating clinical judgment activities.

Many educators have been concerned about how to explain the NCJMM to students. It admittedly is a complicated-looking graphic. You may decide to wait to mention the model to your students until they are further along in your program, while others may decide to introduce it early and talk about it often.

It's a decision your faculty should make and then be consistent in how they introduce the model. Whichever way you choose, introduce Layer 3 (see below) early. It simplifies the process of understanding the iterative nature of the clinical judgment process.

1	2	3	4	5	6
Recognize cues	Analyze cues	Prioritize hypotheses	Generate solutions	Take actions	Evaluate outcomes
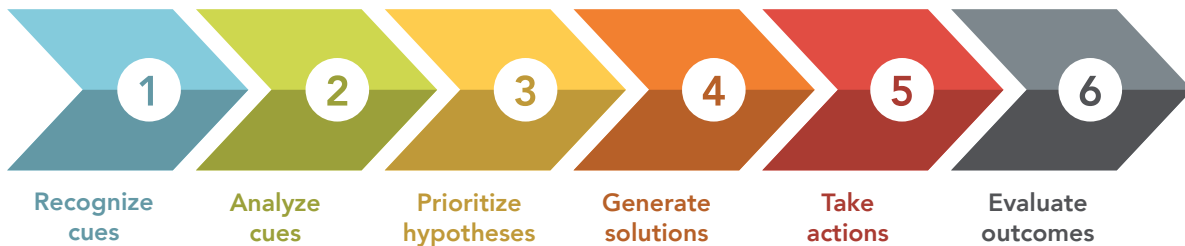
Explain how the functions of clinical judgment in the model align with the nursing process your program uses by showing students an easy-to-understand illustration — "The relationship of approaches fostering clinical judgment" (see following page) —

developed by ATI and included in the "ATI Guide for Clinical Judgment." (Read about the research behind the guide[1].)

Point out the relationship between the nursing process and clinical judgment and how they work in tandem to help nurses deal with complex clinical situations.

The relationship of approaches fostering clinical judgment
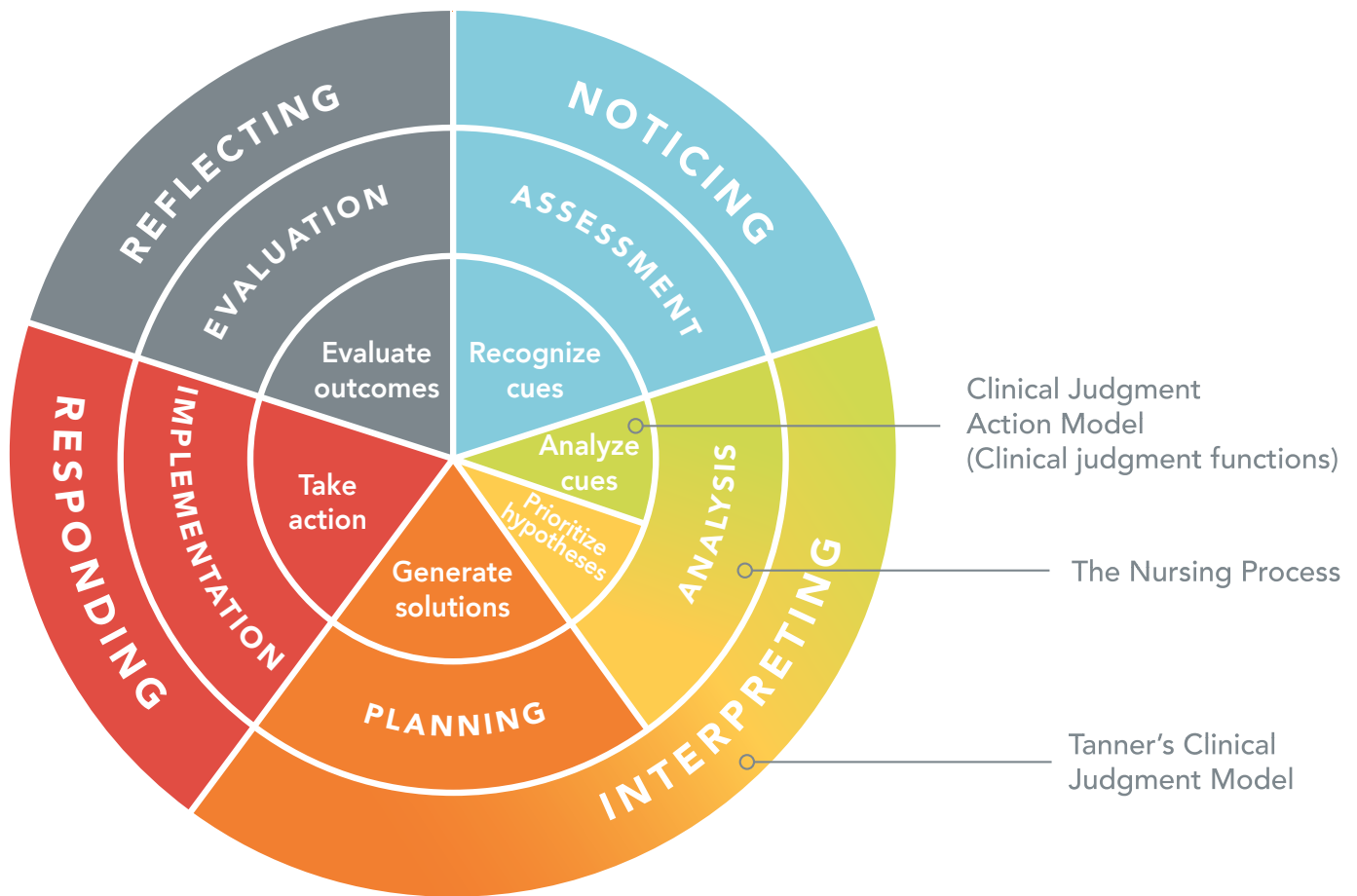
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Step 5: Identify activities you can use to help students develop skills for each function of the clinical judgment model.

Building on the advice regarding teaching techniques and tips mentioned on pages 17, you can start to create more specific activities that enhance the development of each function of clinical judgment.

As you create activities, pay attention to the appropriate nursing actions (expected responses and behaviors) associated with each function.

To help, the following pages identify aspects of each function to help you create a variety of learning activities.

Read on to find out more about:

- The step of the Nursing Process with which each function aligns
- A definition of each function
- Suggestions for activities for each functione.

Notes

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.

Notes

Strategies
to teach clinical judgment

Use NCSBN's action model template: incorporate the NCJMM in lab & clinical settings & on standard written or computer exams.

The NCSBN created an action model template[1] "to define the parts of the CJMM and expected behaviors" that nursing students need to know and perform. Use our simplified version (below) of the NCSBN's original to create activities and ensure you hit all the expected behaviors mentioned in previous pages.

The activities created from this action model can help you determine where students have a solid understanding of the clinical decision-making process and where they need improvement. (We've included details from an NCSBN example to get you started in how to use the tool.)

Function of clinical judgment	Conditioning factor(s)	Expected behaviors
Recognize cues	Environment cues:	Recognize abnormal vs. normal
	Location: ED. Parent present.	Vital signs
	Patient observation cues:	Recognize signs and symptoms
	Present age: 8-10 years. Signs/ symptoms of dehydration: dry mucous membranes, cool extremities, capillary refill 3-4 seconds. Lethargic.	Dehydration
	Medical record cues:	
	Present/imply: Hx of diabetes. Vital signs.	
	Time pressure cues:	Identify history of
	Set time pressure to vary with onset/ acuity of symptoms.	Diabetes
Analyze cues	Requires knowledge of pediatric development, dehydration, and diabetes symptoms.	Describe relationship between level of blood sugar and dehydration. Use evidence to determine client issues.
Prioritize hypotheses	Give vital sign monitors as resources. Set time pressure to vary with vital signs.	Prioritize dehydration. Address dehydration. Avoid glucose.
Generate solutions	Requires knowledge of pediatric developmentally appropriate approach; dehydration treatment and intervention; diabetes treatment and intervention.	
Take actions	Experience:	Nursing intervention...
Evaluate outcomes	Experience:	Reassess vital signs. Reassess lethargy.
	Administering isotonic fluid.	
	Patient observation cue:	
	Show client awake and talking. Imply improvement in vital signs based on actions.	

Create learning outcomes: Make sure functions of clinical judgment are included in unit learning outcomes.

Below, we identify one behavior for each function. But refer back to the variety of behaviors on the previous pages for more ideas when writing objectives.

RECOGNIZE CUES

Identify relevant information related to a client who is experiencing a specific health alteration.

ANALYZE CUES

Identify how pathophysiology relates to the client experiencing a specific health alteration.

PRIORITIZE HYPOTHESES

Organize client assessment information according to changes, patterns, and trends.

GENERATE SOLUTIONS

Determine the potential impact of selected nursing interventions.

TAKE ACTIONS

Monitor the client's response to interventions.

EVALUATE OUTCOMES

Evaluate the effectiveness of the plan of care based on the client's response.

Notes

Strategies
to use in the classroom

Activity: Collecting cues

Present students with a simulated, written, or on-screen scenario.

Ask students to identify the following in the scenario:

RECOGNIZE CUES:
- Identify relevant information related to the client's condition.
- Recognize relevant subjective/objective client data.

ANALYZE CUES
- Identify how pathophysiology relates to clinical presentation.
- Identify data that is of immediate concern.

CLIENT EXAMPLE

History and physical
- 85-year-old male is hospitalized for treatment of pneumonia.
- Medical history of COPD.
- Smokes ½ pack cigarettes/day.

Nurses' notes
- Client has labored breathing and is reporting shortness of breath.
- Lung sounds include crackles in the bases.
- Client has a productive cough with green sputum.
- Oxygen saturation 89% on room air.
- Heart sounds S_1S_2.
- Abdomen soft, nontender.
- Reports chest pain 6/10 on a 0-10 scale.

Vital signs
- Temperature: 101.2 F (38.4 C)
- Respiratory rate: 26/min.
- Heart rate: 89/min.
- B/P: 142/84 mmHg

Activity: **Problem identification**

Create group activity:

- Present students with a written or on-screen scenario.
- Give each student a sheet of adhesive dots in multiple colors (four or five colors needed).
- Use a whiteboard to record student responses.
- Instruct students to identify important data from the scenario.
- As students share information, write it on the board.
- Identify data as "supportive" or "critical" information and underline critical information.
- Invite students to go to the whiteboard and use their colored dots to indicate associated information (e.g., shortness of breath; O2 at 4L per nasal canula; O2 sat 90%).
- Identify data with multiple dots and discuss the associated client problem.

CLIENT EXAMPLE

History and physical
- 74-year-old female
- 5 ft., 8 in.
- 175 lbs.
- Penicillin allergy
- Myocardial infarction 5 years ago

Nurses' notes
- Crackles bilaterally in lung bases
- Last BM 3 days ago
- O2 4L per nasal canula
- O2 sat 89%
- Reports 6/10 back pain
- 3+ pedal edema
- Ejection fraction 32%
- Decreased appetite
- Reports shortness of breath
- Last BM yesterday morning
- Denies weight change

Vital signs
- Temperature: 98.8 F (37.1 C)
- Respiratory rate: 26/min.
- Heart rate: 96/min.
- BP: 154/88 mmHg

Medication administration record (MAR)
- Lasix 40 mg daily
- Potassium 20 mEq PO daily
- Metroprolol 50 mg PO BID
- Albuterol breathing treatment q 6 hr.
- Oxycodone 5 mg PO q 6 hr.

Activity: **Tree of impact**

Organize ideas/actions and subsequent consequences over time.

Assign students to identify:
- Potential consequences (tree roots)
- Interventions/responses (tree branches).

EXAMPLE

What impact does the closing of a healthcare clinic have on a community?

Include the following concepts:
- Healthcare quality
- Healthcare economics
- Healthcare policy
- Health promotion (individual, family, community/population, environment).

Responses

Interventions

Outcomes

Potential client problems and needs

Notes
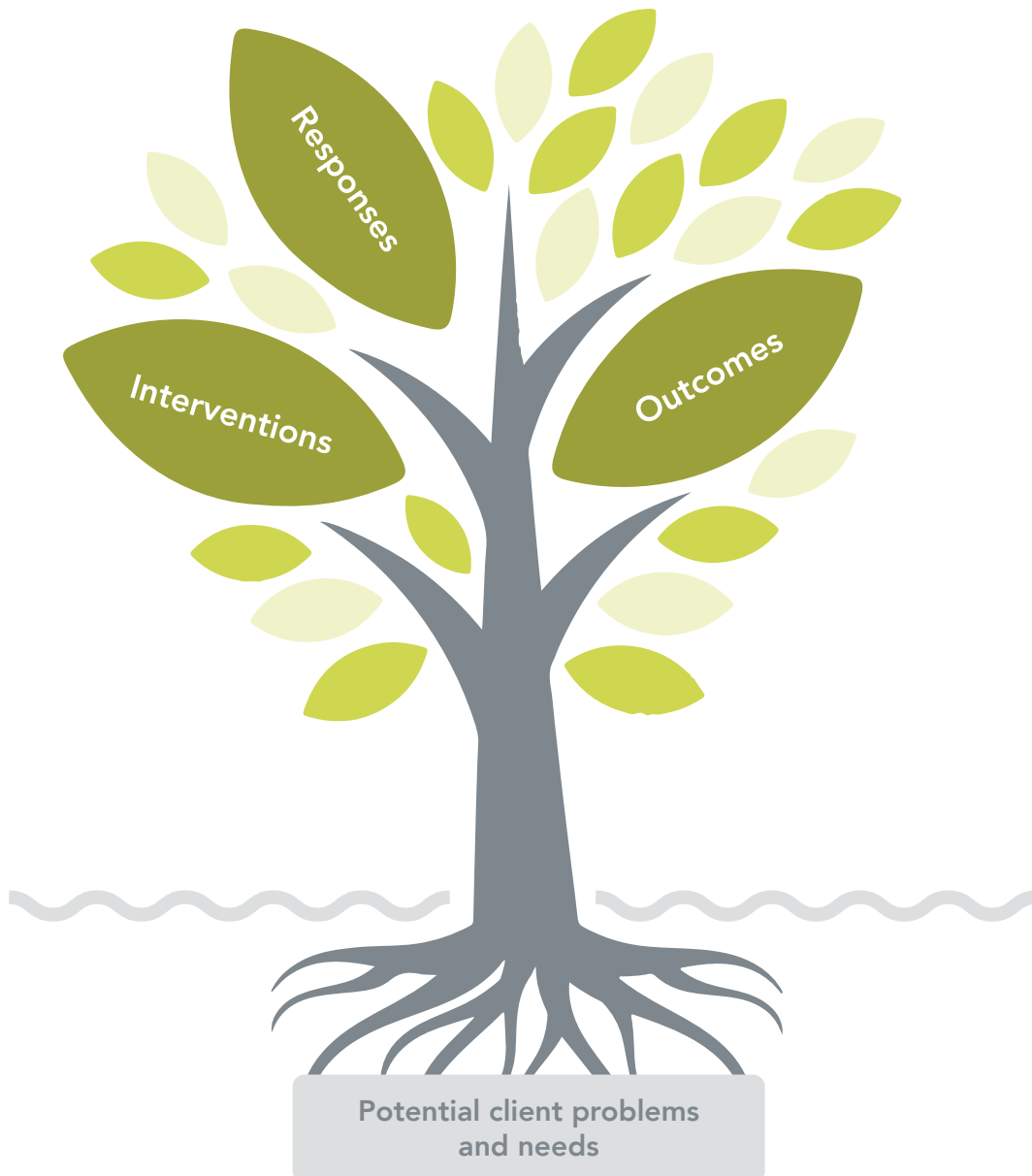
Strategies
to use in the lab/simulation

Activity: **Health assessment**

- Develop a scenario (simulation, written, or on-screen) with unexpected health assessment findings.
- Provide client information.
- Instruct students to do the following:
  - Identify relevant assessment findings.
  - Create a list of additional information to collect from client.
  - Identify the client's priority problem.
  - Identify priority intervention based on findings.
  - Identify desired client outcomes.
  - Document findings in the electronic health record.

CLIENT EXAMPLE

History and physical
- 82-year-old seen in ED with a temperature >101 F (>38.3 C) (oral)
- Abdominal cramps and diarrhea x 4 days
- Medical history of hypertension for 20 years
- Prostrate cancer 5 years ago

Nurses' notes
- Skin warm and dry with tenting
- Care partner says client has become confused and has not urinated for 8 hours
- Reports abdominal pain 8/10, nausea and vomiting x 3
- Reports drinking approximately 5 glasses of water with no food yesterday
- Dry mucus membranes
- Decreased urine output (amber color)
- Lung sounds clear bilaterally
- Heart sounds S_1S_2
- Bowel sounds hyperactive in all 4 quadrants.

Vital signs
- Temperature: 101 F (38.3 C) (oral)
- Respiratory rate: 16/min.
- Heart rate: 118/min.
- B/P: 114/66 mmHg

Strategies
to use in clinical

Activity: Change-of-shift report

Create an end-of-shift report that incorporates information related to the steps of the Nursing Process.
- *Recognize cues (assessment)*: Summarize important information from the change-of-shift report.
- *Generate hypotheses (analysis)*: Identify client problems/needs.
- *Planning (judge hypotheses)*: Select a priority-setting framework and prioritize the client problems/needs.
- *Implementing (take action)*: Identify priority nursing actions.
- *Evaluate outcomes (evaluation)*: Recognize client response to nursing actions.

Repeat the activity using a different priority-setting framework and compare:
- Priority problems/needs
- Priority nursing actions
- Client response to nursing actions.

DISCUSSION
1) Identify client problems.
2) Select a priority setting framework and prioritize the client problems/needs.
3) Identify priority nursing actions.
4) Recognize client response to nursing actions.

See client example on next page.
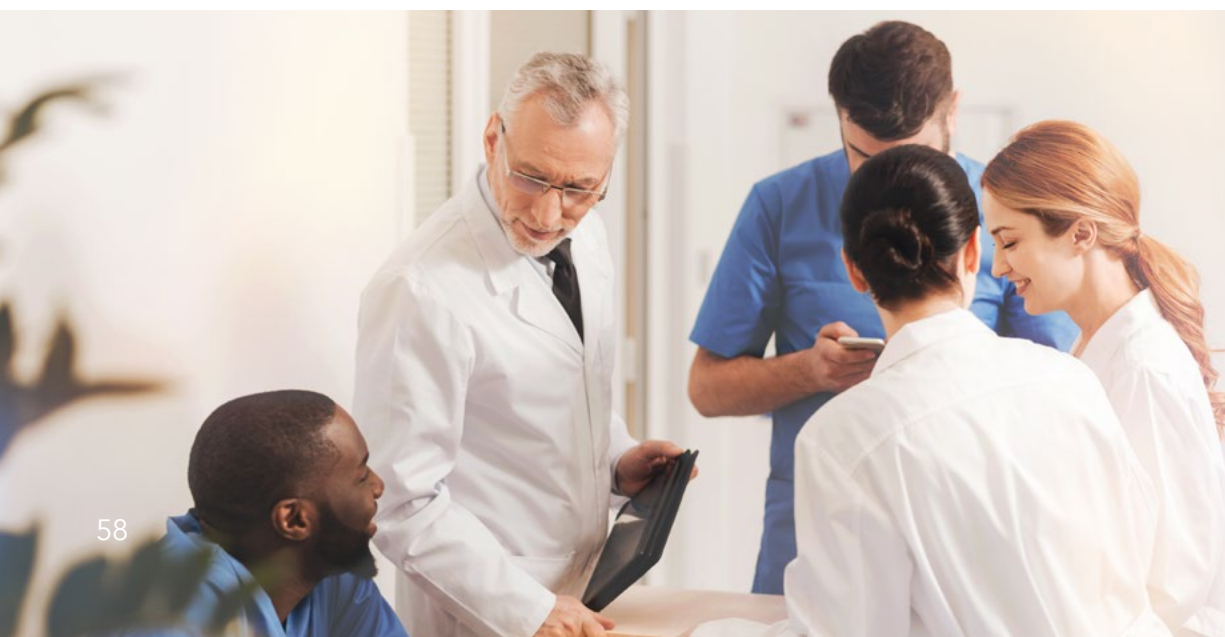
Strategies
to use in clinical/simulation

Activity: Clinical judgment case study

Review the client example below and then follow these steps:

1) **Recognize cues** (assessment): Identify subjective and objective assessment information related to the client's condition and place it in the "Assessment findings" box.
2) **Analyze cues** (analysis); **Prioritize hyphotheses** (analysis): Based on assessment data identify, and prioritize the top three client problems. Write one client problem in each of the "Client problem" boxes.
3) Below each "Client problem," enter the "Supporting assessment" information.
4) **Generate solutions** (planning): Identify a potential client outcome per client problem and enter it in the "Potential client outcomes" box.
5) **Take actions** (implementation): Identify important nursing interventions that should be taken to address each client problem and enter them in the related "Interventions" box for the associated client problem.

CLIENT EXAMPLE

History and physical
- Age: 69
- Weight: 89 kg
- Admitted Dx: Hyperglycemia
- Upon admission, family reported the client had been sick for 3 days experiencing nausea, vomiting, and fever of 102 F (oral)
- PMH: +Nicotine use; DM II; CAD; HTN; Hypercholesterolemia; Neuropathy bilat LE.

Nurses' notes
- Client was confused AOx2
- Turgor-tenting was present; started on an insulin drip that discontinued 4 hours ago and started on regular NPH insulin
- Takes metformin at home for diabetes
- Heart sounds: S_1S_2
- Lung sounds: Expiratory wheezing
- Bowel sounds: Active in all 4 quadrants
- Client reports a headache with a pain level of 8/10
- Client reports excessive thirst and urination

- Client reports fatigue and blurry vision
- Oxygen saturation: 95% on room air
- Serum glucose: 835
- BNP: 32
- Na+: 148
- K+: 4.7

Vital signs
- Temperature: 102.1 F (94.4 C) (oral)
- Respiratory rate: 24/min.
- Heart rate: 108/min.
- B/P: 172/98 mmHg

Assessment findings:

Client problem 2: Add supporting assessment information

Interventions:

Client problem 1: Add supporting assessment information

Interventions:

Client problem 2: Add supporting assessment information

Interventions:

Potential client outcomes

1.
2.
3.

QUESTIONS

- What additional factors should the nurse include in the plan of care for this client? (Generate solutions; Planning)

  - For example: age, religious, nursing knowledge, literacy, or cultural preferences.

- What safety considerations should be included when planning care for this client? (Generate solutions; Planning)

  - For example: fall risk, medication, age, mobility.

- What education should the nurse provide to this client? (Take actions; Implementation)

  - Self-care, health promotion, disease management (for example, medication, diet, activity, ADLs)

- Based on the performed nursing interventions, what client outcomes would you anticipate? (Generate solutions, Planning)

- How will you determine if expected client outcomes are achieved? (Evaluate outcomes; Evaluation)

- Discuss ways to modify or revise the plan of care when client outcomes are not met. (Evaluate outcomes; Evaluation)

Strategies
to use in clinical/simulation

Activity: Clinical and simulation strategy journal

Use the guidelines below for a journal assignment following a clinical experience.

Recognize cues	• Client information • Focused assessment • Medications, lab, and diagnostic tests
Analyze cues	• Identify expected/unexpected findings • Identify potential complications • Identify data of immediate concern
Prioritize hypotheses	• Organize assessment data according to client changes and trends • Prioritize client problems/needs
Generate solutions	• Collaborate with client, care partner, and interprofessional team to establish outcomes and plan of care
Take actions	• Perform nursing actions based on prioritized problems • Accurately document client care data • Monitor client's response to interventions
Evaluate outcomes	• Reassess client condition to determine achievement of expected outcomes • Modify outcomes and/or nursing actions based on client's response

Details

about the new exam

The Next Gen NCLEX will cover 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 changing.

But the NGN won't focus solely on assessing clinical judgment. It will continue to include items that require the application of knowledge.

Assessing knowledge continues to be important. After all, 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.

Remind students that the new test is not designed to trick them or measure whether they are master nurses. Its purpose is to better evaluate each candidate's clinical judgment ability rather than simply measure nursing knowledge.

For a minimum-length test, students will see about 25 percent NGN items, and for a maximum-length test, they will see about 19 percent NGN items.

25%

19%
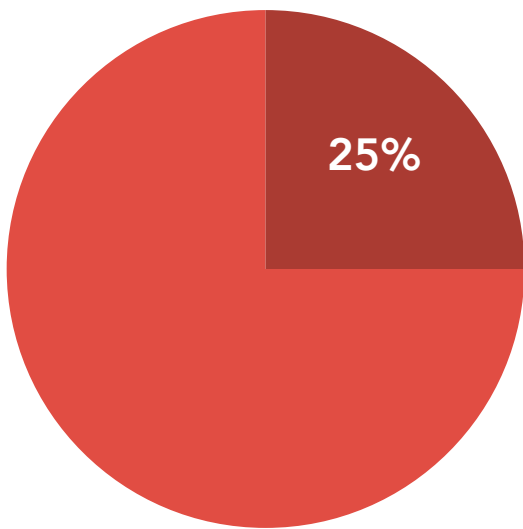
For a minimum-length test, students will see about 25% NGN items.
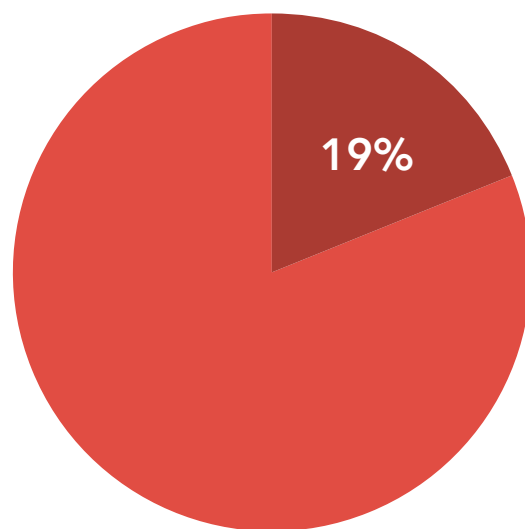
For a maximum-length test, students will see about 19% NGN items.

The length
of the Next Gen NCLEX

The length of the new exam will be slightly different than the current NCLEX.

The NGN will present 70-135 scored items (plus 15 pretest items) based on the test-taker's ability. The unscored items will not contribute to the candidate's test score but will be used for future exam development. In all, the total exam length will be 85-150 items. Among the scored items on a minimum length test, candidates should expect three case studies with 18 of the 85 items (21%) to be NGN.

CASE STUDIES MEASURING CLINICAL JUDGMENT

Every candidate will respond to three case studies that count toward their score. The unscored items on the test may also include case studies or standalone NGN items, so candidates may see more than three case studies in total. Each case study is comprised of six clinical judgment items.

KNOWLEDGE

Every candidate also will answer a minimum of 52 knowledge-focused items.

After answering the initial 85 items (70 scored + 15 pretest), if a student is close to the cut score (see page 69), he or she will be asked additional questions. Most of these will be knowledge-based, but about six to seven will focus on clinical judgment in the form of stand-alone items. The maximum number of questions, then, will be 150 (135 scored + 15 pretest).

Time required

to answer new item types

Students don't need a lot more time to answer items on the new version of the exam.

Initially, the NCSBN theorized that graduates 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 are taking 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 students "carrying knowledge" from one case study question to the next, continually gathering information as the case study unfolds. As a result, they can answer items more quickly.

Reminders
about the NCLEX

Refresh your memory on some important aspects
of the exam that won't be changing.

COMPUTER ADAPTIVE TESTING (CAT)

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

- When an item is answered, the
  computer re-estimates the candidate's
  ability based on each individual item
  and the difficulty of those items.
- The computer selects the next item the
  candidate should have a 50 percent chance
  of answering correctly.
- The computer's estimate of the
  candidate's ability becomes more precise
  as more items are answered.
- When the computer establishes the
  candidate's ability, after the minimum items
  have been answered, the examination ends.

- Note: Items within case studies are not
  computer adaptive.

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 both the
current NCLEX and the NGN are
computer-adaptive, the computer
stops administering items when it is
95 percent certain the candidate's
ability is either clearly above or
clearly below the passing standard.

ACCOMMODATIONS

The future NCLEX will offer the
same accommodations offered
today. For example, a paper-pencil
accommodation would be denied
because the test is adaptive. But a
candidate can request extra time, a
separate room, reader, or recorder.
For the visually impaired, JAWS
software will be used. (Students
should request accommodations from
their state-specific regulatory body.)

Differences between
the current NCLEX & the NGN

What **won't** change from the current NCLEX.

BASIC FACTORS
- The exam will continue to measure the same critical content areas.
- Most items on the entire exam will be standard NCLEX items.
- The scoring *scale* will not change.
- The exam will remain computer-adaptive.

We asked the NCSBN's Dr. Dickison to provide more detail on the factors above:

CONTENT AREAS COVERED
The reason for changing the NCLEX was to measure clinical judgment, but the exam's focus won't change in terms of the overall content it covers.

"Just because we're measuring clinical judgment doesn't mean all the other stuff that we've been measuring is not important; it's still important," Dr. Dickison explained.

MAJORITY OF ITEM TYPES
Dr. Dickison cleared up a misconception for many that the revised exam will focus exclusively on new NGN-style item types.

"The majority of items on a minimum-length exam will still be the standard NCLEX item types," he said.

SAME SCORING SCALE
"We've kept that scale stable for 20 years," Dr. Dickison said. Going forward from the NGN he noted, the exam will continue to offer longitudinal comparisons of nurse ability; scores will be comparable from four years ago to a year after the NGN launches.

What **will** change from the current NCLEX.

BASIC FACTORS

- Each candidate will see new item types.
- Students will be presented with case-study items and stand-alone items.
- Some items on the test will use partial-credit scoring (dichotomous and polytomous).

NEXT GENERATION NCLEX ITEMS

The Next Gen NCLEX will then measure clinical judgment in two different ways:

1) Case study items that reflect real-world clinical situations and the decisions nurses make to address clients' needs and anticipated outcomes.
2) Stand-alone items that are not part of a case study.

CASE STUDY ITEMS

Case study items require candidates to respond to items representing each function of clinical judgment in order: recognize cues, analyze cues, prioritize hypotheses, generate solutions, take actions, and evaluate outcomes.

STAND-ALONE ITEMS

Two stand-alone item types will be offered: the bow-tie and the trend. Candidates who continue beyond the minimum-length exam may receive as many as six to seven of these item types on the rest of their exam.

PARTIAL-CREDIT SCORING

The NCSBN's Dr. Dickison said some new item types on the NGN won't be scored as simply right or wrong. Instead, candidates will receive full, partial, or no credit for an answer based on the selected response. (See page 86.)

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 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 NCJMM.

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 for students, 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?)

1	2	3	4	5	6
Recognize cues	Analyze cues	Prioritize hypotheses	Generate solutions	Take actions	Evaluate outcomes
What matters most?	What does it mean?	Where do I start?	What can I do?	What will I do?	Did it help?
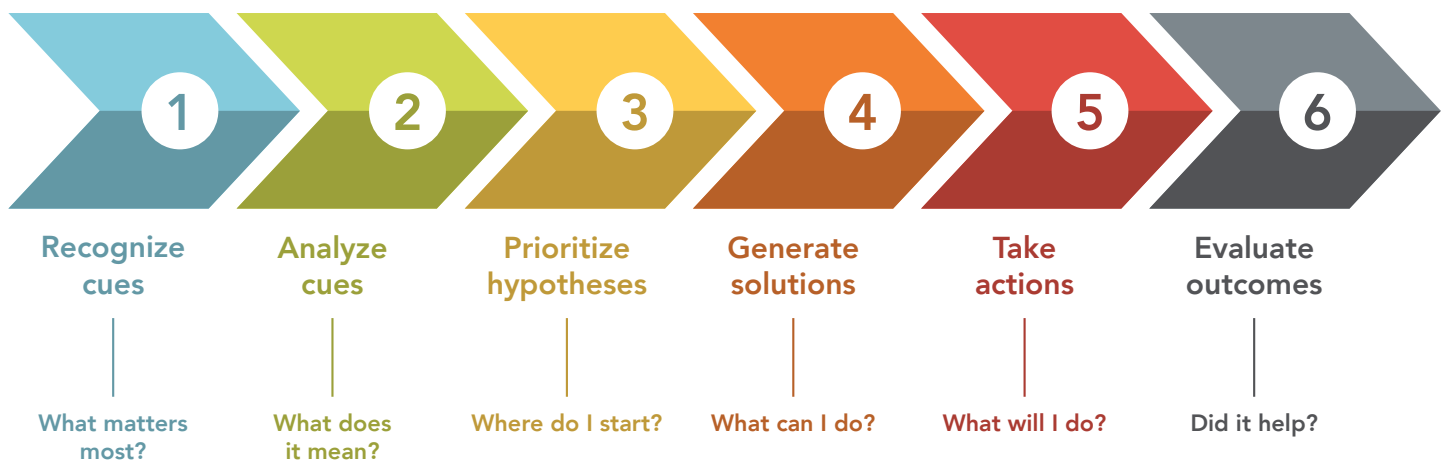
The format of case studies

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 course 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. Note: The red arrow will not appear for students. 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 course 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 NCJMM.

Stand-alone items will consist of two item types:

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

A BOW-TIE ITEM

Bow-tie items address all six steps of the NCJMM in one item. The candidate reads a scenario to recognize whether findings are normal or abnormal (recognize cues), understands the possible complications or medical conditions the client may be experiencing (analyze cues), and identifies possible solutions to address the client's needs and issues (generate solutions). The candidate then answers 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 interventions have been implemented (evaluate outcomes).

TREND ITEM

Trend items are individual items in a scenario in which the candidate reviews 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 NCJMM. 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."

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.

Action to take		Parameters to monitor
	Condition most likely experiencing	
Action to take		Parameters to monitor

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 four to 10 rows and two to three columns. Each row must have only one answer.

A matrix multiple-response will have four to seven rows and two to 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 candidates can or should choose? Look at whether the grid contains circles or boxes. Circles (also known as radio buttons) only allow candidates to choose one option.

Matrix multiple-response example

Assessment finding	Bowel obstruction	Appendicitis	Ruptured spleen
Appetite	○	○	○
Pain level	○	○	○
Bowel pattern	○	○	○
Gastrointestinal symptoms	○	○	○

Matrix multiple-choice example

Assessment finding	Improved	No change	Declined
RR 36	○	○	○
BP 118/68	○	○	○
Pale skin tone	○	○	○
Pulse oximetry reading 91%	○	○	○
Interacting with daughter at bedside	○	○	○

The highlight item type: text & table

On this item type, candidates 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 the candidate clicks to highlight a token that answers the question. Candidates 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. The student 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 drag-and-drop item type: rationale & cloze

On drag-and-drop item types, the candidate will drag word choices (options) from the word choice box to the targets in the question.

DRAG-AND-DROP CLOZE

- Presents information in sentence format
- Contains one to five answer spaces, or targets, that represent a missing word or short phrase
- Answers are dragged from word-choice box to targets
- The word-choice box contains four to 10 word choices
- The word-choice box always includes more word choices than available targets

DRAG-AND-DROP RATIONALE

- Presents information in a single sentence
- The sentence contains two targets (dyad) or three targets (triad)
- Answers are selected from corresponding word boxes and dragged to appropriate targets
- This item type will have two word-choice boxes with five options each.

Example of a drag-and-drop rationale

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

The client is at risk for developing [_____], [_____], and [_____].

Word choices

- wound dehiscence
- infection
- pleural effusion
- dysrhythmias
- contractures
- seizures

Example of a drag-and-drop cloze

> Drag 1 condition and 1 client finding to fill in each blank in the following sentence.

The client is at risk for developing [_____] due to [_____].

Condition	Client findings
infection	bedrest
contractures	chest tube placement
dysrhythmias	wound approximation
pleural effusion	respiratory assessment findings
wound dehiscence	purulent drainage from incision site

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

MULTIPLE-RESPONSE SELECT ALL THAT APPLY

In this item type, there are five to 10 options. Select one to all options to answer the item. (See example below.)

MULTIPLE-RESPONSE SELECT "N"

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

MULTIPLE-RESPONSE GROUPING

Presents information in a sentence format with two to five small groups of options. Each group contains two to four options with one to four 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 86 for scoring on this item type.

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

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	☐ neurologic check every 2 hours
	☐ computed tomography (CT) scan
	☐ morphine 1 mg, IV, every hour p.r.n. pain
	☐ electroencephalogram (EEG)
Cardiovascular	☐ chest x-ray every morning
	☐ oxygen at 2 L/min. via nasal cannula
	☐ arterial blood gas (ABG) every 4 hours
	☐ incentive spirometry every 1 hour
Respiratory	☐ aspirin 81 mg, p.o., every morning
	☐ echocardiogram
	☐ continuous telemetry
	☐ defibrillator at bedside

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

DROP-DOWN CLOZE
- Presents information in sentence format.
- Contains two to five drop downs that represent missing information in the form of a word or short phrase; each drop down has three to five options, and the candidate selects an option from each drop down to complete the sentence.

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. The candidate selects 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 the candidate must answer.
- The candidate selects an option from each drop down.

Example of a drop-down cloze

> Complete the following sentence by using the list of options

The nurse should first address the client's [Select ▾] | Abdominal pain / Respiratory status / Laboratory test results

followed by the client's [Select ▾]

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 [Select ▾]

Select... / hypoxia / stroke / dysrhyhmias / a pulmonary embolism

as evidenced by the client's

Select
Select...
vital signs
neurologic assessment
respiratory assessment
cardiovascular assessment

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	Select ▾
Respiratory	Select ▾
Cardiovascular	Select ▾

Notes

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, 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 a candidate partial credit. This is referred to as polytomous scoring.

Partial credit scoring can be assigned in different ways:

- **+/- scoring:** Candidates 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:** Candidates earn one point for each correct response and points are not deleted for incorrect responses. Points are summed together to get the item total score.
- **Rationale scoring:** In a dyad, candidates earn one point when both responses in a paired set are answered correctly. In a triad, candidates get one point if they get the cause and one effect correct. The candidate gets two points if they 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. In 2023, Multiple-response items will receive partial scoring.)

82

Developing & assessing

clinical judgment skills

The art and science behind assessments

ATI relies on a scientific approach to develop and maintain the highest-quality assessments. We apply four basic processes:

1) Applying scientific principles and research to create rigorous and trustworthy products and solutions
2) Instituting processes that meet or exceed testing-industry, publishing, and ethical standards for product and assessment development
3) Insisting on exceptional caliber originality, accuracy, and consistency
4) Setting rigorous expectations that ensure legal defensibility of products and accreditation status.

NOTE: During the National Simulation Study (2014), the NCSBN selected ATI 's Content Mastery Series® exams as their measurement tool for student nursing knowledge.

We rely on a team of experts with decades of experience in five key disciplines:

RESEARCH & PSYCHOMETRICS

Master's- and PhD-level experts who ensure the science behind ATI assessments.

CONTENT DEVELOPMENT

Master's- and doctorate-prepared nurses with years of content-specific experience and teaching who have mastered item writing and a strong network of diverse external experts who develop creative and original content.

ASSESSMENT & LEARNING PRODUCTS

Test developers, editors, and designers who create products and assessments that meet an array of specifications.
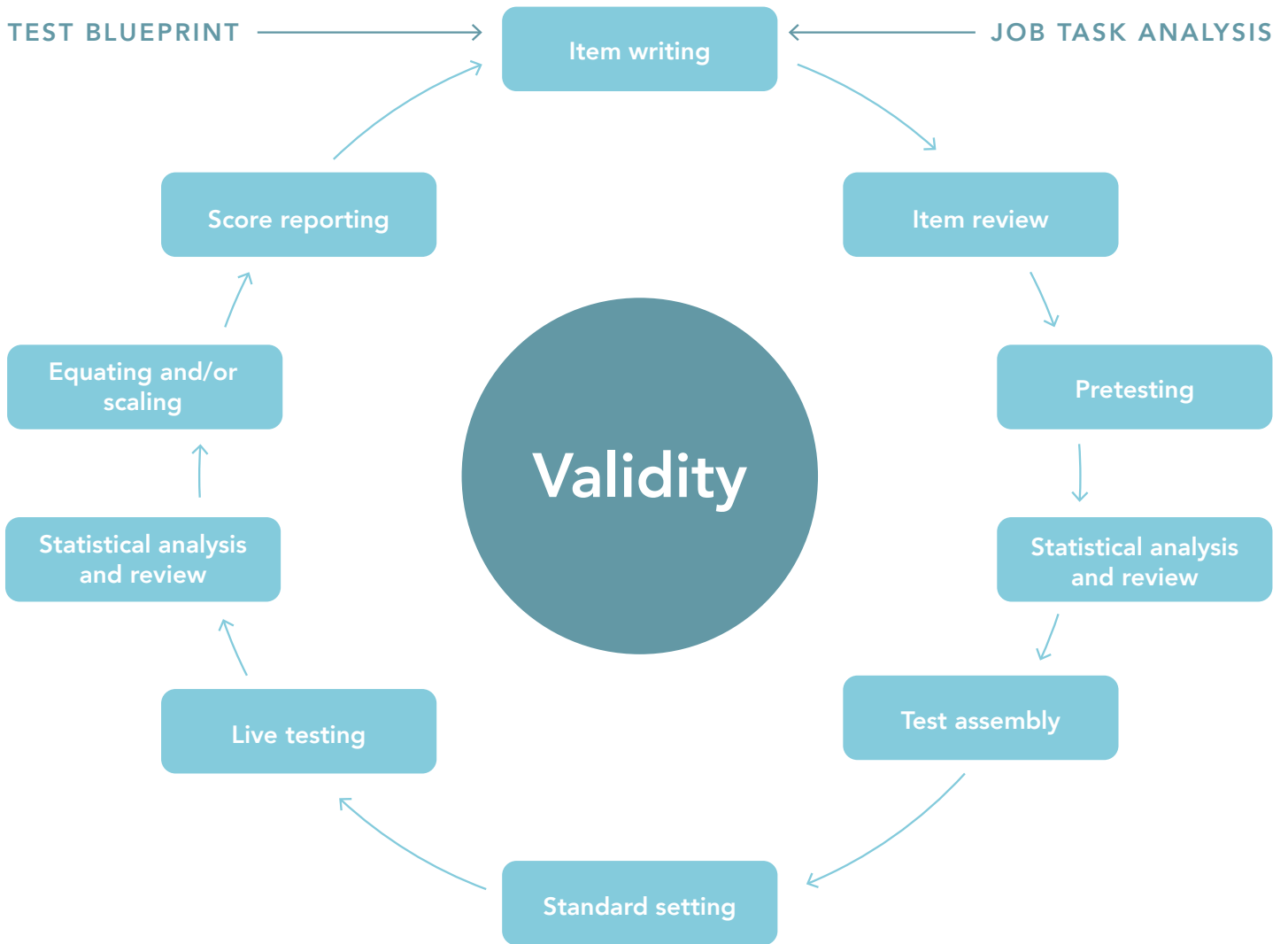
MEDIA DEVELOPMENT

Skilled professionals who engage every type of learner with thoughtful applications using a variety of innovative media tools that allow access to those with disabilities.

TEST SECURITY

Experts who actively protect the validity and intellectual property of our products through preventive and correction efforts.

The ATI process of item development

→ Item writing ←

Score reporting

Item review

Equating and/or scaling

Pretesting

Validity

Statistical analysis and review

Statistical analysis and review

Live testing

Test assembly

Standard setting

An overview: Assessment development

ATI maintains a rigorous process to establish and support the reliability, validity, and trustworthiness of its assessments. Establishing the validity of an assessment requires an ongoing collection of procedural and empirical evidence throughout the life of the product. It starts early, and it continues throughout the ATI Assessment Development Process:

- Test-plan development
- Item-level development
- Test-level development
- Test maintenance
- Outcomes assessment.

Item development is a meticulous process. It consists of:

CONTINUOUS ITEM DEVELOPMENT

The steps involved include:
- A strong network of diverse internal and external content experts
- Content experts who consistently apply evidence-based practices to ensure content is valid and defensible
- ATI item-writing guidelines that mirror NCLEX style of items.

ITEM REVIEW MEETINGS CONDUCTED BY TEST DEVELOPERS AND EXPERIENCED NURSE EDUCATORS

These meetings include:
- A review of each item by two content experts
- An analysis that ensures all content is relevant and tied to a blueprint task
- Confirmation that all items meet the item-writing guidelines
- A determination whether proctored items are ready for pretesting
- A final review of items that didn't fall into the statistical range originally set for them.

Three key steps align job analysis and the NCLEX test blueprint for both the NCSBN and ATI:

THE NCSBN
- Performs a Job Analysis Study every three years
- Develops the NCLEX-RN and NCLEX-PN test plans
- Researches aspects of nursing to aid in improved client care, such as the range and number of tasks expected of entry-level nurses.

ATI NURSING EDUCATION
- Conducts a Test-Plan Development Meeting as needed.
- Performs a crosswalk of the new NCSBN test plan and adjusts our current test plans to align.
- Finalizes the ATI test plan.

Testing & equating

Is your test harder than mine? Why equating is important.

- Total scores are adjusted between different assessment versions to compensate for (small) differences in difficulty.
- Most ATI proctored assessments are equated, meaning that different versions of the assessment and their scores can be used interchangeably.

After an item is approved, it will then be pretested to ensure it is psychometrically sound.

Assessments are often comprised of both operational items (scored) and pretest items (unscored). Operational items have already completed the full development process, are known to perform to an acceptable standard, and are used to determine the candidate's score on the assessment.

Pretest items, however, do not contribute to a candidate's score. Candidates are not able to differentiate between operational and pretest items.

This process allows ATI to collect high-quality administration data. Once we have this data, we examine the items for their psychometric performance. For example, we review their difficulty and their ability to discriminate between high-performing and low-performing candidates.

Items that don't perform well are reviewed and potentially revised.

Test security

for proactive protection

ATI employs a variety of technical controls and test designs

EMBEDDED CONTROLS

Built within proctored assessments, this preventive measure alerts the proctor if a candidate attempts to navigate away from the assessment, which could indicate exam misconduct or compromise of exam items.

APPLICATION SECURITY REVIEWS

Web application security reviews identify security risks associated with high-severity vulnerabilities found by an independent third-party (professional hacker) in our environment.

PROPRIETARY TECHNOLOGY FOR DETECTING IP (INTELLECTUAL PROPERTY)

This technology mitigates risk associated with content theft and assists in easier identification of ATI content with quick determination whether the content has been compromised.

ENHANCED ASSESSMENT DISTRIBUTION

ATI randomly distributes a set of items nationwide to decrease item exposure and lessen predictability.

Clinical judgment tools
for development & assessment

For years, ATI has focused on improving students' clinical judgment skills, evaluating new item types, exploring scoring methods, and developing new items.

Tools for development

REAL LIFE CLINICAL REASONING SCENARIOS
Screen-based simulation to encourage critical thinking, clinical decision-making, and clinical judgment with deep engagement in realistic client scenarios. Using branching logic, students are challenged to make important healthcare decisions as they progress through each scenario, significantly impacting client outcomes.

NURSE'S TOUCH SUITE
With six active-learning solutions, students receive the crucial opportunity to build their skills in realistic, challenging scenarios. Then, upon entering an actual clinical setting, they're well-versed with that special touch of a professional nurse. Media-rich tutorials, video case studies, virtual simulations, and nationally normed NCLEX-style item assessments boost student confidence and elevate their preparedness to a professional level.

HEALTHASSESS
In a single health assessment teaching solution, HealthAssess offers a combination of learning modules and authentic practice simulations to fully prepare nursing students to perform health assessments on all major body systems using the most current techniques and practices.

VIDEO CASE STUDIES
Video Case Studies offer an easier way for students to grasp difficult concepts. The scenarios, which feature live actors, help students visualize what to expect in clinicals and then end with a question. Students formulate their own plan of care instead of choosing from a set of options, challenging them to flex and refine clinical judgment skills along the way.

NURSE LOGIC 2.0

Teaches students to "think like a nurse." It gives a formal introduction to critical thinking methods, the nursing process, priority setting frameworks, and test-taking strategy.

SKILLS MODULES 3.0

With the knowledge delivered from 30 modules — each featuring tutorials, step-by-step demonstration videos, checklists, quick references, animations, pre- and post-tests, challenge cases, remediation, and more — students will enter the on-site skills lab with more refined clinical judgment skills.

ATI ENGAGE SERIES

A 40-lesson alternative to students' fundamentals textbooks equips students with modules that are broken into easy-to-digest segments of content and interwoven with rich multimedia graphics, videos, and engaging activities that help students apply their learning. Plus, students find clarity in consistent skills techniques with embedded videos from ATI's Skills Modules and through practice with active EHR documentation from ATI's fully integrated EHR Tutor.

SWIFT RIVER VIRTUAL CLINICALS

Virtual Clinicals offers a series of more than 600 screen-based simulation scenarios covering all the major clinical areas. Students become more prepared and confident for the clinical setting, gaining experience through exposure to hundreds of diverse client scenarios. They are given the opportunity to begin making clinical decisions, including practice with analytical thinking, prioritization, and delegation.

Tools for assessment

THE NCLEX EXPERIENCE
Available for RN and PN, this product gives students an orientation and an opportunity to practice with Next Generation NCLEX item types in a low-stakes environment.

CONTENT MASTERY SERIES
The Content Mastery Series is designed to provide data related to a student's mastery of specific concepts related to the NCLEX. Each core content area includes a proctored assessment and online practice assessment, as well as remediation materials in print and online.

CUSTOM ASSESSMENT BUILDER
This tool allows you to create and maintain exams quickly and easily by providing you with thousands of test items from an expansive ATI item bank and giving you the ability to create your own custom items. Select individual items to create an assessment or design a test blueprint and opt for the Custom Assessment Builder to handle item selection for you.

COMPREHENSIVE PREDICTOR –
WITH NGN ITEMS
COMING SOON!
Comprehensive Predictor is the last stop for students before they enter intensive NCLEX prep. This three-hour, 180-item, proctored test is designed to help students assess their likelihood of passing the NCLEX while detailing areas for further remediation.

CONCEPT-BASED CURRICULUM –
WITH NGN ITEMS
COMING SOON!
ATI's standardized RN Concept-Based Assessments are the first of their kind to provide nationally normed tests with proficiency benchmarks for use in concept-based curricula. Forty-six different key nursing concepts are covered in our online practice and proctored assessments, all featuring NCLEX-style questions. At four progressive stages across a nursing program's curriculum, nurse educators can monitor and measure student mastery in each concept.

ATI tools in development + available now

ASSESSMENT FUNCTIONALITY & ENHANCEMENTS

- Writing NGN-style items. **ONGOING**
- A new testing engine to support NGN-item types. **IN PROGRESS**
- New scoring methods for NGN items. **COMPLETED**
- Pretesting NGN items. **ONGOING**
- NGN items in select Content Mastery Series assessments. **AVAILABLE NOW & ONGOING**
- NGN items in the Comprehensive Predictor assessment. **COMING 2022**
- NGN items in Custom Assessment Builder assessments. **AVAILABLE NOW & ONGOING**
- NGN items in Concept-Based assessments. **COMING 2022**
- The NCLEX Experience. **IN PROGRESS**
- Next Generation NCLEX Questions Overview. **RECENTLY UPDATED**
- Next Generation NCLEX Item Scoring Videos. **IN PROGRESS**

Following are the ATI Content Mastery Series assessments that will also have NGN items:

- Fundamentals
- Mental Health
- Adult Medical Surgical
- Maternal Newborn
- Nursing Care of Children
- Comprehensive Predictor

Notes

How to stay up-to-date

on Next Gen NCLEX

Where can you find the most up-to-date resources to help you prepare for the Next Generation NCLEX (NGN)? In the ATI Next Generation NCLEX Resource Center[1]. It compiles all of the crucial information delivered by the NCSBN and builds on it with advice offered by experts from throughout the nursing profession.

- Get expert guidance on the NGN:
  - The latest information and resources
  - Foundational information about the new test.
- Learn about clinical judgment, the backbone of the NGN:
  - A guide to assist you in developing learning materials
  - How simulation can help build clinical judgment skills.

- Get up-to-date information from the NCSBN:
  - Clinical Judgment Measurement Model
  - Item types
- Search ATI's suite of products and tools to incorporate into your lessons and prepare students for the NGN.

Talk to someone at ATI to answer your questions.

Get all your questions answered about NGN

The development of students' clinical judgment isn't simply about helping them pass the NCLEX. It's about ensuring they are ready for the rigors of real-life practice and providing better patient care.

What can you do today to prepare students for the new future that NGN will introduce?

Turn to ATI's teaching and learning solutions to help you develop and sharpen students' clinical judgment skills. Whether you want more information on the resources provided here or on ATI's Next Generation NCLEX Resource Center, or if you have questions unique to your institution, we're ready to help.

OFFICE HOURS
6 a.m.–9 p.m. (CT)
Monday–Friday

TECHNICAL SUPPORT HOURS
7 a.m.–7 p.m. (CT)
Monday–Friday

SEASONAL SUPPORT HOURS
8 a.m.–noon (CT)
Saturdays, April 10–May 15

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