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NCSBN

Leading Regulatory Excellence

Next Generation NCLEX: We Have Lift-Off!

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Overview

1. Why did the NCLEX change?
2. What do the items look like?
3. What does the full exam look like?
4. How are the items scored?
5. Post NGN Launch
6. NCSBN Resources and Updates

Why did the NCLEX change?

The Beginning

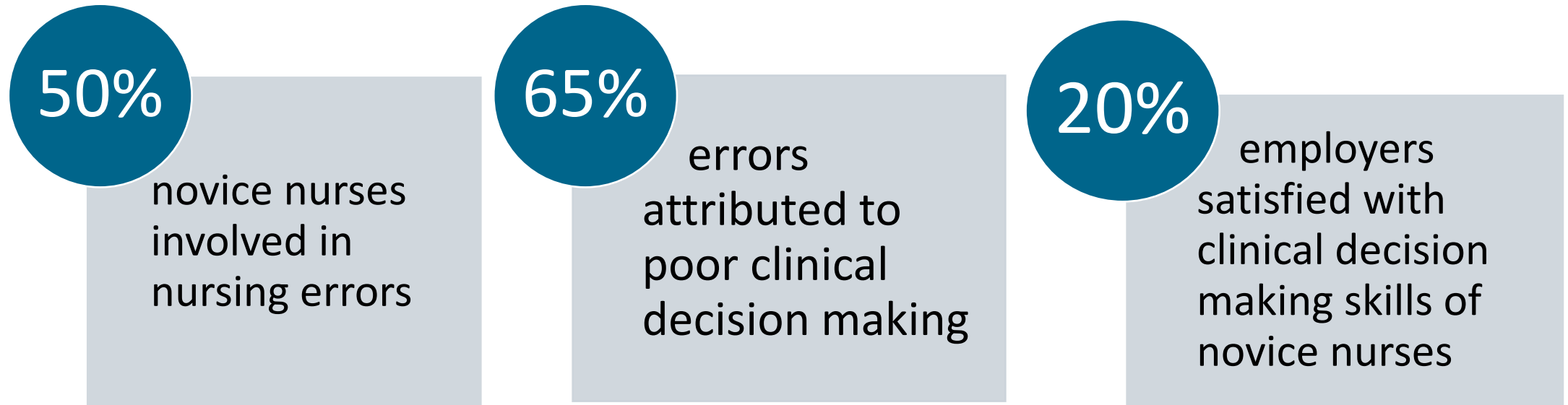


- “Is the NCLEX measuring the right things?”
- Growing awareness: Adverse effects could be prevented with CJ decision-making
- NCSBN begins investigating potential to measure CJ skills at entry level
- Clinical Judgment Measurement Model development



Literature Review Findings

- Education regarding critical thinking, clinical decision making, and clinical judgment has already become a standard part of nursing curricula



- Clinical judgment, even at the entry-level, is critical to patient safety and public protection

Conclusions

1

Clinical judgment is an important and necessary skill, even at the entry-level

2

The current NCLEX addresses clinical judgment indirectly but is limited by the item types available

3

Providing a more direct, evidence-based measure of clinical judgment requires both additional research and the use of new item types



Measuring Clinical Judgment

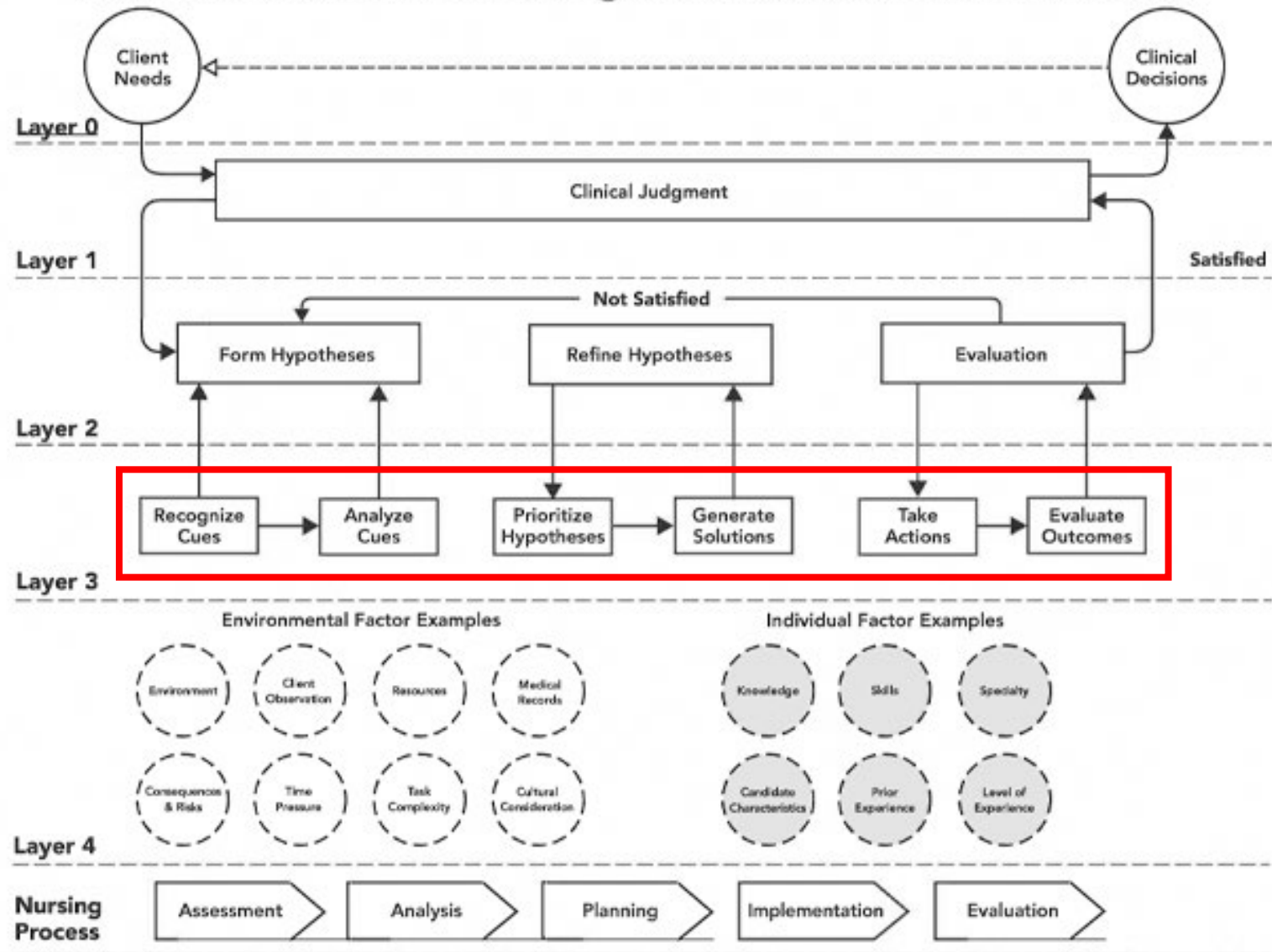


NGN News - Winter 2019

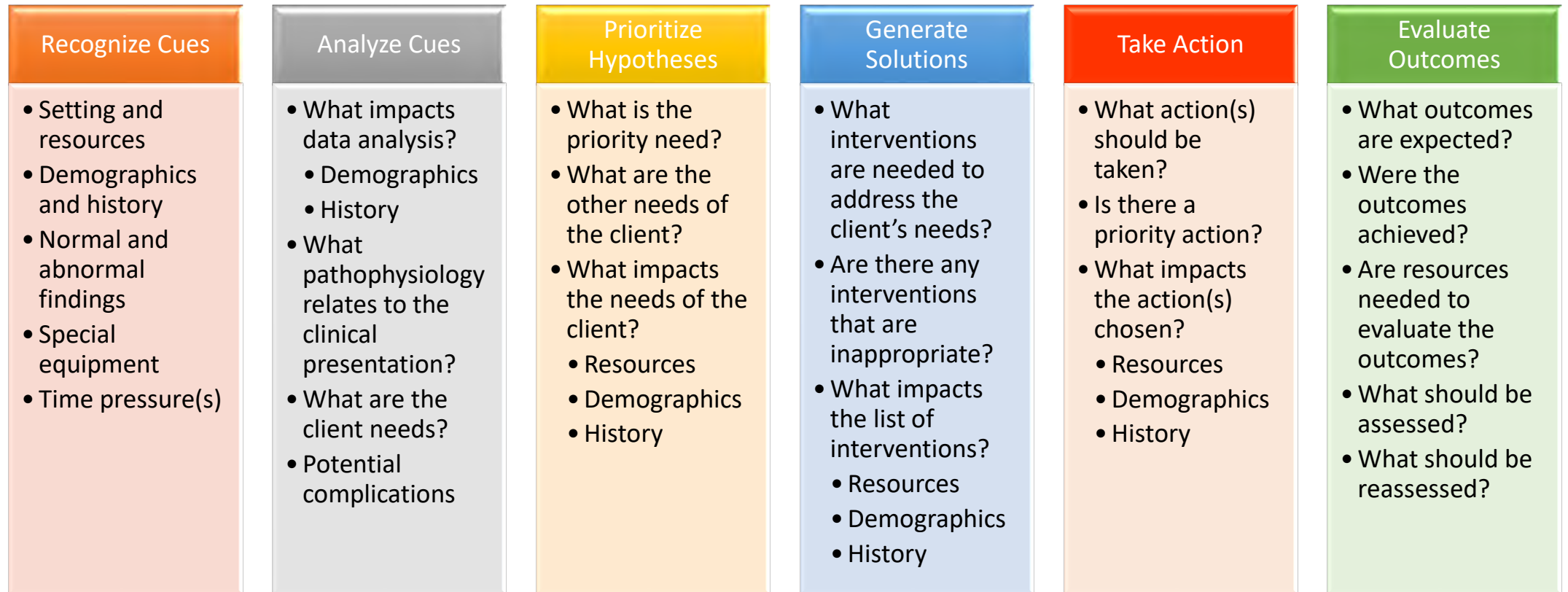
Topic: The NGN Clinical Judgment Measurement Model

2019 | PUBLICATION

The NCSBN Clinical Judgment Measurement Model

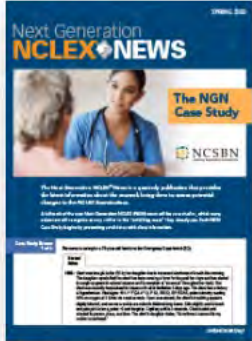


Clinical Judgment Measurement Model Layer 3



What do the new items look like?

NGN Case Study



NGN News – Spring 2020

Topic: The NGN Case Study

2020 | PUBLICATION

Sample Case Study

Case Study Screen 1 of 6

1

2

The nurse is caring for a 17-year-old male client who reports a recent injury to the left thoracic cage.

History and Physical

Nurses' Notes

Vital Signs

Laboratory Results

3

reports in his left rib being struck by a mechanically pitched baseball in a batting cage last week. He has significant bruising and feels light-headed. He also reports having some intermittent pain in the left shoulder. He denies any shortness of breath, but has some discomfort in the left lower chest when taking a deep breath. He reports feeling abdominal fullness and is occasionally nauseous. Patient has no significant past medical history. His surgical history includes an orthoscopic repair to the left shoulder for a torn rotator cuff last year. He has not felt well enough to attend baseball practice since the injury.

4

5

6

7

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

- productive cough
- BP 90/50, P 116, RR 24
- intermittent left shoulder pain
- ECG showing normal sinus rhythm
- slightly diminished breath sounds on the left
- T 97.8° F (36.6° C), O₂ saturation 98% on room air
- Hgb 9 g/dL (90 g/L), HCT 27% (0.27), WBC 19,000/mm³ (19.0 x 10⁹/L)
- tenderness upon palpation and dullness to percussion over the abdomen

Our scenario

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 mucus and to complain of "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: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink 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."

Recognize Cues item

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 mucus and to complain of "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: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink 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."

➤ Drag the top 4 client findings that would require follow-up to the box on the right.

Client Findings

Top 4 Findings

Recognize Cues

Identify relevant and important information from different sources (e.g., medical history, vital signs).

- What information is relevant/irrelevant?
- What information is most important?
- What is of immediate concern?

Do not connect cues with hypotheses just yet.



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Analyze Cues item

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 mucus and to complain of "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: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink 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."

➤ For each client finding below, click to specify if the finding is consistent with the disease process of **Condition X, Condition Y, or Condition Z.** Each finding may support more than 1 disease process.

Client Findings	Condition X	Condition Y	Condition Z
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Analyze Cues

Organizing and linking the recognized cues to the client's clinical presentation.

- What client conditions are consistent with the cues?
- Are there cues that support or contraindicate a particular condition?
- Why is a particular cue or subset of cues of concern?
- What other information would help establish the significance of a cue or set of cues?

Consider multiple things that could be happening. Narrowing things down comes at the next step.



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Prioritize Hypotheses item

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 mucus and to complain of "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: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink 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."

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

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

- vital signs
- neurologic assessment
- respiratory assessment
- cardiovascular assessment

- hypoxia
- stroke
- dysrhythmias
- a pulmonary embolism

Prioritize Hypotheses

Evaluating and ranking hypotheses according to priority (urgency, likelihood, risk, difficulty, time, etc.).

- Which explanations are most/least likely?
- Which possible explanations are the most serious?

Item development should focus on ranking the potential issues and should use phrases such as “most likely.”



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Generate Solutions item

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 mucus and to complain of "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: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink 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 difficult to arouse, pale, and diaphoretic in appearance. Vital signs: T 101.5° F (38.6° C), P 112, RR 32, BP 90/62, pulse oximetry reading 91% on oxygen at 2 L/min via nasal cannula.

The nurse has reviewed the Nurses' Notes entries from 1000 and 1200 and is planning care for the client.

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

Potential Intervention	Indicated	Contraindicated
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>

Generate Solutions

Identifying expected outcomes and using hypotheses to define a set of interventions for the expected outcomes.

- What are the desirable outcomes?
- What interventions can achieve those outcomes?
- What should be avoided?

Focus on goals and multiple potential interventions—not just the best one—that connect to those goals. Potential solutions could include collecting additional information.



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Take Action item

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 mucus and to complain of "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: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and coarse crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink 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 difficult to arouse, pale, and diaphoretic in appearance. Vital signs: T 101.5° F (38.6° C), P 112, RR 32, BP 90/62, pulse oximetry reading 91% on oxygen at 2 L/min via nasal cannula.

The nurse has received orders from the physician.

➤ Click to highlight below the 3 orders that the nurse should perform right away.

1215:

-
-
-
-
-



Take Action

Implementing the solution(s) that addresses the highest priorities.

- Which intervention or combination of interventions is most appropriate?
- How should the intervention(s) be accomplished (performed, requested, administered, communicated, taught, documented, etc.)?

For “how” questions, ensure that specific elements from the scenario are what determines approach. Avoid memorized or “textbook” procedures. The item stem and/or the responses should include action verbs.



Evaluate Outcomes item

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

Nurses' Notes

Orders

1215:

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

The nurse has performed the interventions as ordered by the physician for the client.

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

Assessment Finding	Improved	No Change	Declined
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Evaluate Outcomes

Comparing observed outcomes against expected outcomes.

- What signs point to improving/declining/unchanged status?
- Were the interventions effective?
- Would other interventions have been more effective?

Item development should focus on the efficacy of the intervention(s) from the previous items.



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Case Study – Summary

- Real-world nursing scenario
- Six items with clinical judgment focus (in order):
 - Recognize Cues
 - Analyze Cues
 - Prioritize Hypotheses
 - Generate Solutions
 - Take Action
 - Evaluate Outcomes
- Setting – Wherever entry-level nurses are
- Eligible content – Anything in the Test Plan

More ways to measure clinical judgment

- The case study is the **main** way but not the only way the NGN will measure clinical judgment
- Two “standalone” item types will also be used
 - Trend items
 - Bowtie items



NGN News – Spring
2021

Topic: Stand-alone Items

2021 | PUBLICATION

Sample Bow-tie Item

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

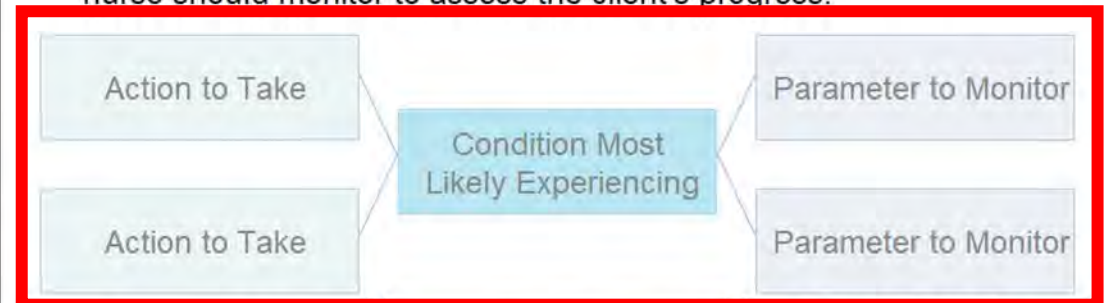
Nurses' Notes

History and Physical

1215: Client accompanied to ED by daughter, right-sided ptosis with facial drooping noted. Right-sided hemiparesis and expressive aphasia present. Daughter reports client recently had an influenza infection. Lung sounds are clear, apical pulse is irregular. Bowel sounds are active in all 4 quadrants, skin is warm and dry. Incontinent of urine 2 times in the ED, daughter reports that the client is typically continent of urine. Capillary refill sluggish at 3 seconds. Peripheral pulses palpable, 2+. Vital signs: T 97.5° F (36.4° C), P 126, RR 18, BP 188/90, pulse oximetry reading 90% on room air. Capillary blood glucose obtained per protocol, 76 mg/dL (4.2 mmol/L). ED physician notified.

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

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



Actions to Take	Potential Conditions	Parameters to Monitor
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

Sample Trend Item

The nurse in the emergency department (ED) is caring for a 10-day-old client who is experiencing projectile vomiting after drinking formula.

Flow Sheet

Intake and Output	1000	1400	1800
Intake	480 mL of formula over the past 24 hrs	60 mL of formula over the past 4 hours	60 mL of formula over the past 4 hours
Output	3 small yellow stools over the past 24 hrs	40 mL of emesis 30 min after feeding	40 mL of emesis 30 min after feeding

Nurses' Notes

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

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

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

The nurse is preparing to speak with the physician about the client's plan of care.

- Which of the following diagnostic procedures should the nurse anticipate the physician would order? Select all that apply.
- barium enema
 - abdominal x-ray
 - abdominal ultrasound
 - complete metabolic panel
 - esophagogastroduodenoscopy (EGD)



**NGN News - Winter
2022**

Topic: NGN Test Design
2022 | PUBLICATION

What does the test look like?

Approved NGN Test Design

Design Specification	NCLEX Today	Next Generation NCLEX (NGN)
Time Allowed	5 hours	5 hours
Delivery method	Variable-length CAT	Variable-length CAT *
Total Items (min – max)	75 – 145	85 – 150
Total Scored Items (min – max)	60 – 130	70 – 135
Case Studies	N/A	3 (18 items)
Standalone items (traditional NCLEX + bowtie + trend, etc.)	60 – 130 (None are bowtie/trend)	52 – 117 (About 10% are bowtie/trend)
Unscored (Pretest) Items	15	15**

* Items within a Case Study are static, not adaptive

** May include case studies, bowtie items, trend items

How does scoring work?



NGN News – Summer
2021

Topic: Scoring Models

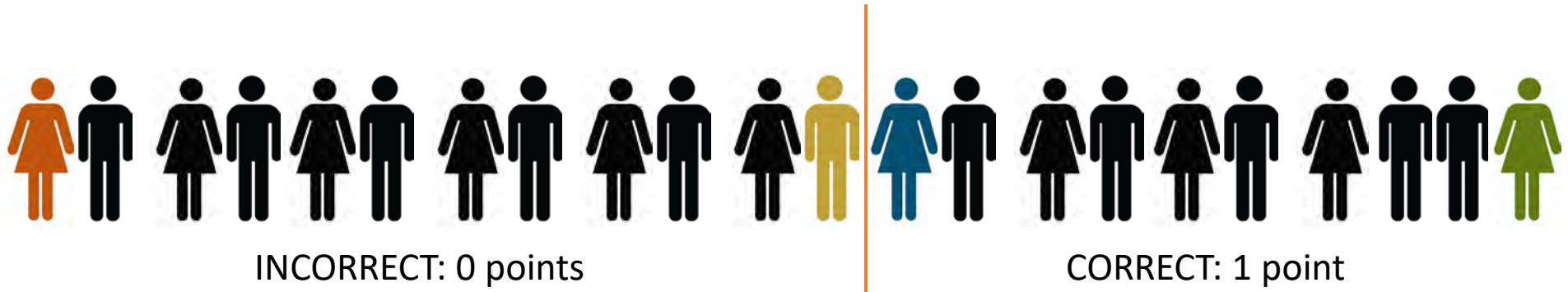
2021 | PUBLICATION

A new approach to scoring

- NCLEX prior to April 1 – A candidate's response to an item is either correct or incorrect
 - Points possible: 0 or 1
- Next Generation NCLEX - A candidate's response may be partially correct and receive partial credit
 - Points possible: 0, 1, 2, 3, etc.
- **Three** methods of scoring on NGN

What are the benefits of partial credit scoring?

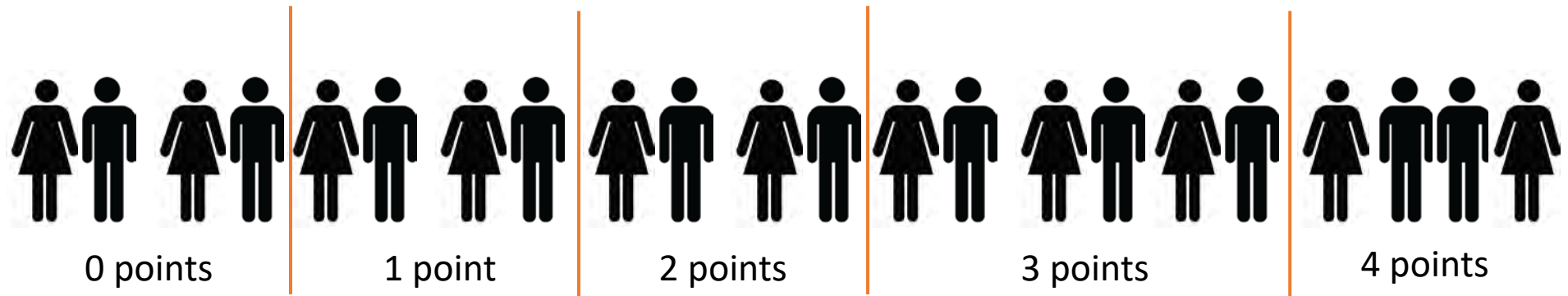
- Measurement precision



- Appropriateness
- Fairness

What are the benefits of partial credit scoring?

- Measurement precision



- Appropriateness
- Fairness

New Scoring Methods

- Partial credit scoring model for polytomous items
 - 0/1 scoring rule
 - +/- scoring rule
 - Rationale scoring
- Extension of previous scoring model
- Partial knowledge is still of value

0/1 Scoring Rule

- Classic approach to scoring exam questions
- 1 point for a correct response
- 0 points for incorrect responses
- Multipoint items
 - Total score = sum of all correct responses
- Used when candidates are instructed to choose a specific number of responses

+/- Scoring Rule

- Used when candidates are instructed to choose an unspecified number of responses
 - Example: Select All That Apply
 - Allows candidates to over or under respond
- Scoring
 - Earn points: (+1) for selecting correct information
 - Lose points (-1) for selecting incorrect information
- Identifying more pertinent information results in higher scores
- Max points = number of correct options
- Min points = 0
 - No negative scores

Rationale Scoring Rule

- Requires a full understanding of paired information
- Concepts require justification through a rationale
- Both **X** and **Y** must be correct to earn a point
- Max points = dyad, 1 point; triad, 2 points

- Dyad examples
 - A nurse must do **X** because of **Y**.
 - A client has **X** as evidenced by **Y**.
- Triad examples
 - A nurse must do **X** because of **Y** and **Z**.
 - A client has **X** as evidenced by **Y** and **Z**.

Post NGN Launch

ncsbn.org



April 1, 2023 NGN Launch

- Some of the work supporting the NGN launch:
 - 127 item development panels
 - 600 plus nurse contributors in item development
 - 680,000 NCLEX candidate participants in the Special Research Section
 - 143 NGN presentations conducted, reaching more than 22,000 attendees

The NGN Work Continues

Ongoing clinical judgment item development



NCSBN Resources

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NGN Newsletters



NGN News - Summer 2022

Topic: Overview of the 2021 PN Practice Analysis
2022 | PUBLICATION



NGN News - Spring 2022

Topic: Overview of the 2021 RN Practice Analysis
2022 | PUBLICATION



NGN News - Winter 2022

Topic: NGN Test Design
2022 | PUBLICATION



NGN News - Fall 2021

Topic: NGN Case Study and Stand-alone Comparison
2021 | PUBLICATION



NGN News - Summer 2021

Topic: Scoring Models
2021 | PUBLICATION



NGN News - Spring 2021

Topic: Stand-alone Items
2021 | PUBLICATION



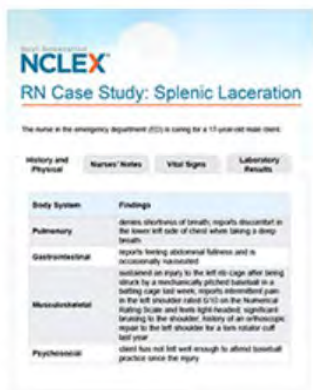
NGN News - Fall 2020

Topic: Licensed Practical/Vocational Nurses
2020 | PUBLICATION



NGN News - Summer 2020

Topic: Layer 4 of the NCJMM
2020 | PUBLICATION



Sample Questions

Experience the NGN's new item types with our sample pack.

- 3 RN Case Studies
- 2 PN Case Studies
- Additional examples

[FREE DOWNLOAD >](#)



Exam Preview

See how the new item types fit into the overall exam with our exam preview.

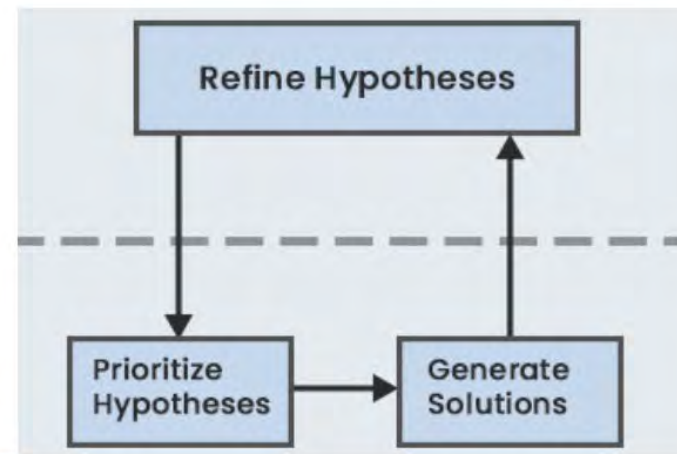
[FREE DOWNLOAD >](#)



Take the NGN Tutorial



The Secret to Computer Adaptive Testing



Clinical Judgment Measurement Model



The NCLEX® Depends on You...

*Apply to be an Item Writer or
Item Reviewer Today*



Questions