Next Gen NCLEX® Update

Tips for teaching Clinical Judgment Measurement Model and writing Next Gen Items

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National League for Nursing

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Attendance, Evaluation, and Continuing Education

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- Attend the entire 1-hour session.
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- Next Steps
  - We will email you the evaluation form which must be returned within 7 days.
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Purpose

This presentation is designed for nurse educators to improve their understanding and use of the NCSBN® Clinical Judgment Measurement Model and NextGen NCLEX® Testing to better prepare students for prelicensure testing.

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Objectives

1. Discuss the changes being made by NCSBN® for Next Generation NCLEX®.
2. Discuss a variety of classroom activities that improve clinical judgment application.
3. Compare exam item examples similar to what will be on the NextGen NCLEX®.

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Disclaimer

- Some images contained within the presentation are examples provided by NCSBN Next Gen NCLEX® Project. The uses of these items is the original work of the presenter.
- More information can be found at https://www.ncsbn.org/next-generation-nclex.htm

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History of Next Gen NCLEX®

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NGN – What we Know/Anticipate

- Beta testing for NGN will begin Spring, 2022
- PN and RN full launch April 1, 2023
- Number of items will be 70 – 135 (+15 pilot)
- 5 hours allowed
- 3 CJ Case Items – 6 questions each (18 items)
- Stand alone items – measures 1 or more areas
  - Single CJ items after minimum is met then Bowtie & Trend items

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Exam Comparison

Design Specification	NCLEX Today	NGN Minimum Length Exam	NGN Maximum Length Exam
Time Allowed	5 hours	5 hours	5 hours
Case Studies	N/A	3 (i.e., 18 items)	3 (i.e., 18 items)
Clinical Judgment Standalones	N/A	0	Approx. 7 *
Knowledge Items	60-130	52	Approx. 110
Total Scored Items	**60-130**	**70**	**135**
Unscored (Pretest) Items	15	15	15
Delivery method	CAT	CAT **	CAT **

* Approximately 10% of the final 65 items on the exam
** Items within a Case Study are static, not adaptive

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Failure to Notice

Failure to Communicate

Failure to Act or Respond

What is the most common reason that a new grad nurse loses his/her license in the first year?

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Clinical Judgment from NCSBN®

Observed outcome of critical thinking and decision-making

Uses knowledge to **observe and assess** Identifies **priorities**

Generate the best possible **evidence-based** solutions for **safe care**

Iterative Repetition of a process to generate a sequence of outcomes

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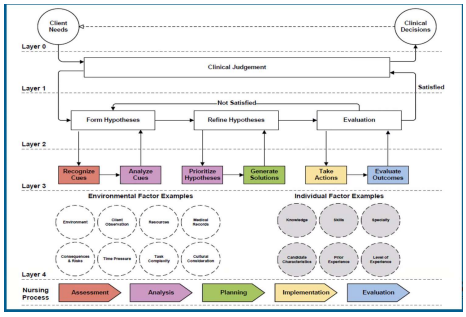

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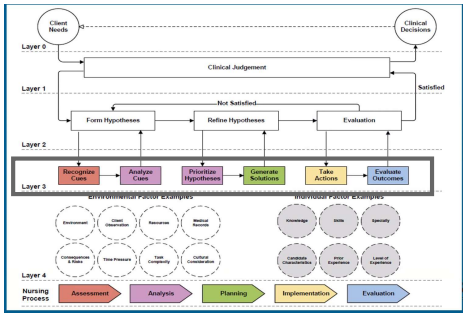

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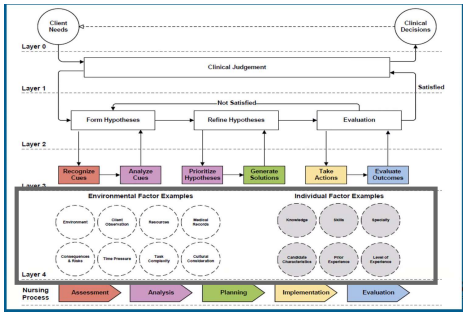

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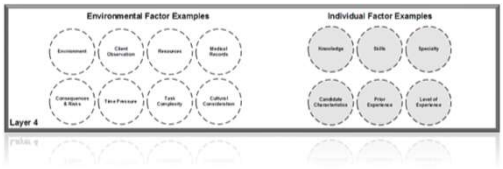
Add Context



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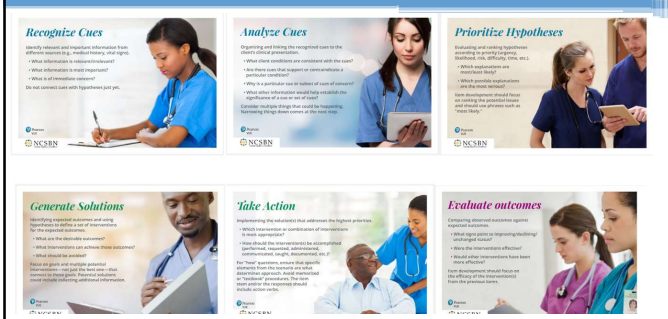

https://www.ncsbn.org/NGN_Winter19.pdf

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The problem-solving model we should teach

Take Action NOW!

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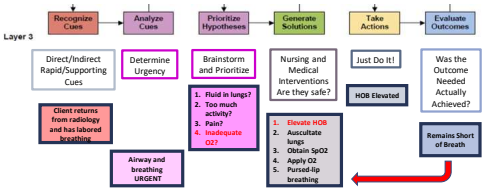
The problem-solving model we should teach



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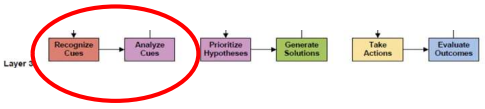
Teach How to Recognize and Analyze Cues



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Direct Cues vs Indirect Cues
Cue Progression

1st semester – Client's K+ is 2.9 mEq/L

2nd semester – Client takes furosemide daily

3rd semester – Client's NG output 800 mL/12-hour shift

4th semester – Client's SR with PVCs.

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Rapid Cues vs Supporting Cues

Crackles in lungs
UO < 50 mL/hr.
SpO2 90%
O2 at 2L/NC

Platelets 79,000
Stool + blood
Vomit 150 mL coffee grounds
BP 100/64 mmHg

Blood alcohol level 247 mg/dL
Slurring words
Becoming belligerent

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Cue Cluster

300 mL emesis
K+ 3.2 mEq
Dizzy when standing
Na+ 130 mEq
Crackles in lungs
Hypovolemia
Glucose 325 mg/dL
Confused
Hypervolemia
Decreased LOC
Flaccid right arm
Heart rate 112
Furosemide 20 mg IV
Hemoccult + stool
Resp Rate 24
Metoprolol 50 mg PO
BP 88/47 mmHg
BP 189/104 mmHg

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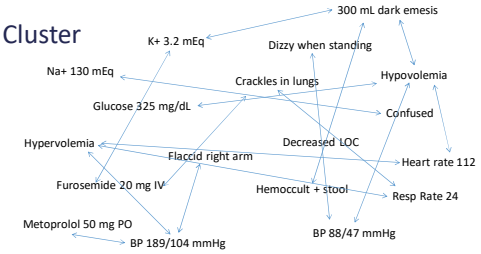
Cue Cluster



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List the Cues

The nurse is caring for a client who is 16-years-old, 35 weeks pregnant, and an insulin dependent diabetic. She has been living at a shelter since her boyfriend physically abused to her two weeks ago.

List 10 cues that indicate there could be a concern.

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List the Cues Activity – Actual vs. Potential

The nurse is caring for an older adult client with dementia who fell at the care center, fracturing her right hip. She is placed on bedrest and an orthopedic surgeon has been consulted. Surgery is expected later this evening. She frequently yells out for her mother.

List 5 cues that indicate there is a concern. (Actual)

1.
2.
3.
4.
5.

List 5 cues that indicate there could be a concern. (Potential)

1.
2.
3.
4.
5.

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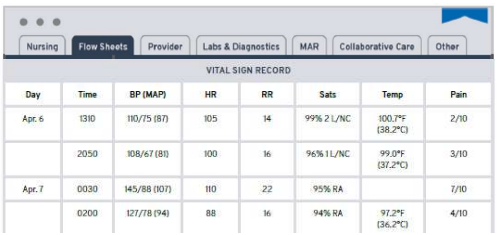

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Teach How to Prioritize Hypotheses

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Prioritization Progression

Select ALL concerning information.
Eliminate less important
Finalize to the most important

Prioritization of several clients with complex data collection.

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Unfolding Prioritizing with Hypotheses

Greg	88 years	Bowel obstruction	Vomited 100 mL - bile colored
Marcia	38 years	Appendicitis	Pain 7 out of 10
Peter	15 years	Crohn's disease	Frequent watery stools
Jan	59 years	Liver failure	Jaundiced

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Unfolding Prioritizing with Hypotheses

Greg	88 years	Bowel obstruction	Vomited 100 mL - bile colored	NG Tube ordered
Marcia	38 years	Appendicitis	Pain 7 out of 10	Temp. 102.7° F
Peter	15 years	Crohn's disease	Frequent watery stools	Blood pressure 95/50 mmHg
Jan	59 years	Liver failure	Jaundiced	Confused

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The nurse is caring for 5 clients

- Pulse Ox = 92%
- Hgb = 10.1 gm/dL
- HR = 108 bpm
- BP = 70/54 (59) mmHg

- Pulse Ox = 96%
- Hgb. 12.9 mg/dL
- HR = 122 bpm
- BP = 80/56 (64) mmHg

- Pulse Ox = 96%
- Hgb. 12.9 mg/dL
- HR = 105 bpm
- BP = 80/56 (64) mmHg

- Pulse Ox = 96%
- Hgb. 14.9 mg/dL
- HR = 112 bpm
- BP = 90/56 (66) mmHg

- Pulse Ox = 94%
- Hgb = 6.8 g/dL
- HR = 87 bpm
- BP = 149/88 (108) mmHg

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Teach How to Generate Solutions & Take Action

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Generating Solution Progression

With of Resources
Open Brain, Open Book

Without Resources
Open Brain, Closed Book

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Nursing vs Medical Actions

Nursing Interventions	Medical Interventions (Order Needed)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

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What if…

- Your client passes out while getting out of bed post-operatively?
- Your client pulls out his indwelling catheter with the balloon intact?
- Your client vomits 400 mL of bright red blood?
- Your client tells you he has a gun and wants to kill himself?
- Your client's fetal heart rate drops to 50 beats/minute?
- Your pediatric client's father tells you his wife hits their child?

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Build Speed for Taking Action

- While walking in the hall the client says, "I feel really dizzy."
- The urine output is 2100 mL in one shift, previous shift was 150 mL.
- Blood pressure is 78/56, previously 156/99. Client alert.

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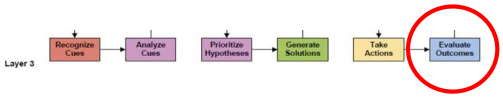
Step 4:
Teach How to Evaluate Outcomes



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Evaluate Outcomes

- Temperature change from 102.1°F to 101.9°F 15-minutes after acetaminophen 650 mg PO is administered.
- Temperature change from 102.1°F to 101.9°F 1-hour after acetaminophen 650 mg PO is administered.
- Pulse oximeter reading changes from 89% to 91% 15 minutes after oxygen 2L/NC is applied.
- Client states "my chest pain is down to a 3 after the nitroglycerin."
- Urine output of 100 mL/hr. 2 hours after furosemide 40 mg IV.

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Next Gen Item Style Types

Items Style Types	
Multiple Choice	Matrix multiple choice
Multiple Response	Multiple response select all that apply Multiple response select N Multiple response grouping Matrix multiple response
Drag-and-Drop	Drag-and-drop cloze Drag-and-drop rationale
Drop Down	Drop-down cloze Drop-down rationale Drop-down table
Highlight	Highlight text Highlight table
Stand Alone Items	
Bow-Tie **Trends**	

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Pause and Share…

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Scoring

1. 0/1 rule
2. +/- rule
3. +/- scoring per row or per column

The maximum score is often the number of correct answers
There are no negative scores

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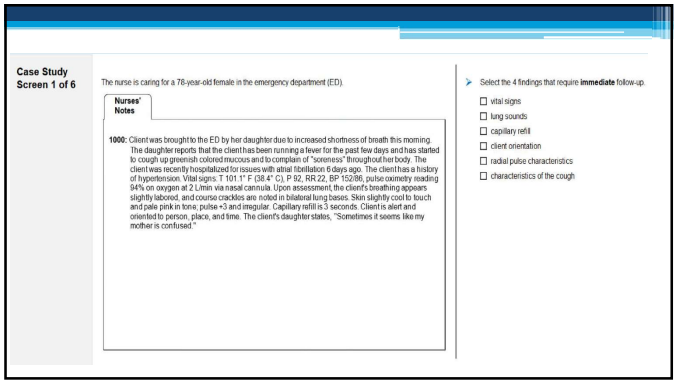

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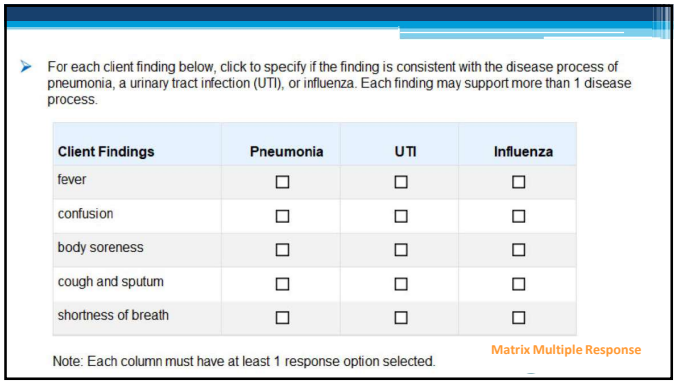
For each client finding below, click to specify if the finding is consistent with the disease process of pneumonia, a urinary tract infection (UTI), or influenza. Each finding may support more than 1 disease process.
Client Findings
Pneumonia
UTI
Influenza
fever
confusion
body soreness
cough and sputum
shortness of breath
Matrix Multiple Response
Note: Each column must have at least 1 response option selected.

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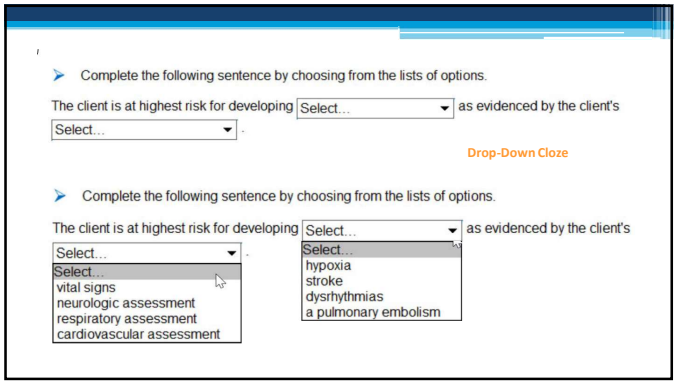
Complete the following sentence by choosing from the lists of options.
The client is at highest risk for developing Select... as evidenced by the client's Select... .
Drop-Down Cloze
Complete the following sentence by choosing from the lists of options.
The client is at highest risk for developing Select... as evidenced by the client's Select... .
Select...
vital signs
neurologic assessment
respiratory assessment
cardiovascular assessment
Select...
hypoxia
stroke
dysrhythmias
a pulmonary embolism

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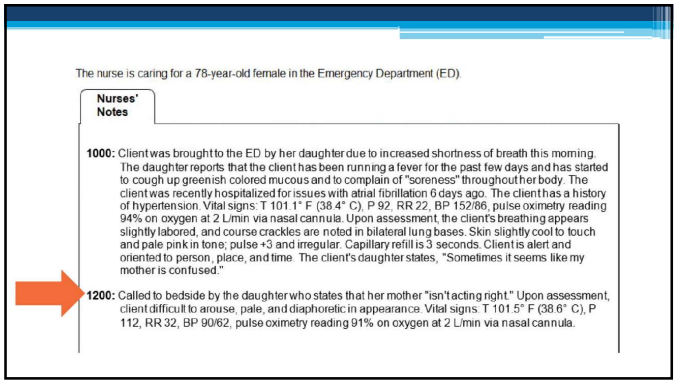
The nurse is caring for a 78-year-old female in the Emergency Department (ED).
Nurses' Notes
1000: Client was brought to the ED by her daughter due to increased shortness of breath this morning. The daughter reports that the client has been running a fever for the past few days and has started to cough up greenish colored mucous 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: T 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. 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 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.

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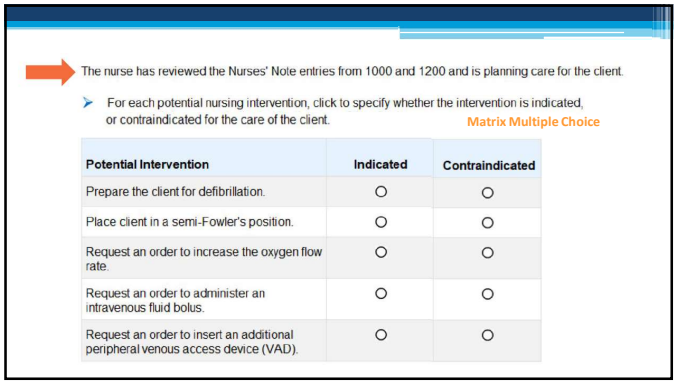
The nurse has reviewed the Nurses' Note entries from 1000 and 1200 and is planning care for the client.
For each potential nursing intervention, click to specify whether the intervention is indicated, or contraindicated for the care of the client.
Matrix Multiple Choice
Potential Intervention
Indicated
Contraindicated
Prepare the client for defibrillation.
Place client in a semi-Fowler's position.
Request an order to increase the oxygen flow rate.
Request an order to administer an intravenous fluid bolus.
Request an order to insert an additional peripheral venous access device (VAD).

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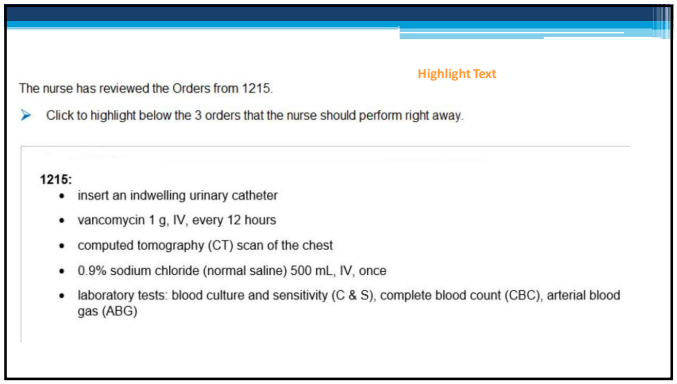
Highlight Text
The nurse has reviewed the Orders from 1215.
Click to highlight below the 3 orders that the nurse should perform right away.
1215:
insert an indwelling urinary catheter
vancomycin 1 g, IV, every 12 hours
computed tomography (CT) scan of the chest
0.9% sodium chloride (normal saline) 500 mL, IV, once
laboratory tests: blood culture and sensitivity (C & S), complete blood count (CBC), arterial blood gas (ABG)

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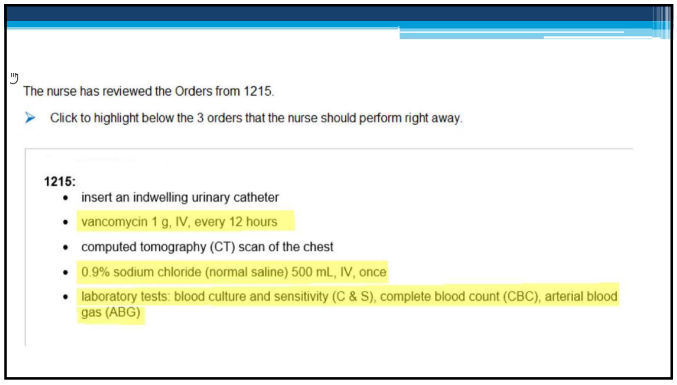
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The nurse has performed the interventions as ordered by the physician for the client.

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

Matrix Multiple Choice

Assessment Finding	Improved	No Change	Declined
RR 36	○	○	○
BP 118/68	○	○	○
pale skin tone	○	○	○
pulse oximetry reading 91%	○	○	○
interacting with daughter at bedside	○	○	○

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Item	Clinical Judgement Focus	Item Type
1	Recognize Cues	Multiple Response
2	Analyze Cues	Matrix/Grid – Select All
3	Prioritize Hypotheses	Cloze (Pull-Down Menu)
4	Generate Solutions	Matrix/Grid – Select One
5	Take Action	Highlighting
6	Evaluate Outcomes	Matrix/Grid – Select One

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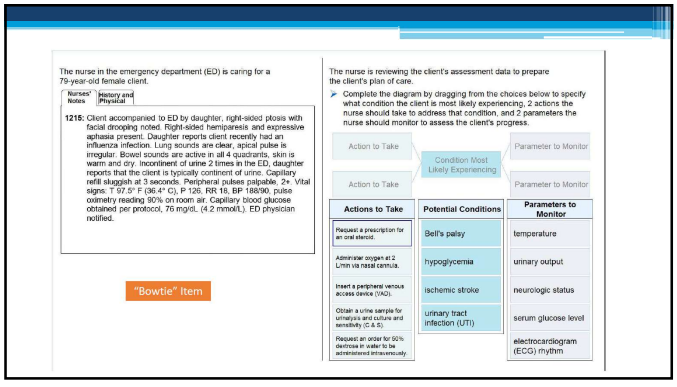

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Pause and Share…

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Build the Case – Generating Ideas

- Case Studies
- Clinical Experiences
- Simulation
- Care Plan
- Concept Map
- Textbooks
- Consider Student Build (Blooms - create)

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Build the Case - Considerations

- Give details – the student needs to differentiate between 'need to know' and 'nice to know' information.
  - **"Make it dirty"**
  - In class and lab, consider a verbal hand-off report to deliver this information

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NGN - Guidelines

Eliminate names and initials	Include gender, age, race – tie it to the case	Use client, healthcare provider, parent, and prescription
Generic medication names only	Remove 'of the following'	No nursing diagnosis

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Q & A

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