Next Generation NCLEX: Countdown to Launch

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# Overview

1. Why is the test changing?

2. What do the items look like?

   – BONUS: Interactive item writing

3. What does the test look like?

4. How will scoring work?

   – BONUS: Interactive scoring activity

5. NCSBN Resources and Updates

6. Ask me anything!

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Why is the NCLEX changing?
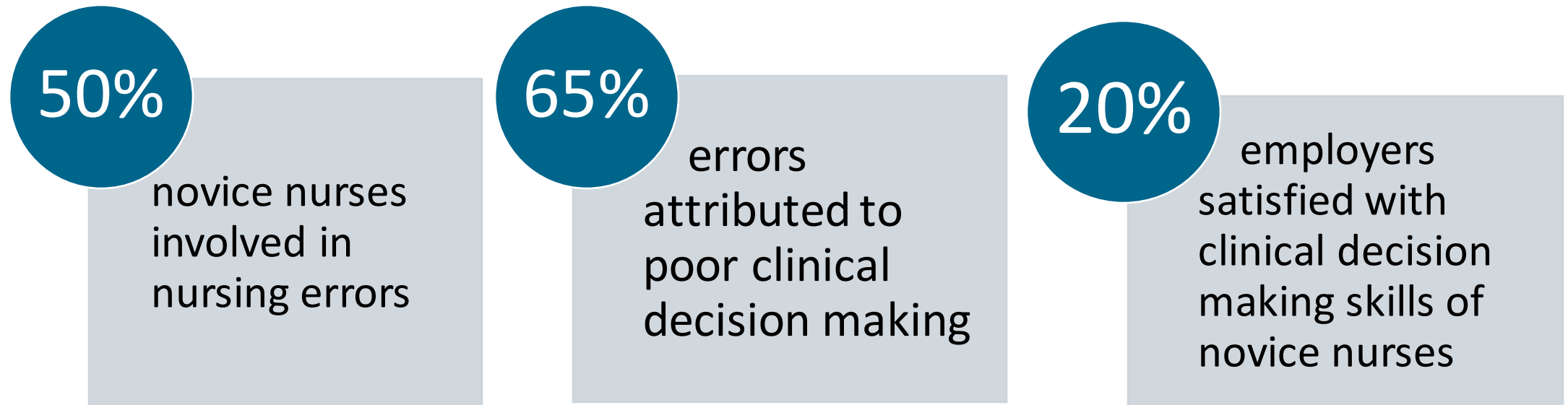
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NGN origin story

- **2012 NCLEX Examination Committee--**
  "Is the NCLEX measuring the right things?"
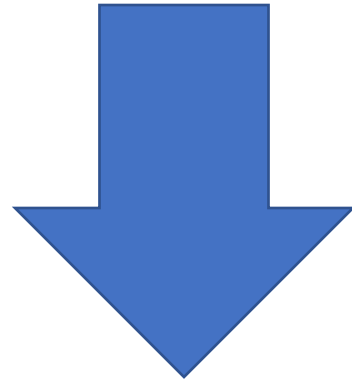
- Literature review
- Strategic Practice Analysis

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Literature Review Findings

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

50% novice nurses involved in nursing errors

65% errors attributed to poor clinical decision making

20% employers satisfied with clinical decision making skills of novice nurses

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

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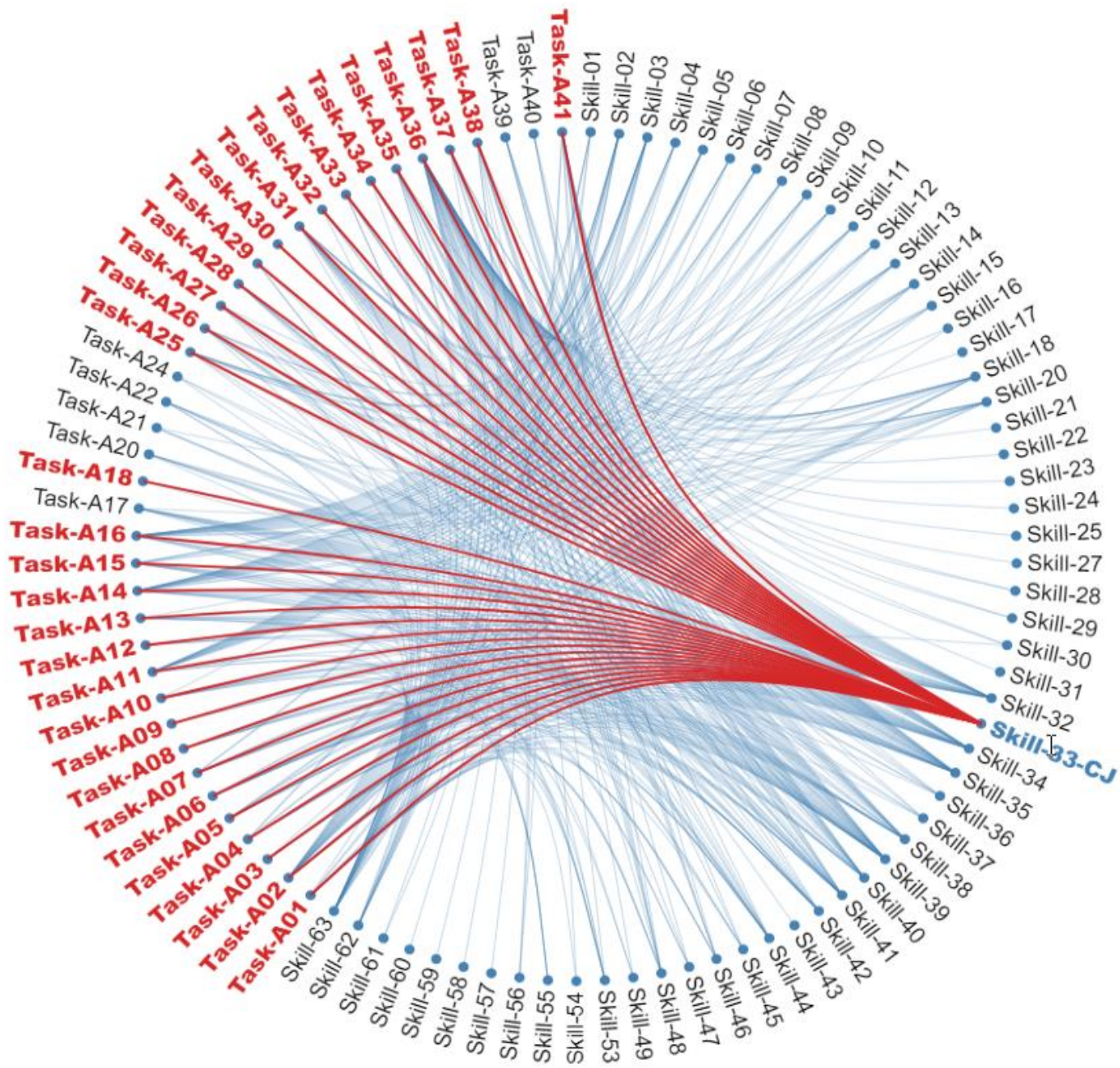
Conclusions

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

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Measuring Clinical Judgment

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The NCSBN Clinical Judgment Measurement Model
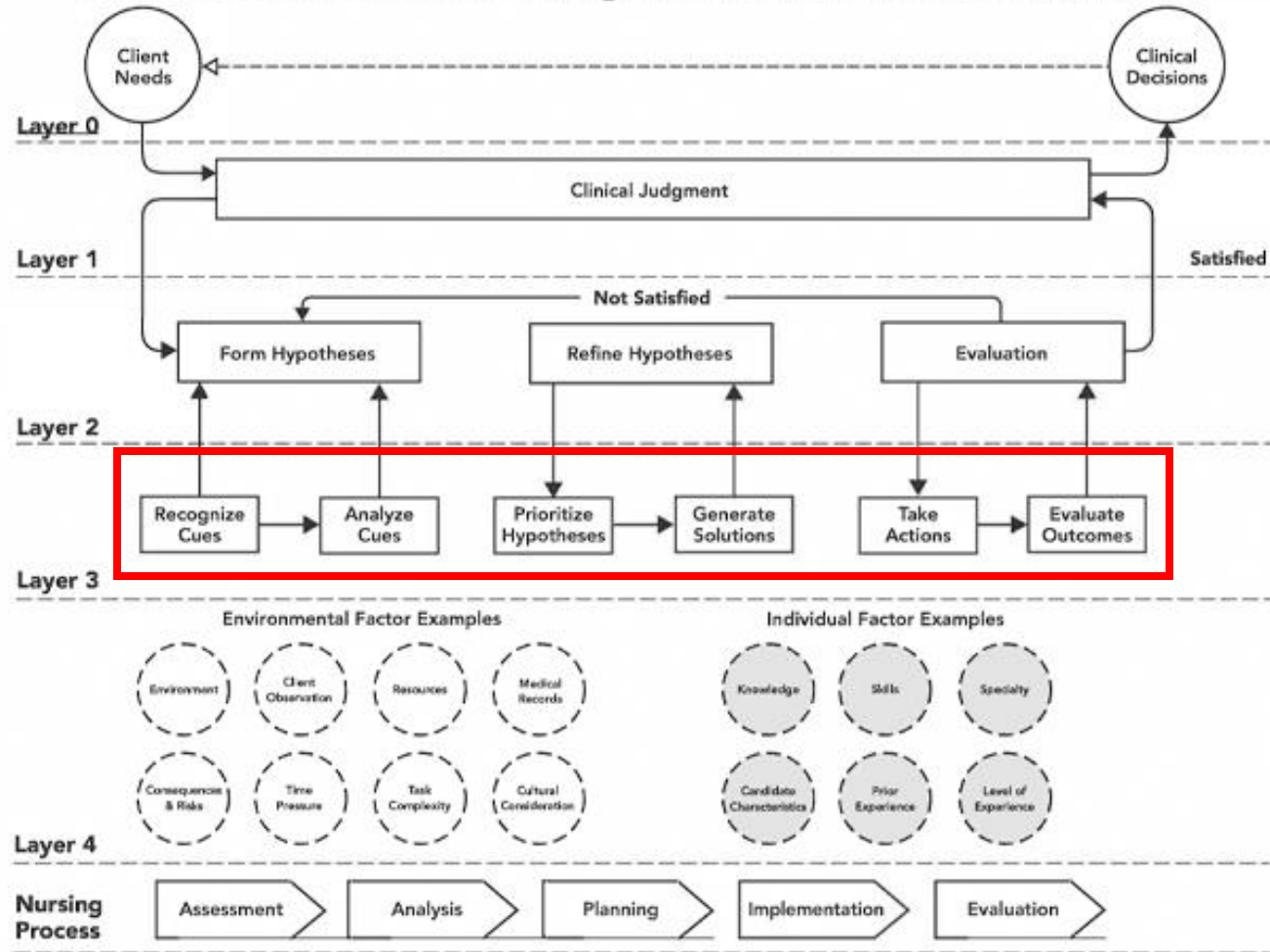
What will the new items look like?

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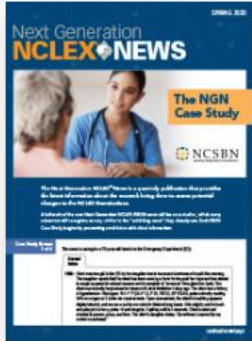
NGN Case Study

NGN News – Spring 2020

Topic: The NGN Case Study

2020 | PUBLICATION

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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 **[3]** | Nurses' Notes **[4]** | Vital Signs **[5]** | Laboratory Results **[6]** |

reports in____is left rib___being stru___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.

[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), O$_2$ 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

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.

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

Patient appears pale and slightly diaphoretic. Large amount of bruising noted along the left torso and over the left upper quadrant (LUQ) of the abdomen. Patient is guarded and there is tenderness upon palpation and dullness to percussion over the abdomen. Slightly diminished breath sounds on the left, productive cough noted. Electrocardiogram (ECG) shows normal sinus rhythm.

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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 |

Vital signs:

- BP 90/50

- P 116

- RR 24

- T 97.8° F (36.6° C)

- O$_2$ saturation 98% on room air

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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**

Laboratory Test	Result	Reference Range
Hemoglobin (Hgb)	9 g/dL (90 g/L)	Male: 13.2–17.3 g/dL (132–173 g/L) Female: 11.7–15.5 g/dL (117–155 g/L)
Hematocrit (HCT)	27% (0.27)	Male: 39%–50% (0.39–0.50) Female: 35%–47% (0.35–0.47)
White blood cell count (WBC)	19,000/mm³ (19.0 x 10⁹/L)	5,000–10,000/mm³ (5–10 x 10⁹/L)

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➤ 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), O_2 saturation 98% on room air

☐ Hgb 9 g/dL (90 g/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

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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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➤ Which of the following potential issues is the client at risk for developing? **Select all that apply**.

- ☐ stroke
- ☐ hemothorax
- ☐ bowel perforation
- ☐ splenic laceration
- ☐ pulmonary embolism
- ☐ abdominal aortic aneurysm

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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.

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 |

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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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The nurse is speaking with the physician regarding the treatment plan for the client who was just diagnosed with a splenic laceration and a left-sided hemothorax.

➤ 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	○	○

Matrix (Grid) Item

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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➤ The nurse has been asked to prepare the client 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.

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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.

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Highlighting Item

➤ 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.

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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.

![NCSBN logo — Leading Regulatory Excellence]

Case Study – Summary

- Real-world nursing scenario
- Six items with clinical judgment focus (in order):

- Setting – Wherever entry-level nurses are
- Eligible content – Anything in the Test Plan

Case Study – Let's try one together!

- Based on sample from Spring 2020 NGN Newsletter
- A chance to get comfortable with the new item types

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Sample 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."

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Recognize cues – "what matters most?"

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Nurses' Notes

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

Client Findings	Top 4 Findings

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Analyze cues – "what could it mean?"

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➤ 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
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

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

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Prioritize hypotheses – "Where do I start?"

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

Nurses' Notes

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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... ▼]

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

Select...
hypoxia
stroke
dysrhythmias
a pulmonary embolism

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Generate solutions – "what might I do?"

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

Nurses' Notes

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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
	O	O
	O	O
	O	O
	O	O
	O	O

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Take action – "what will I do?"

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:

-
-
-
-
-

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Evaluate outcomes – "did it help?"

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
	O	O	O
	O	O	O
	O	O	O
	O	O	O
	O	O	O

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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

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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)

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.

Action to Take | Parameter to Monitor

Condition Most Likely Experiencing

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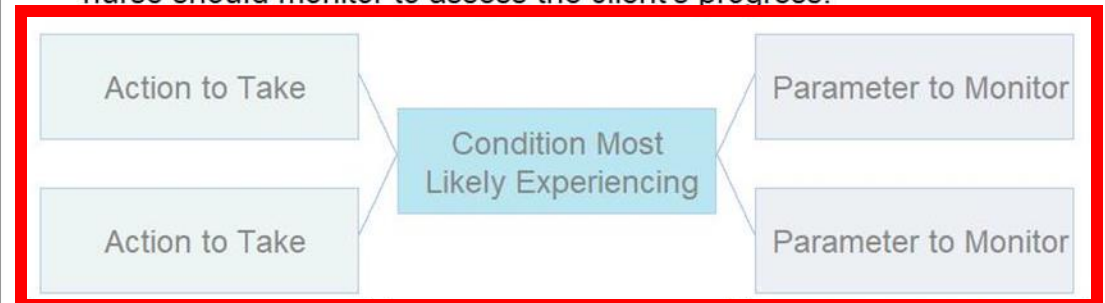
Actions to Take	Potential Conditions	Parameters to Monitor
Request a prescription for an oral steroid.	Bell's palsy	temperature
Administer oxygen at 2 L/min via nasal cannula.	hypoglycemia	urinary output
Insert a peripheral venous access device (VAD).	ischemic stroke	neurologic status
Obtain a urine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

What will the test look like?

NGN News – Winter 2022

Topic: NGN Test Design

2022 | PUBLICATION

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How different is the NGN from NCLEX?

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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

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How will scoring work?

NGN News – Summer 2021

Topic: Scoring Models

2021 | PUBLICATION

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# A new approach to scoring

- NCLEX today – A candidate response to an item is either correct or incorrect
  - Points possible: 0 or 1

- Next Generation NCLEX - A candidate response may be partially correct and receive partial credit
  - Points possible: 0, 1, 2, 3, etc.

- **Three** methods of assigning partial credit on NGN

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Method #1: +/- Scoring

- Candidates receive a point for correct responses and **lose a point** for incorrect responses.

- Note that any negative overall scores are "rounded up" to zero.

- Why do we take away points?

Which of these U.S. presidents was born in Virginia?
Select all that apply.

❑ John Adams
❑ James Madison
❑ Abraham Lincoln
❑ Thomas Jefferson
❑ George Washington

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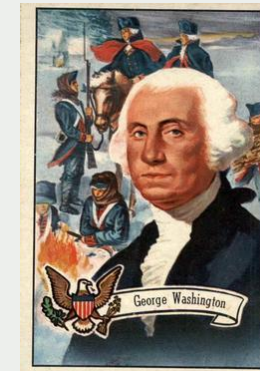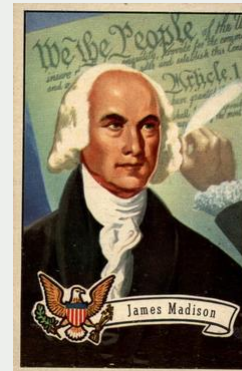
Method #1: +/- Scoring

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- Note that any negative overall scores are "rounded up" to zero.

- Why do we take away points?

Which of these U.S. presidents was born in Virginia? **Select all that apply.**

❑ John Adams
☑ James Madison   +1 CORRECT
☑ Abraham Lincoln   -1 INCORRECT
☑ Thomas Jefferson   +1 CORRECT
❑ George Washington

*Using **+/-** scoring this candidate earns 2 – 1 = **1 point** out of a maximum of 3 points possible (Madison, Jefferson, Washington).*

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Method #2: 0/1 Scoring

- Candidates receive a point for correct responses but **do not lose points** for incorrect responses.
- Why is no penalty applied?

Which **three** of these U.S. presidents were born in Virginia?

❑ John Adams
❑ James Madison
❑ Abraham Lincoln
❑ Thomas Jefferson
❑ George Washington

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Method #2: 0/1 Scoring

- Candidates receive a point for correct responses but **do not lose points** for incorrect responses.

- Why is no penalty applied?

Which **three** of these U.S. presidents were born in Virginia?

- ☐ John Adams
- ☑ James Madison   +1 CORRECT
- ☑ Abraham Lincoln   0 INCORRECT
- ☑ Thomas Jefferson   +1 CORRECT
- ☐ George Washington

*Using **0/1** scoring this candidate earns **2 points** out of a maximum of 3 points possible (Madison, Jefferson, Washington).*

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Method #3: Rationale Scoring

- Multiple response elements are combined into a single scorable unit

- Used when the relationship, reasoning, or connection is what is being measured

- Example: "The nurse should recognize X because of Y"

Complete the statement using the pull-down menus.

The capital of [Select... ▼] is [Select... ▼] .

| Virginia |
| New Mexico |
| West Virginia |

| Richmond |
| Atlantic City |
| Indianapolis |

Even though one of the selections might be considered correct, scoring is at the level of the entire statement or relationship. Therefore, the response earns 0 out of 1.
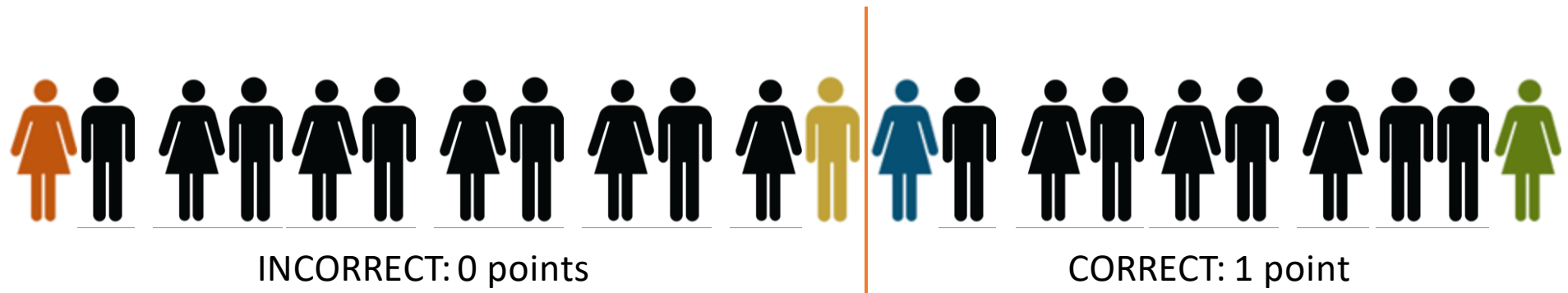
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What are the benefits of partial credit scoring?

- Measurement precision

INCORRECT: 0 points   CORRECT: 1 point

- Appropriateness
- Fairness

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What are the benefits of partial credit scoring?

- Measurement precision

0 points   1 point   2 points   3 points   4 points

- Appropriateness
- Fairness

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Scoring – Let's try it together!

- Reference: Case Study sample items from earlier today
- Which scoring method should be applied?
  - +/- scoring
  - 0/1 scoring
  - rationale scoring
- How many points should be awarded?

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➤ Which of the following potential issues is the client at risk for developing? **Select all that apply**.

☐ stroke

☐ hemothorax

☐ bowel perforation

☐ splenic laceration

☐ pulmonary embolism

☐ abdominal aortic aneurysm

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➤ Which of the following potential issues is the client at risk for developing? **Select all that apply**.

🚫 ☑ stroke

⭐ ☑ hemothorax

⭐ ☑ bowel perforation

⭐ ☑ splenic laceration

🚫 ☑ pulmonary embolism

☐ abdominal aortic aneurysm

Use **+/- scoring** since candidates can select as many responses as they like.

3 − 2 = 1

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The nurse is speaking with the physician regarding the treatment plan for the client who was just diagnosed with a splenic laceration and a left-sided hemothorax.

➤ 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	○	○

The nurse is speaking with the physician regarding the treatment plan for the client who was just diagnosed with a splenic laceration and a left-sided hemothorax.

➢ 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	●	○	🚫
p⋯	○	●	🚫
s⋯	●	○	⭐
c⋯	●	○	🚫
in⋯	●	○	🚫
administration of prescribed pain medication	●	○	⭐

Use **0/1 scoring** since candidates cannot click all the bubbles.

$3 - 0 = 3$

➤ 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.

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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.

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Use **+/- scoring** since candidates can highlight as many "tokens" as they like.

1 – 2 = -1 → 0

NCSBN Resources and Updates

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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

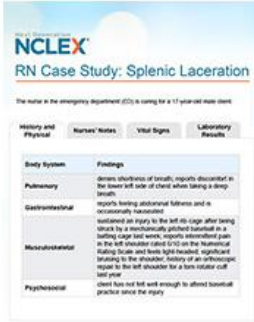## NGN News - Fall 2020

Topic: Licensed Practical/Vocational Nurses

2020 | PUBLICATION

NGN News - Summer 2020

Topic: Layer 4 of the NCJMM

2020 | PUBLICATION

NCLEX®

Sample Questions

NCLEX®
RN Case Study: Splenic Laceration

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

Become familiar with how the exam will appear in the Pearson VUE software.
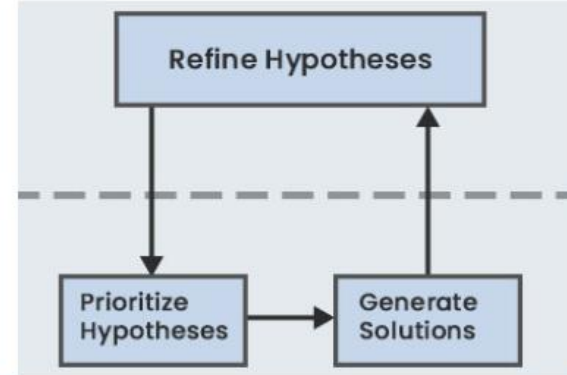
SEE TUTORIAL >

FRANÇAIS >

The Secret to Computer Adaptive Testing

The NCLEX uses computer adaptive testing (CAT). Learn how CAT helps the NGN get the most precise measurement in the fewest number of questions.

WATCH VIDEO >

Clinical Judgment Measurement Model

Clinical judgment is critical to nursing. NCSBN developed a model to measure clinical judgement that can also be used as a way of thinking and teaching.

FIND OUT MORE >

Refine Hypotheses

Prioritize Hypotheses → **Generate Solutions**

NCSBN Updates

- NCLEX-RN and NCLEX-PN Test Plans
  - Effective April 1, 2023
  - Available NOW!

- NCLEX-RN and NCLEX-PN passing standards
  - Effective April 1, 2023
  - Passing standards will remain the same as they are now (0.00 RN, -0.18 PN)
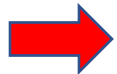
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NCLEX-RN Test Plan

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%

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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 newsletters | Spring 2020 Newsletter (Case Study)
- ❑ NGN Item Writing – Volunteer sign-up page
- ❑ NCSBN Sample items and case studies – Available at NextGenNurses.org
- ❑ NCLEX Test Plans – Posted here
- ❑ **Download this slide deck** – scan QR code ➡️
- ❑ Contact Jason anytime – jschwartz@ncsbn.org

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