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Next Generation NCLEX Action Model Training

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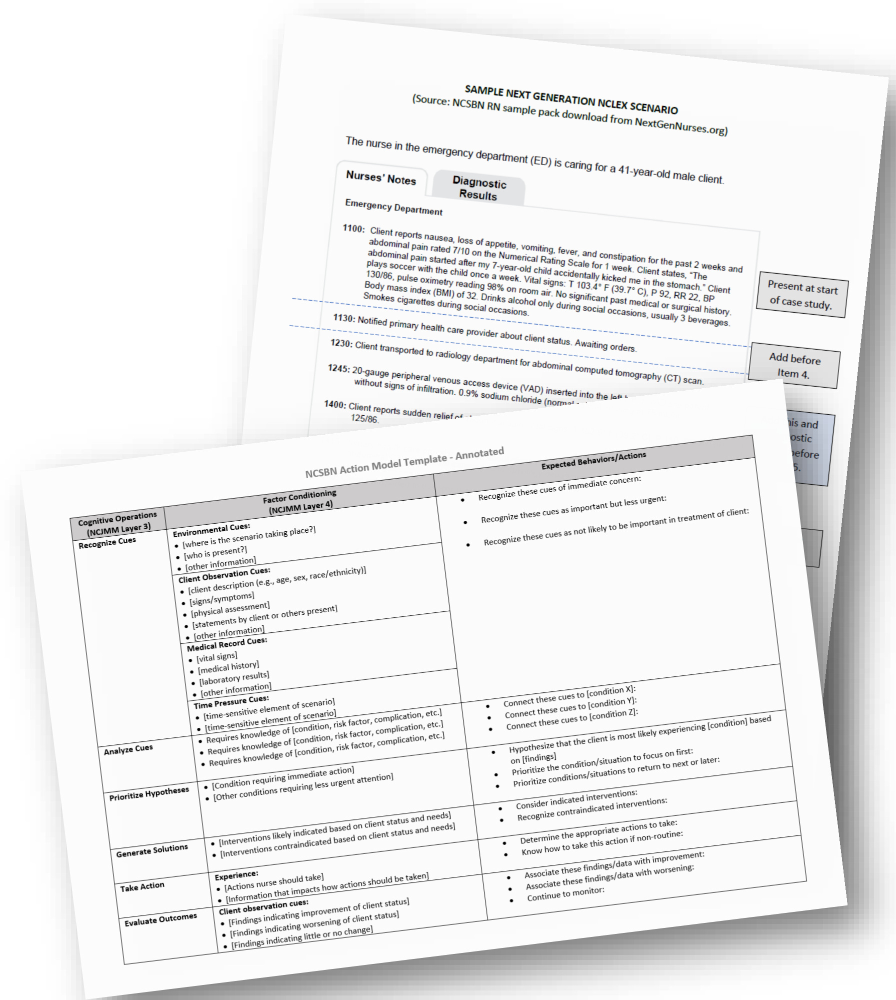
Overview

1. Review of NCSBN Clinical Judgment Measurement Model
2. Writing a successful case study scenario
3. Using the **NCSBN Action Model** to create case studies
4. Some “low tech” workarounds
5. NCSBN Resources and Updates
6. Your questions



SAMPLE NEXT GENERATION NCLEX SCENARIO
(Source: NCSBN RN sample pack download from NextGenNurses.org)

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

Nurses' Notes | **Diagnostic Results**

Emergency Department

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

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

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

1245: 20-gauge peripheral venous access device (VAD) inserted into the left … without signs of infiltration. 0.9% sodium chloride (normal …

1400: Client reports sudden relief of … 125/86.

Present at start of case study.

Add before Item 4.

NCSBN Action Model Template - Annotated

Cognitive Operations (NCJMM Layer 3)	Factor Conditioning (NCJMM Layer 4)	Expected Behaviors/Actions
Recognize Cues	**Environmental Cues:** • [where is the scenario taking place?] • [who is present?] • [other information] **Client Observation Cues:** • [client description (e.g., age, sex, race/ethnicity)] • [signs/symptoms] • [physical assessment] • [statements by client or others present] • [other information] **Medical Record Cues:** • [vital signs] • [medical history] • [laboratory results] • [other information] **Time Pressure Cues:** • [time-sensitive element of scenario] • [time-sensitive element of scenario]	• Recognize these cues of immediate concern: • Recognize these cues as important but less urgent: • Recognize these cues as not likely to be important in treatment of client:
Analyze Cues	• Requires knowledge of [condition, risk factor, complication, etc.] • Requires knowledge of [condition, risk factor, complication, etc.] • Requires knowledge of [condition, risk factor, complication, etc.]	• Connect these cues to [condition X]: • Connect these cues to [condition Y]: • Connect these cues to [condition Z]:
Prioritize Hypotheses	• [Condition requiring immediate action] • [Other conditions requiring less urgent attention]	• Hypothesize that the client is most likely experiencing [condition] based on [findings] • Prioritize the condition/situation to focus on first: • Prioritize conditions/situations to return to next or later:
Generate Solutions	• [Interventions likely indicated based on client status and needs] • [Interventions contraindicated based on client status and needs]	• Consider indicated interventions: • Recognize contraindicated interventions:
Take Action	**Experience:** • [Actions nurse should take] • [Information that impacts how actions should be taken]	• Determine the appropriate actions to take: • Know how to take this action if non-routine:
Evaluate Outcomes	**Client observation cues:** • [Findings indicating improvement of client status] • [Findings indicating worsening of client status] • [Findings indicating little or no change]	• Associate these findings/data with improvement: • Associate these findings/data with worsening: • Continue to monitor:

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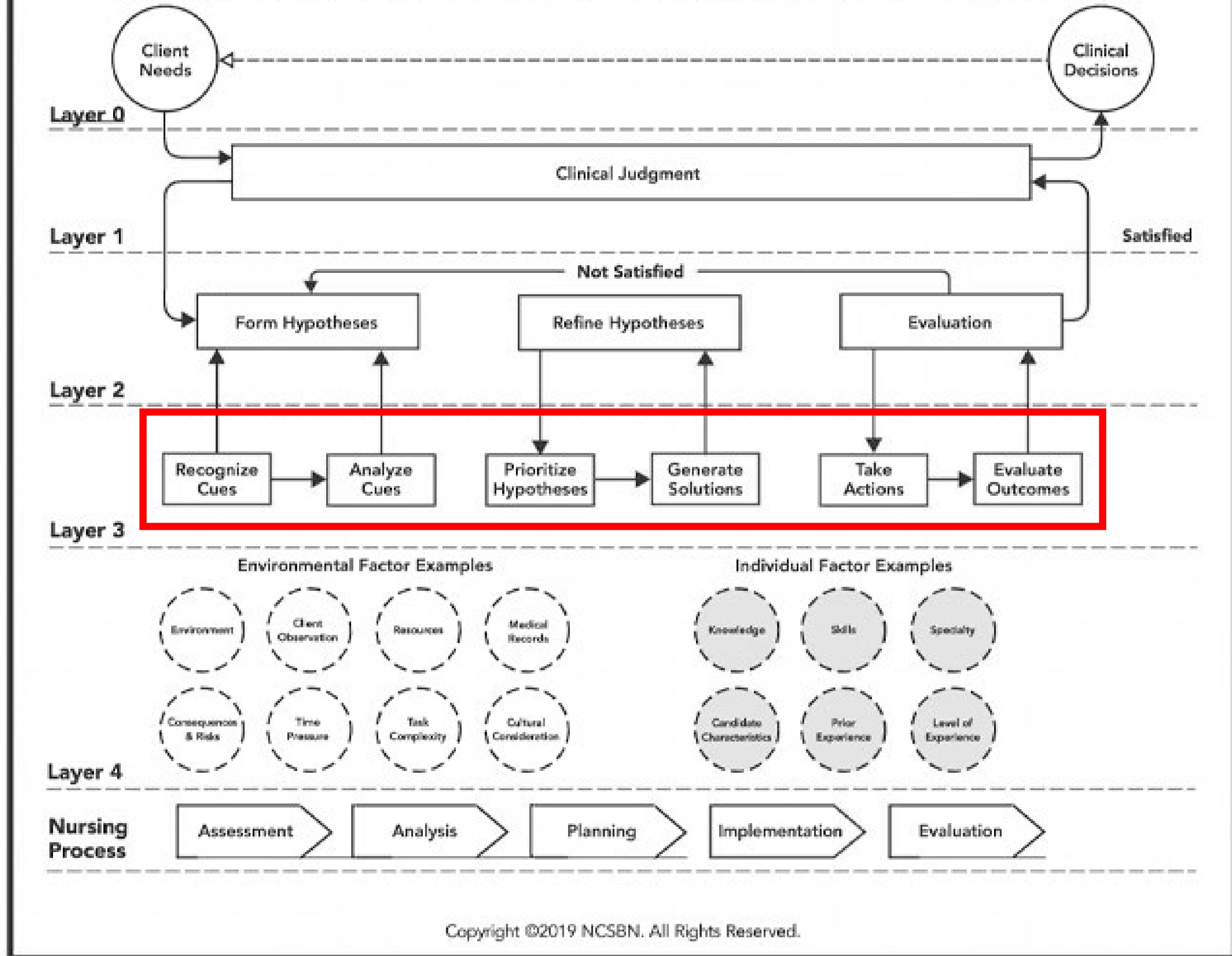
NCSBN Clinical Judgment Measurement Model

NGN News - Winter 2019

Topic: The NGN Clinical Judgment Measurement Model

2019 | PUBLICATION



NGN Case Study

- Real-world scenario
- Six test items, each targeting a different aspect of clinical judgment

ncsbn.org

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Real-world scenario PLUS…

Recognize Cues

What matters most?

Do not connect cues with hypotheses just yet.

Analyze Cues

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

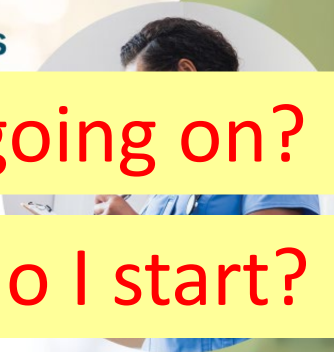
- What client conditions are consistent with

Why?

- the significance of a cue or set of cues?

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

Prioritize Hypotheses



What's going on?

Where do I start?

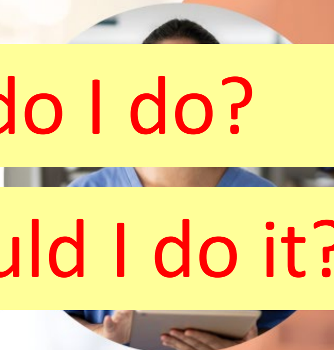
Generate Solutions

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

What could help?

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

Take Action



What do I do?

administered, communicated, taught.

How should I do it?

should include action verbs.

Evaluate Outcomes

Comparing observed outcomes against expected

How'd it go?

more effective?

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

Think real-world!

Multiple choice question
- Client has one issue
- Client needs one thing

Clinical judgment scenario
- Multiple issues
- Multiple needs
- Some things more important/urgent than others
- Some info that might not matter
- Need for prioritization

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

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

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

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

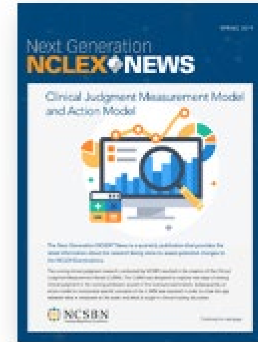
Body System	Findings
Neurological	spinal cord injury at C4 from a gunshot injury 2 years ago; uses sip-and-puff wheelchair
Pulmonary	receiving pressure-controlled portable mechanical ventilation, tracheostomy
Endocrine	diabetes mellitus (type 1)
Psychosocial	family lives 3 hours away from the facility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

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

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

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

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



NGN News - Spring 2019

Topic: The NGN Clinical Judgment Measurement Model and Action Model

2019 | PUBLICATION

NCSBN Action Model

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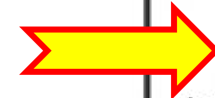
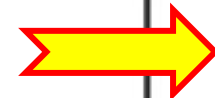
NCSBN Action Model

- Template for creating case studies based on NCJMM
- Focuses on Layer 3 and Layer 4
- Acts as a recipe for combining the ingredients in your scenario





The NCSBN Clinical Judgment Measurement Model

Client Needs
Clinical Decisions
Layer 0
Clinical Judgment
Layer 1
Satisfied
Not Satisfied
Form Hypotheses
Refine Hypotheses
Evaluation
Layer 2
Recognize Cues
COGNITIVE OPERATIONS
Evaluate Outcomes
Layer 3
Environmental Factor Examples
Individual Factor Examples
Environment
Client Observation
Resources
Consequences & Risks
Time Pressure
Task Complexity
Cultural Consideration
CONTEXT
Knowledge
Skills
Specialty
Candidate Characteristics
Prior Experience
Level of Experience
Layer 4
Nursing Process
Assessment
Analysis
Planning
Implementation
Evaluation

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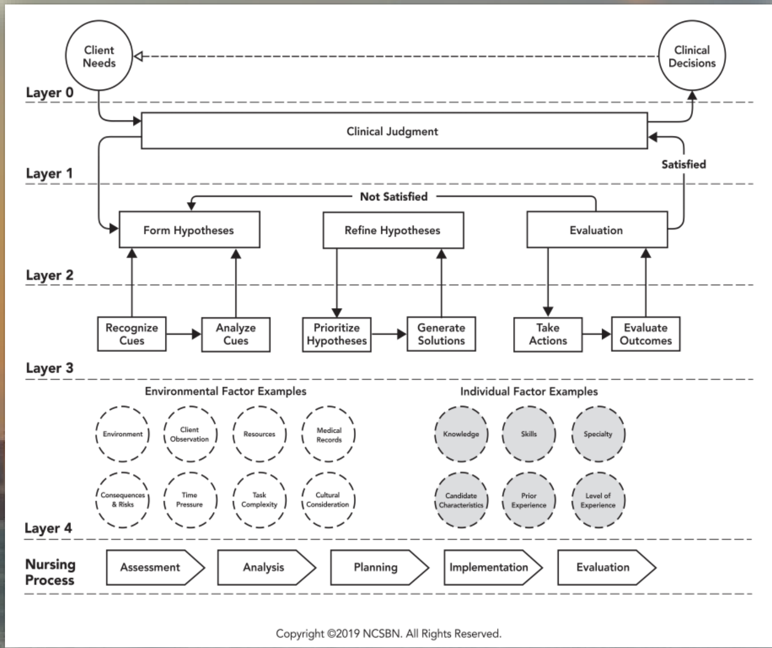
The Action Model is a **bridge** between the NCJMM and NGN Case Studies



Case Study Screen 1 of 6

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**

Client reports injuring his left ribs after 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.

Drag the assessment findings that require immediate follow-up to the box on the right.

Assessment Findings	Assessment Findings That Require Immediate Follow-up
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), O_2 saturation 98% on room air	
Hgb 9 g/dL (19.0 x 10^9/L), HCT 27% (0.27), WBC 19,000/mm^3 (19.0 x 10^9/L)	
tenderness upon palpation and dullness to percussion over the abdomen	

Image credit: Creative Commons

Action Model template with sample content

Cognitive Operations (NCSBN CJMM Layer 3)	Factor Conditioning (NCSBN CJMM Layer 4)	Expected Behaviors/Actions
Recognize Cues	**Environmental cues:** • Location: Emergency Department • Parent present **Client observation cues:** • Present age: 8-10 years • Present: signs/symptoms of dehydration: dry mucous membranes, cool extremities, capillary refill 3-4 seconds • Present/imply: lethargy **Medical record cues:** • Present/imply: Hx of diabetes • Present/imply: Vital signs **Time pressure cues:** • Set time pressure to vary with onset/acuity of symptoms	• Recognize signs/symptoms of dehydration • Identify history of diabetes • Recognize abnormal vital signs • Hypothesize dehydration • Hypothesize diabetes
Analyze Cues	• Requires knowledge of pediatric development • Requires knowledge of dehydration symptoms • Requires knowledge of diabetes symptoms	• Describe relationship between level of blood sugar and dehydration • Use evidence to determine client issues

Dickison, Haerling & Lasater, 2019

Cognitive Operations (NCSBN CJMM Layer 3)	Factor Conditioning (NCSBN CJMM Layer 4)	Expected Behaviors/Actions
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 • Requires knowledge of dehydration treatment and intervention • Requires knowledge of diabetes treatment and intervention	
Take Actions	**Experience:** • Requires experience of administering isotonic fluid	• Administer isotonic fluid
Evaluate Outcomes	**Experience:** • Requires experience of administering isotonic fluid **Client observation cues:** • Show client awake and talking • Imply improvement in vital signs based on actions	• Reassess vital signs • Reassess lethargy

Dickison, Haerling & Lasater, 2019

Action Model template annotated for use

Cognitive Operations (NCJMM Layer 3)	Factor Conditioning (NCJMM Layer 4)	Expected Behaviors/Actions
Recognize Cues	**Environmental Cues:** • [where is the scenario taking place?] • [who is present?] • [other information]	• Recognize these cues of immediate concern: • Recognize these cues as important but less urgent:
	Client Observation Cues: • [client description (e.g., age, sex, race/ethnicity)] • [signs/symptoms] • [physical assessment] • [statements by client or others present] • [other information]	
	Medical Record Cues: • [vital signs] • [medical history] • [laboratory results] • [other information]	
	Time Pressure Cues: • [time-sensitive element of scenario] • [time-sensitive element of scenario]	
Cues	• Requires knowledge of [condition, risk factor, complication, etc.] • Requires knowledge of [condition, risk factor, complication, etc.] • Requires knowledge of [condition, risk factor, complication, etc.]	
Prioritize Hypotheses	• [Condition requiring immediate action] • [Other conditions requiring less urgent attention]	
Generate Solutions	• [Interventions likely indicated based on client status and needs] • [Interventions contraindicated based on client status and needs]	
Take Action	**Experience:** • [Actions nurse should take] • [Information that impacts how actions should be taken]	
Evaluate Outcomes	**Client observation cues:** • [Findings indicating improvement of client status] • [Findings indicating worsening of client status] • [Findings indicating little or no change]	

Environmental Cues:
- [where is the scenario taking place?]
- [who is present?]
- [other information]

Client Observation Cues:
- [client description (e.g., age, gender)]
- [signs/symptoms]
- [physical assessment]
- [statements by client or others present]
- [other information]

Medical Record Cues:
- [vital signs]
- [medical history]
- [laboratory results]
- [other information]

Time Pressure Cues:
- [time-sensitive element of scenario]
- [time-sensitive element of scenario]

Action Model template annotated for use

Cognitive Operations (NCJMM Layer 3)	Factor Conditioning (NCJMM Layer 4)	Expected Behaviors/Actions
Recognize Cues	**Environmental Cues:** • [where is the scenario taking place?] • [who is present?] • [other information] **Client Observation Cues:** • [client description (e.g., age, sex, race/ethnicity)] • [signs/symptoms] • [physical assessment] • [statements by client or others present] • [other information] **Medical Record Cues:** • [vital signs] • [medical history] • [laboratory results] • [other information] **Time Pressure Cues:** • [time-sensitive element of scenario] • [time-sensitive element of scenario]	• Recognize these cues of immediate concern: • Recognize these cues as important but less urgent: • Recognize these cues as not likely to be important in treatment of client:
Analyze Cues	• Requires knowledge of [condition, risk factor, complication, etc.] • Requires knowledge of [condition, risk factor, complication, etc.] • Requires knowledge of [condition, risk factor,	• Connect these cues to [condition X]: • Connect these cues to [condition Y]:
Prioritize Hypotheses	• [Condition requiring immediate action] • [Other conditions requiring less urgent attenti	
Generate Solutions	• [Interventions likely indicated based on client • [Interventions contraindicated based on client	
Take Action	**Experience:** • [Actions nurse should take] • [Information that impacts how actions should	
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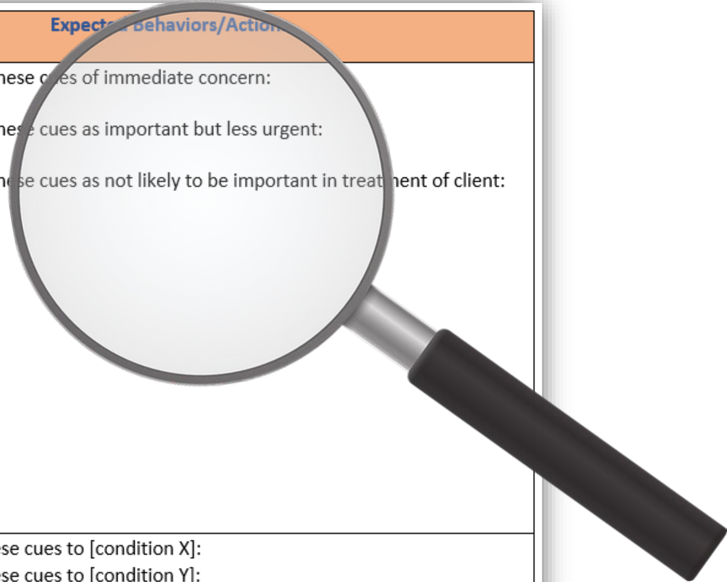

- Recognize these cues of immediate concern:
- Recognize these cues as important but less urgent:
- Recognize these cues as not likely to be important in treatment of client:

Applying the Action Model

Today's scenario

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

Nurses' Notes

Emergency Department

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

Recognize cues

Expected Behaviors/Actions

- Recognize these cues of **immediate concern**:
  -
  -
  -

Source of KEYS

- Recognize these cues as important but **less urgent**:
  -
  -
  -

Source of strongest DISTRACTORS

- Recognize these cues as not likely to be important in treatment of client:
  -
  -
  -

Source of weaker DISTRACTORS

Recognize Cues item

Which of the following findings are of immediate concern? **Select all that apply.**

- ❑
- ❑
- ❑
- ❑
- ❑
- ❑
- ❑

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Analyze cues

Expected Behaviors/Actions

- Connect these cues to [Condition X]:
  -
  -
  -
- Connect these cues to [Condition Y]:
  -
  -
  -
- Connect these cues to [Condition Z]:
  -
  -
  -

Analyze Cues item

For each client finding below, click to indicate if the finding is consistent with the disease process of [Condition X], [Condition Y], or [Condition Z]. Each finding may support more than one disease process.

Client Finding	Condition X	Condition Y	Condition Z
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

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Prioritize hypotheses

Expected Behaviors/Actions
• Hypothesize that the client is most likely experiencing [condition/situation] based on [findings]
• Prioritize the condition/situation to focus on first:
• Prioritize conditions/situations to return to next or later:

Prioritize hypotheses item

The nurse should first address the client's [Select… ▼] followed by the client's [Select… ▼]

<option one>
<option two>
<option three>

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Today's scenario

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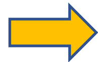

1130: Notified primary health care provider about client status. Awaiting orders.

Generate solutions

Expected Behaviors/Actions
• Consider indicated interventions: • Recognize contraindicated interventions:

Generate Solutions item

For each potential order, click to specify if the order is anticipated or contraindicated for the client.

Potential Order	Anticipated	Contra-indicated
	O	O
	O	O
	O	O
	O	O
	O	O
	O	O

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Nurses’ Notes | **Diagnostic Results**

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

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

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

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

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

Nurses’ Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

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

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Take action

Expected Behaviors/Actions
• Determine the appropriate actions to take: • Know how to take this action if non-routine:

Take Action item

The nurse is assisting with <some aspect of care>. Which of these actions should the nurse perform? Select all that apply.

- ❑
- ❑
- ❑
- ❑
- ❑
- ❑
- ❑
- ❑

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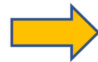

1800: Client transported to the operating room for an open appendectomy.

Medical-Surgical Unit

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

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

Nurses’ Notes | **Diagnostic Results**

Abdominal CT scan

1230: Acute gangrenous appendix with calcified appendicolith.

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

Evaluate outcomes

Expected Behaviors/Actions

- Associate these findings/data with improvement:
- Associate these findings/data with worsening:
- Associate these findings/data with no significant change
- Continue to monitor:

Evaluate Outcomes item

For each data collection finding, click to indicate if the client's status has improved, worsened, or is unchanged.

Client Finding	Improved	Worsened	Unchanged
	O	O	O
	O	O	O
	O	O	O
	O	O	O
	O	O	O

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Action model summary

- The NCSBN Action Model's "expected behaviors" for each step provide material you can use in item writing
- The examples we used today are not the only way to go. Review the NCSBN NGN Sample Pack for other approaches.

Low-tech workarounds

“My school doesn’t have software for…”

- Not all educators have the technology to create the more advanced NGN item types (e.g., pull-down menus, matrix)
- Fortunately, just about everything we can test with the advanced item types can also be tested with simpler ones (e.g., multiple choice, select all that apply)…if we’re a bit creative
- The *what* (clinical judgment) will always matter more than the *how* (item type)

Example 1: Highlighting

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➤ 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 a 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.

High tech

➤ Which findings indicate the client is not progressing as expected, post-op day #3?

- ❑ Able to ambulate in the corridor 3-4 times daily with minimal assistance
- ❑ Clear breath sounds with left chest tube in place attached to closed-chest drainage system
- ❑ Tidaling of the water chamber noted with deep inspiration
- ❑ Refusing to use the incentive spirometer stating it causes left-sided chest pain
- ❑ Utilizing prescribed patient-controlled analgesia (PCA) device maximally every hour
- ❑ 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

Low tech

WRITING TIPS

- No special software to create this **highlighting item**? Not a problem.
- You can measure the same clinical judgment skills using the **extended multiple response** format!
- Turn the sentences for highlighting into ordinary answer choices in a select all that apply item.

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Example 2: Pull-down menus

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

➤ Complete the following sentence by using the list of options.

The nurse should first address the client's [abdominal pain ▾] followed by the client's [Select... ▾].

- Select...
- abdominal pain
- respiratory status
- laboratory test results

High tech

➤ What should the nurse address first?

- ○ abdominal pain
- ○ respiratory status
- ○ laboratory test results

Low tech

➤ What should the nurse address second?

- ○ abdominal pain
- ○ respiratory status
- ○ laboratory test results

WRITING TIPS

- No special software to create this **pull-down menu item**? Not a problem.
- You can measure the same clinical judgment skills using one or more **multiple choice** items!

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Example 3 – Matrix Item

For each potential order, click to specify whether the potential order is anticipated or contraindicated for the client.

Potential Order	Anticipated	Contraindicated
echocardiogram		
intravenous fluids		
abdominal ultrasound		
preparation for surgery		
serum type and screen		
chest percussion therapy		
insertion of a nasogastric (NG) tube		
administration of prescribed pain medication		

High tech

Which of these potential orders should the nurse anticipate? **Select all that apply.**

- ❑ echocardiogram
- ❑ intravenous fluids
- ❑ abdominal ultrasound
- ❑ preparation for surgery
- ❑ serum type and screen
- ❑ chest percussion therapy
- ❑ insertion of a nasogastric (NG) tube
- ❑ administration of prescribed pain medication

Low tech

WRITING TIPS

- No special software to create this **matrix item**? Not a problem.
- You can measure the same clinical judgment skills using the **select all that apply** format!

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Example 4 – Matrix with Select All

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WRITING TIPS

- No special software to create this **matrix item** with multiple selections possible in each row? Not a problem.
- You can measure the same clinical judgment skills using a series of **select all that apply** items!

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	☐	☐	☐

High tech

- Which of these findings is consistent with pneumonia? **Select all that apply**.
  - ❑ fever
  - ❑ confusion
  - ❑ body soreness
  - ❑ cough and sputum
  - ❑ shortness of breath

Low tech

- Which of these findings is consistent with a urinary tract infection (UTI)? **Select all that apply**.
  - ❑ fever
  - ❑ confusion
  - ❑ body soreness
  - ❑ cough and sputum
  - ❑ shortness of breath

- Which of these findings is consistent with influenza? **Select all that apply**.
  - ❑ fever
  - ❑ confusion
  - ❑ body soreness
  - ❑ cough and sputum
  - ❑ shortness of breath

Workshop summary

- Educators can use the NCSBN Action Model to assist in developing clinical judgment case studies similar to those on the Next Generation NCLEX
- Take advantage of existing sample items that you can use or adapt as templates…no need to start from scratch immediately
- If you do not have tools for creating advanced item types, use “low tech” workarounds based on MC or Select All that Apply formats

TRAINING TIPS

- Clinical judgment is the key!
- Do not settle for items that LOOK like NGN but only measure memorized facts.
- The NGN will use these case studies for high-stakes assessment, but educators can use more flexibly and broadly.

NCSBN Resources and Updates

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

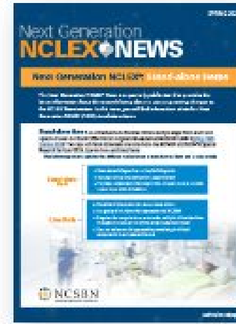
Topic: NGN Case Study and Stand-alone Comparison

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

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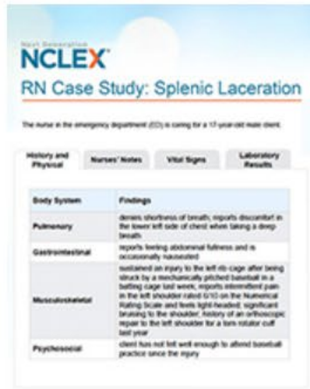


Sample Questions

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

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

FREE DOWNLOAD >

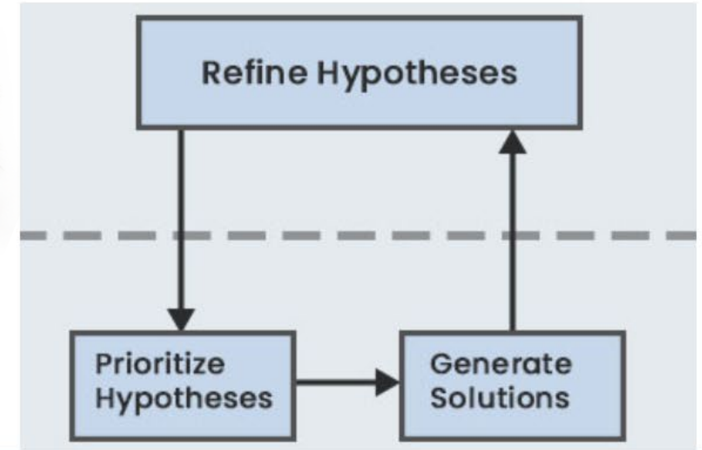
Exam Preview

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

NCSBN Updates

- NCLEX-RN and NCLEX-PN Test Plans
  - Effective April 1, 2023
  - Now available on NCSBN website

- NCLEX-RN and NCLEX-PN passing standards
  - Effective April 1, 2023
  - Staying the same as before (0.00 RN, -0.18 PN)

NCLEX-RN Test Plan

Client Needs category	Percentage (2019)	Percentage (2023)
Safe and Effective Care Environment		
Management of Care	20%	**18%**
Safety and Infection Control	12%	**13%**
Health Promotion and Maintenance	9%	9%
Psychosocial Integrity	9%	9%
Physiological Integrity		
Basic Care and Comfort	9%	9%
Pharmacological and Parenteral Therapies	15%	**16%**
Reduction of Risk Potential	12%	12%
Physiological Adaptation	14%	14%

NCLEX-PN Test Plan

Client Needs category	Percentage (2020)	Percentage (2023)
Safe and Effective Care Environment		
Coordinated Care	21%	21%
Safety and Infection Control	13%	13%
Health Promotion and Maintenance	9%	9%
Psychosocial Integrity	12%	12%
Physiological Integrity		
Basic Care and Comfort	10%	10%
Pharmacological Therapies	13%	13%
Reduction of Risk Potential	12%	12%
Physiological Adaptation	10%	10%

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NCSBN Resource Links

- NGN Newsletters – All NGN newsletters | Spring 2020 Newsletter (Case Study) | Summer 2021 Newsletter (Scoring)
- NGN Item Writing – Volunteer sign-up page
- NCSBN Sample items and case studies – Available at NextGenNurses.org
- NCLEX Test Plans – Updated 2023 Test Plans have been published here
- More information on NCLEX passing standard
- NCSBN Contact: Jason Schwartz, Director of Outreach – jschwartz@ncsbn.org

Questions