FALL 2021

Next Generation NCLEX® NEWS

Next Generation NCLEX®: Comparison between Case Studies and Stand-alone Items

The Next Generation NCLEX® News is a quarterly publication that provides the latest information about the research being done to assess upcoming changes to the NCLEX Examinations. In this issue, you will find a comparison between the two item types on the Next Generation NCLEX (NGN), Case Studies and Stand-alone Items.

NGN Case Study and Stand-alone items measure clinical judgment by targeting one or more of the steps from Layer 3 of the NCSBN Clinical Judgment Measurement Model (NCJMM). The information provided below will assist you in identifying and comparing some of the characteristics of each item type.

Comparisons

Case Study items (Spring 2020 Newsletter): unfolding case studies of evolving real-world nursing scenarios accompanied by different approved NGN item types (Fall 2019 Newsletter).

Stand-alone items (Spring 2021 Newsletter): individual items that present client information accompanied by an approved NGN item type that specifically targets one of the important clinical judgment elements of the NCJMM. There are also two unique types of Stand-alone items: Bow-tie and Trend Items. These are

continued

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unique because, as single, stand-alone items, they measure more than one element of the NCJMM within the single item. Regular stand-alone clinical judgment items can use any of the approved item types and will target specific elements of the NCJMM.

The following table presents differences between Case Study and Stand-alone items:

	Case Study	Stand-alone	
		Bow-Tie	Trend
Steps from Layer 3 of NCJMM addressed	All of the six steps	All of the six steps	One or more of the six steps
# of items	Six items	One item	One item
# of clinical decisions required from the candidate	Multiple clinical decisions	Multiple clinical decisions	One or more clinical decisions
Action-model approach	Combines the individual components of the NCJMM in a six-item sequence structured format	Combines the individual components of the NCJMM in one item	Presents one or more of the individual components of the NCJMM in one item

Examples of Each Item Type

Case Study Screen | 1 of 6

RECOGNIZE CUES

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 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."

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

Client Findings	Top 4 Findings
vital signs	
lung sounds	
capillary refill	
client orientation	
radial pulse characteristics	
characteristics of the cough	

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ANALYZE CUES

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

Nurses' Notes

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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	☐	☐	☐

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

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PRIORITIZE HYPOTHESIS

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

Case Study Screen | 4 of 6

GENERATE SOLUTIONS

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 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.

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.

Potential Intervention	Indicated	Contraindicated
Prepare the client for defibrillation.	O	O
Place client in a semi-Fowler's position.	O	O
Request an order to increase the oxygen flow rate.	O	O
Request an order to administer an intravenous fluid bolus.	O	O
Request an order to insert an additional peripheral venous access device (VAD).	O	O

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TAKE ACTIONS

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 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."

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The nurse has received orders from the physician.

➢ 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)

Case Study Screen | 6 of 6

EVALUATE OUTCOMES

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

Nurses' Notes | Orders

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 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.

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
RR 36	O	O	O
BP 118/68	O	O	O
pale skin tone	O	O	O
pulse oximetry reading 91%	O	O	O
interacting with daughter at bedside	O	O	O

Sample Bow-tie Item

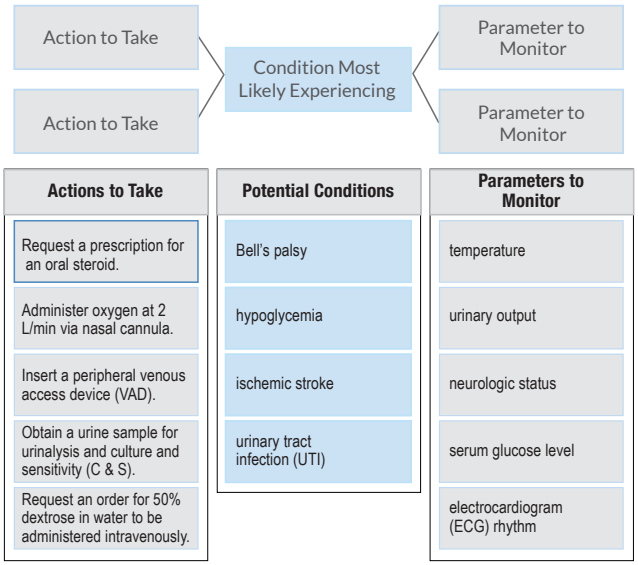
The nurse in the emergency department (ED) is caring for a 79-year-old female client.

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 nurses should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



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 hrs	60 mL of formula over the past 4 hrs
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 sound 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 clients plan of care.

➤ Which of the following diagnostic procedures should the nurse anticipate the physician would order? Select all that apply.

- ☐ barium enema
- ☐ abdominal x-ray
- ☐ abdominal ultrasound
- ☐ complete metabolic panel
- ☐ esophagogastroduodenoscopy (EGD)

NGN Resources

For more information regarding the NGN project, please visit the NCSBN website and our Frequently Asked Questions, which address common questions from candidates and educators. The NGN Resources page includes past publications of the NGN News. The newsletter is published quarterly and provides the latest information about the work to assess potential changes to the NCLEX Examinations. NGN Talks & Videos houses short NGN videos on topics related to the NGN.

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