February 2020

Next Generation NCLEX

update

Presented by Sheryl Sommer, PhD, RN, CNE
Vice President, Chief Nursing Officer

in coordination with details shared by

NCSBN

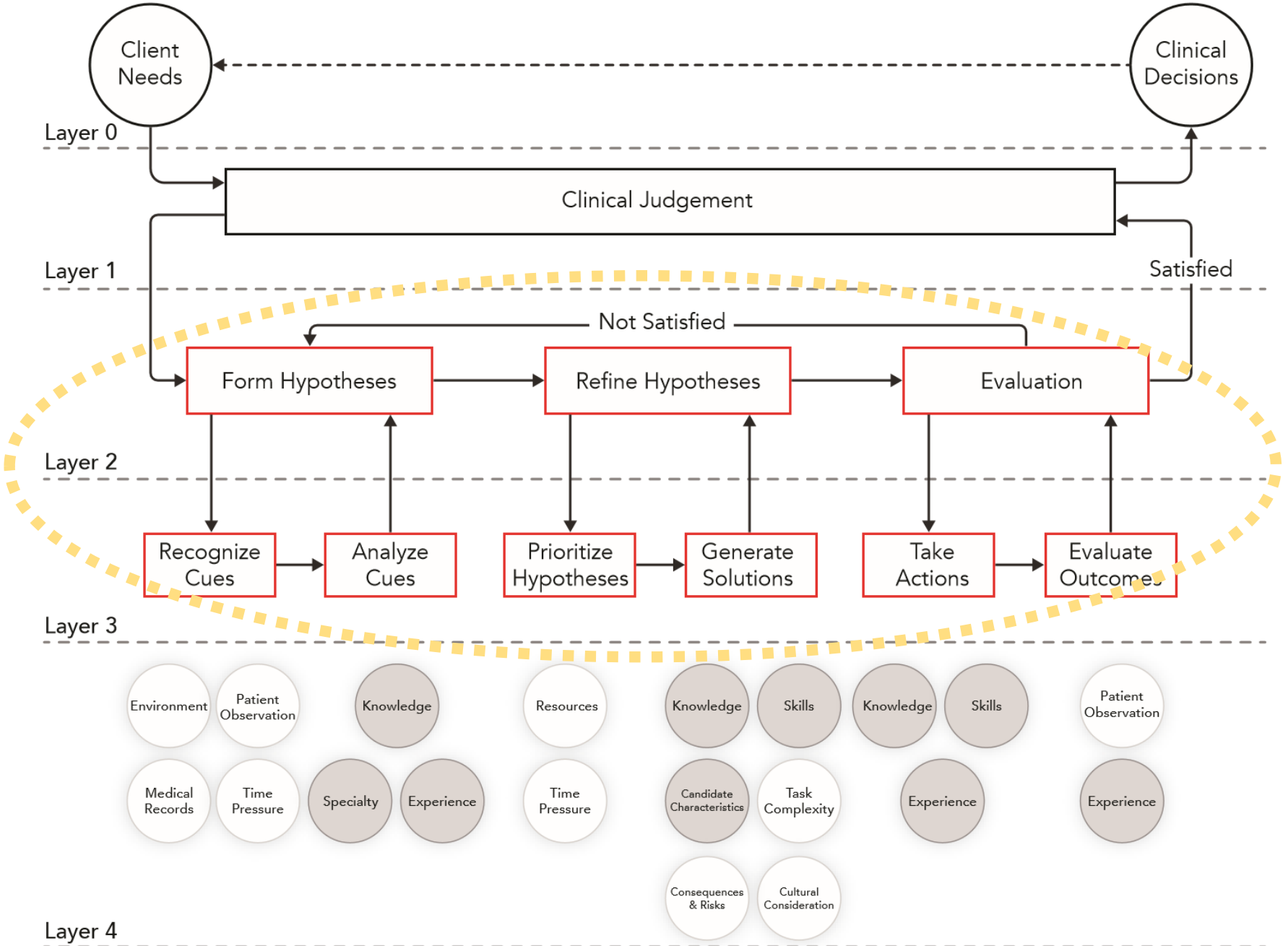
National Council of State Boards of Nursing

ati

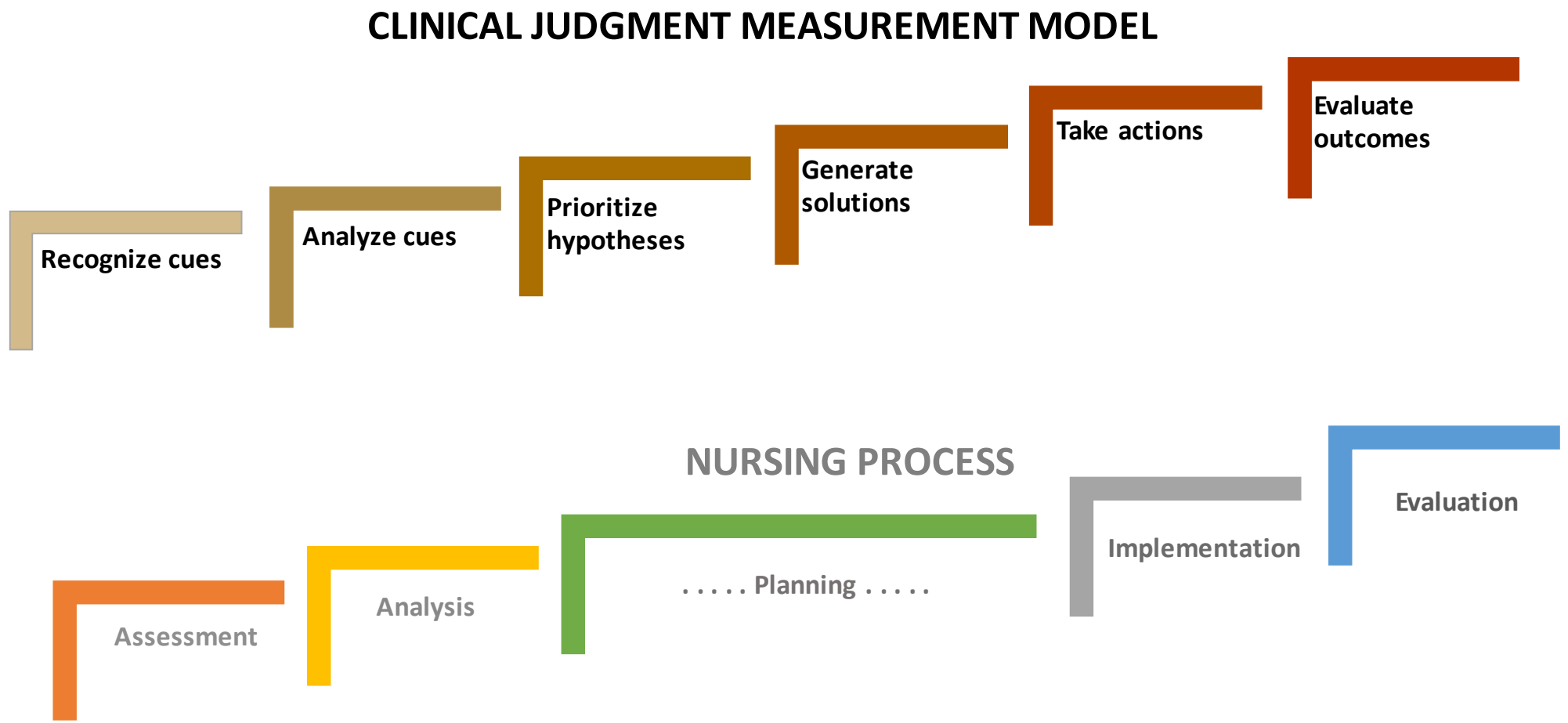
NCSBN News

- The anticipated launch of the Next Generation NCLEX is 2023 or 2024.
- The NGN will launch for RNs and PNs simultaneously.

Clinical Judgment Measurement Model



Clinical Judgment Models



ATI Clinical Judgment Survey

- A survey was developed to identify important skills related to Clinical Judgment and activities indicating that a nursing student/nurse possesses them.
- Cognitive domains from NCSBN"s Clinical Judgment Measurement Model were assessed.
- Respondents included
  - 14 hospital-based nurse educators
  - 97 nurse educators from PN, ADN, and BSN nursing programs.

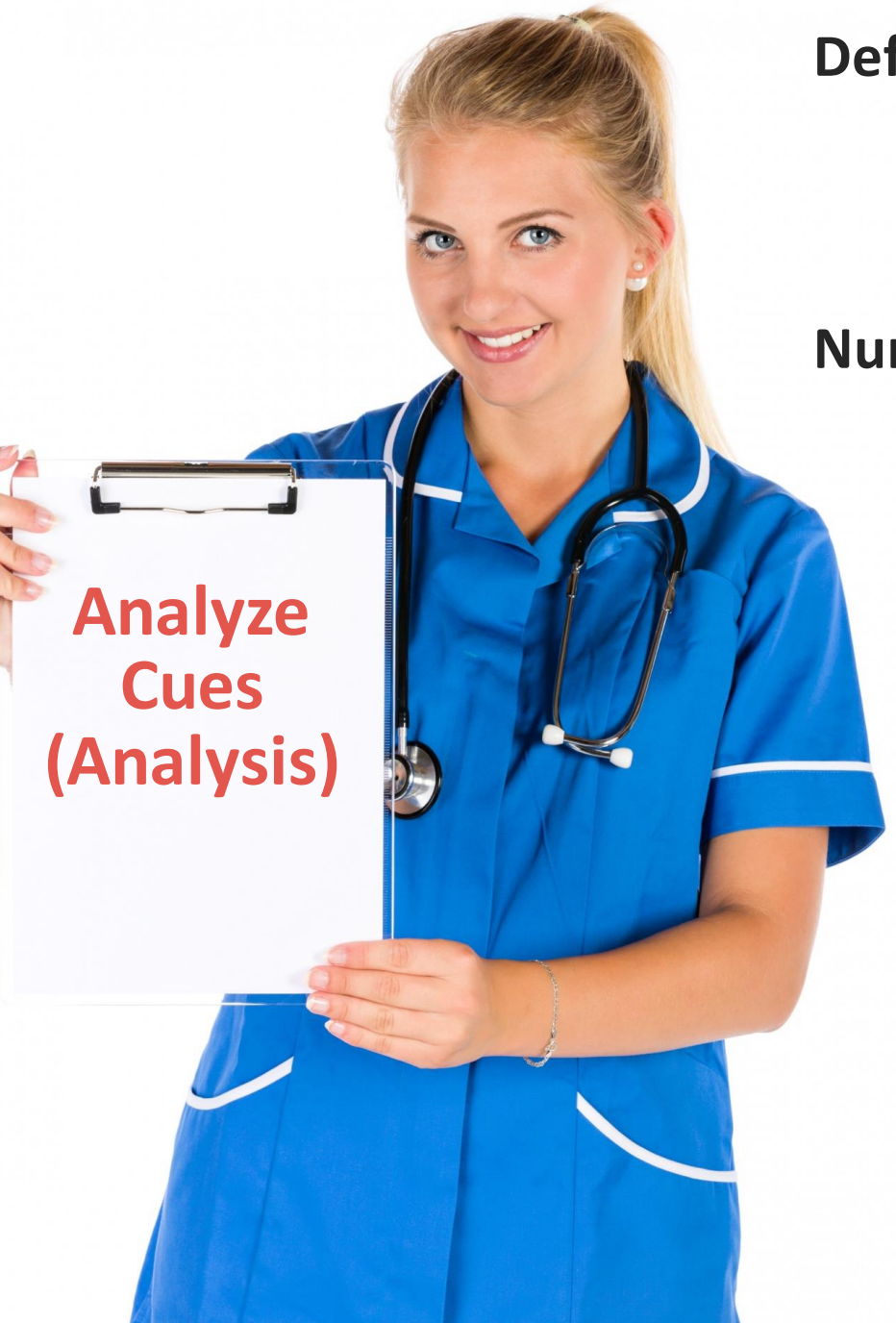
Recognize Cues (Assessment)

Definition

- Filtering information from different sources (e.g., signs, symptoms, medical history).

Nursing actions

- Use knowledge, experience, and evidence to assess clients
- Collect relevant subjective/objective client data
- Identify subtle and apparent changes in client condition and related factors.



Definition

- Linking recognized cues to client's clinical presentation and establishing probable client needs, concerns, or problems.

Nursing actions

- Compare client findings to evidence-based resources and standards of care
- Document and communicate expected/unexpected patterns/trends/changes in clinical findings
- Recognize when to seek guidance from more experienced colleagues
- Differentiate signs/symptoms of a client's condition that present similarly to different health problem
- Analyze un/expected findings in health data
- Anticipate illness/injury and wellness progression
- Identify client problems, related health alterations.

Prioritize Hypotheses (Planning)

Definition

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

Nursing actions

- Organize client-assessment information/data according to changes, patterns, and trends
- Use standards of care and empirical frameworks for priority setting
- Establish and prioritize hypotheses based on the analysis of information and factors.

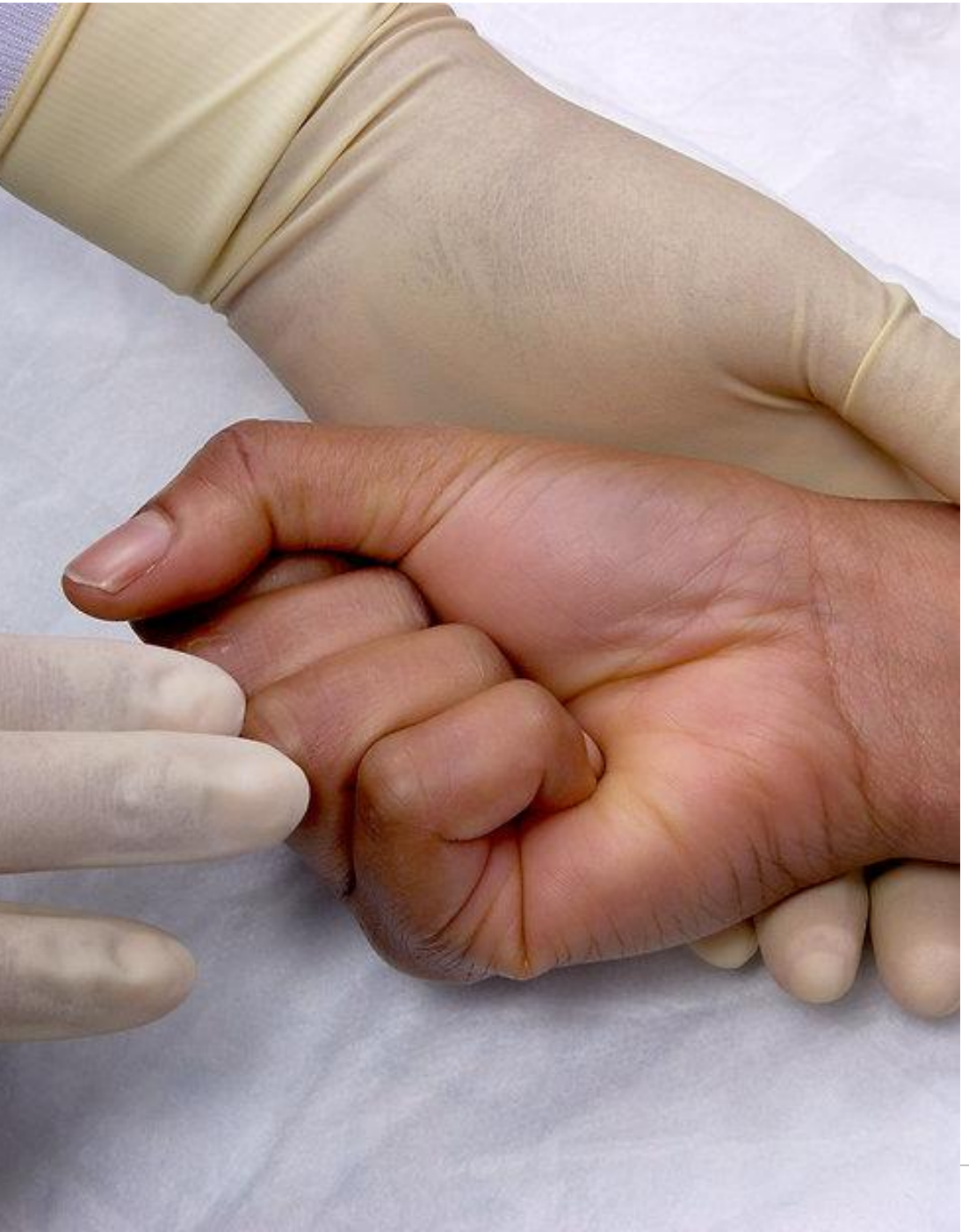
Generate Solutions (Planning)

Definition

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

Nursing actions

- Identify optimal client outcomes based on information and factors
- Identify evidence-based nursing actions to effectively address the underlying cause of the client's health problem
- Prioritize plan of care to achieve optimal client outcomes
- Prioritize nursing care when caring for multiple clients
- Re-prioritize nursing actions as the client's condition changes
- Modify a plan of care to assure achievement of optimal client outcomes when indicated.



Take Actions (Implementation)

Definition

- Implementing the solution(s) that addresses the highest priorities; sometimes no action is an action itself.

Nursing actions

- Promptly and accurately perform nursing actions based on prioritized client problems
- Incorporate client preferences and needs when performing nursing actions
- Provide education to the client and/or care partner(s) regarding their health condition and care management
- Participate in coordination of care with the client and healthcare team.

Evaluate Outcomes (Evaluation)

Definition

- Comparing observed outcomes against expected outcomes.

Nursing actions

- Reassess client condition to determine achievement of expected outcomes.
- Evaluate efficacy of nursing actions to determine if client outcomes were met.
- Modify client outcomes and/or nursing actions based on the client's response and clinical findings when indicated.
- Update and revise the plan of care.

Next Generation NCLEX item types

- Extended multiple response
- CLOZE
- Enhanced hot spot
- Extended drag and drop
- Matrix

Extended multiple response

Use the following client data to answer the question.

The nurse is assessing a client who reports having frequent diarrhea for three days.

Vital Signs	Temperature 38.3°C (101°F) Heart rate 88/min Respiratory rate 22/min Blood pressure 112/68
Physical examination	Lethargy Headache
Medications	Protonix 40 mg IV qd
Activity	Activity as tolerated
Diagnostic results	Hemoglobin 17.8 g/dL Hematocrit 50% Sodium 160 mEq/L Potassium 4.4 mEq/L

Which of the following actions should the nurse take? Select all that apply.

- ❑ Check the client's pupils
- ❑ Check the client's output
- ❑ Request an order for bumetanide
- ❑ Request an order for intravenous fluids
- ❑ Instruct the client to cough and deep breathe every hour
- ❑ Instruct the client to ask for help to get out of bed

CLOZE

Read the following case study then refer to the case study to answer the question.

A nurse is preparing to administer medications to a client who is 2 hours post-op following a total knee replacement. The nurse has the following data:

Diagnosis:	Osteoarthritis of left knee
Current vital signs	Blood pressure 99/70 mm Hg Temperature 37.2°C (99°F) Heart rate 54/min Respiratory rate 16/min
Allergies	Peanuts
Medical history	Migraines Hypertension Hyperlipidemia Cholecystectomy 3 years ago
Laboratory tests	Creatinine 1 mg/dL Hgb 8 g/dL Sodium 140 mEq/L Potassium 3.2 mEq/L Platelets 250,000/mm^3
Diet:	2 g sodium diet

Which three medications require clarification prior to administration? (Complete the following sentences by choosing from the dropdown lists. Do not use the same medication selection more than once.)

The nurse should not administer the Select ▼ because Select ▼

The nurse should not administer the Select ▼ because Select ▼

The nurse should not administer the Select ▼ because Select ▼

Enhanced hot spot

Use the following scenario and client data to answer the question.

A nurse is preparing to administer a dose of clozapine to a client. The nurse has not administered this medication before and is using a drug reference to review information about the medication. Which client and drug reference information supports the nurse's decision to withhold the clozapine? (Click in both tables to highlight the text that supports your response.)

Client information	
Diagnosis	Schizoaffective disorder
Current vital signs	Blood pressure 118/74 mm Hg Heart rate 78/min Respiratory rate 16/min Temperature 37° C (98.6° F)
Medical history	Coronary artery disease Nicotine use Hypertension Allergic rhinitis Bacterial pneumonia 2 wk ago
Physical exam	BMI 29 Client appears Client reports sore throat disheveled
Laboratory results	Hemoglobin 14 gm/dL Hematocrit 46% Glucose 86 mg/dL
Current medications	Clozapine 300 mg PO once daily Multivitamin PO once daily Hydrochlorothiazide 25 mg PO once QD Propranolol 10 mg PO twice daily Prazosin 1 mg PO at bedtime Diphenhydramine 25 mg PO q 4hr PRN

Drug reference	
Medication	Clozapine
Classification	Antipsychotic
Indications	Schizophrenia spectrum disorders
Contraindications/ Precautions	Decreased WBC Decreased ANC
Adverse reactions / Side effects	Agranulocytosis. Urinary retention, Wt. gain
Interactions	Antihistamines Antidepressants
Route/Dosage	300 mg oral daily
Assessment	Monitor orthostatic BP, Monitor Weight Laboratory test considerations: monitor WBC and absolute neutrophil count (ANC) weekly
Implementation	Slowly increase dose until desired therapeutic response occurs. Increase fiber and fluid intake

Extended drag and drop

Drag assessment findings that require immediate attention to the boxes on the right.

Assessment findings
Hgb 10.5 g/dL
Syncope
88% oxygen saturation on room air
Right lower extremity pain, edema and redness
Dark stool after taking iron
Hematuria
BP: 128/82, P: 88, R: 26
Sudden loss of hearing in left ear

Findings that require immediate follow-up

Matrix

The nurse is caring for a client admitted to the Emergency Department following multiple deep stab wounds to the left leg with active bleeding requiring a fresh dressing every hour.

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

Potential order	Anticipated	Nonessential	Contraindicated
Serum Hgb and Hct	○	○	○
Intravenous fluids	○	○	○
Blood type and screen	○	○	○
Vital signs every 15 minutes	○	○	○
Regular diet	○	○	○
Serum Magnesium	○	○	○
Bathroom privileges	○	○	○
Pain medication	○	○	○

ATI Continues to Support Students and Educators

- NGN updates
- ATItesting.com/education/blog

Resources

- NGN FAQs for Educators. https://www.ncsbn.org/11447.htm
- NGN Talks and Videos. https://www.ncsbn.org/ngn-talks.htm
- ATItesting.com/educator/blog. (Choose category: Next Generation NCLEX)