



NCSBN

Leading Regulatory Excellence

Next Generation NCLEX: Countdown to Launch

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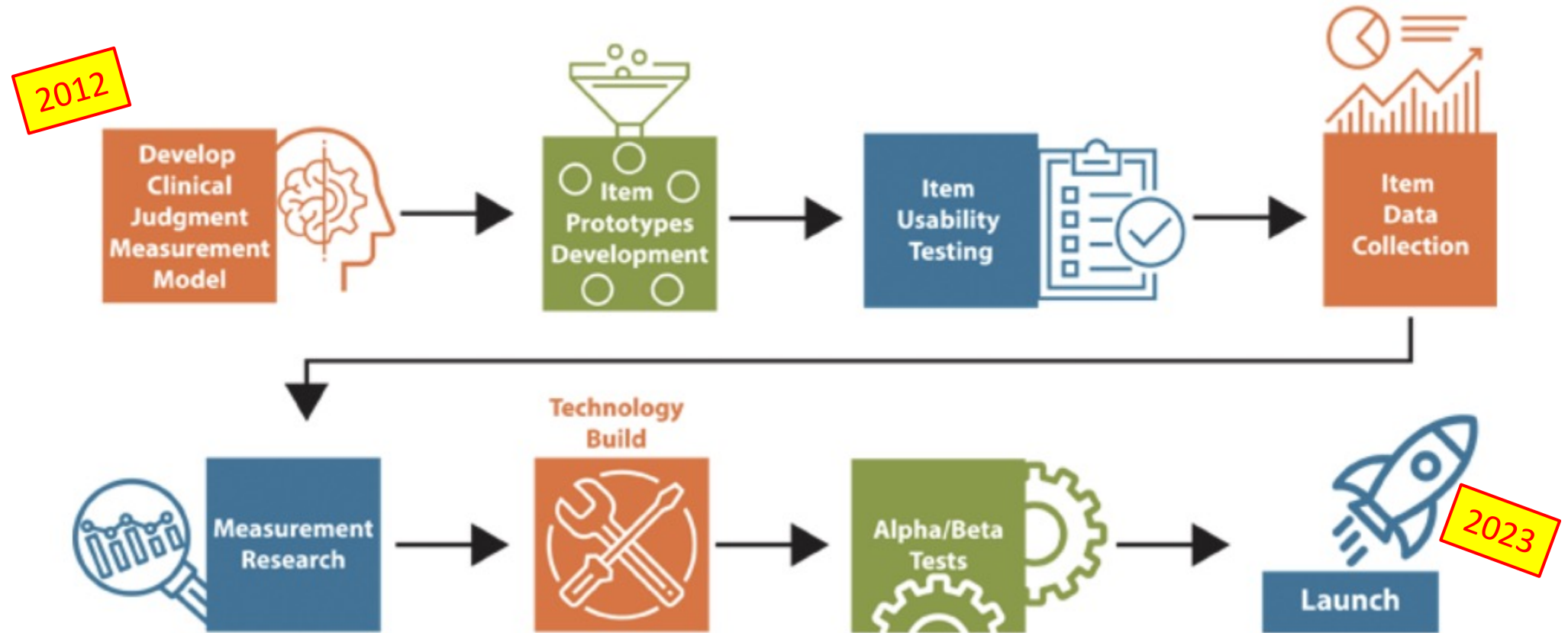
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Overview

1. Next Generation NCLEX timeline
2. Research foundations of the NGN
3. NGN Sample Items + **Hands-on Activity**
4. NGN Test Design
5. NGN Scoring + **Hands-on Activity**
6. NGN Resources
7. Questions

NGN Timeline

NGN Pre-Launch Checklist



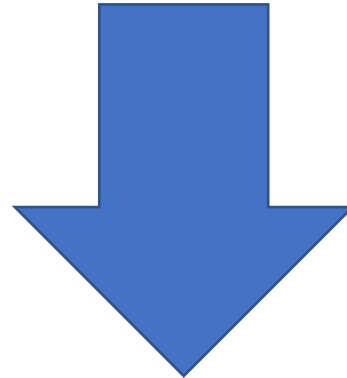
Foundations

ncsbn.org



NGN origin story

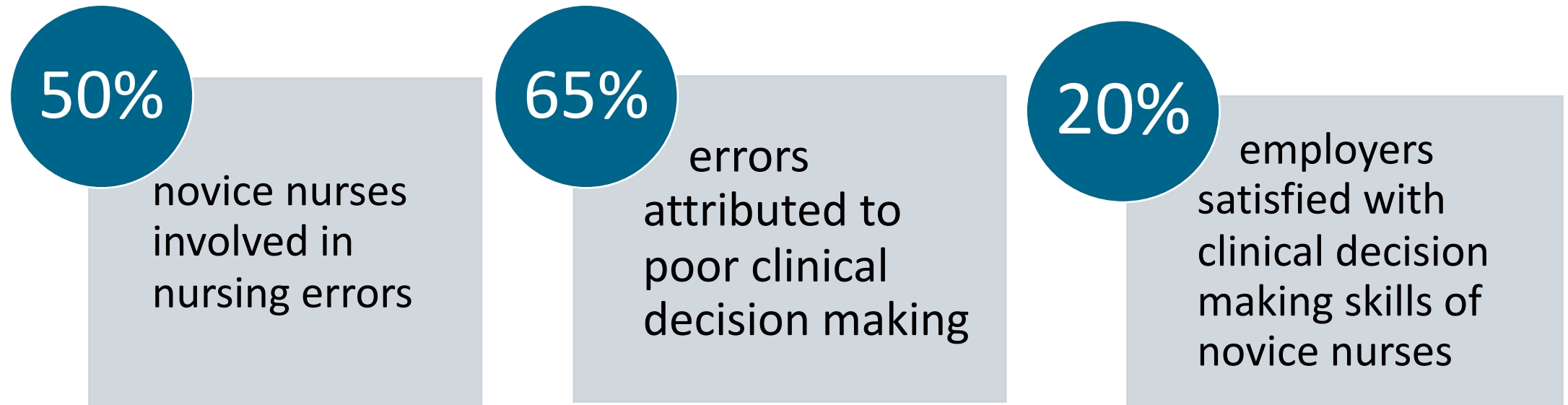
- **2012 NCLEX Examination Committee--**
“Is the NCLEX measuring the right things?”



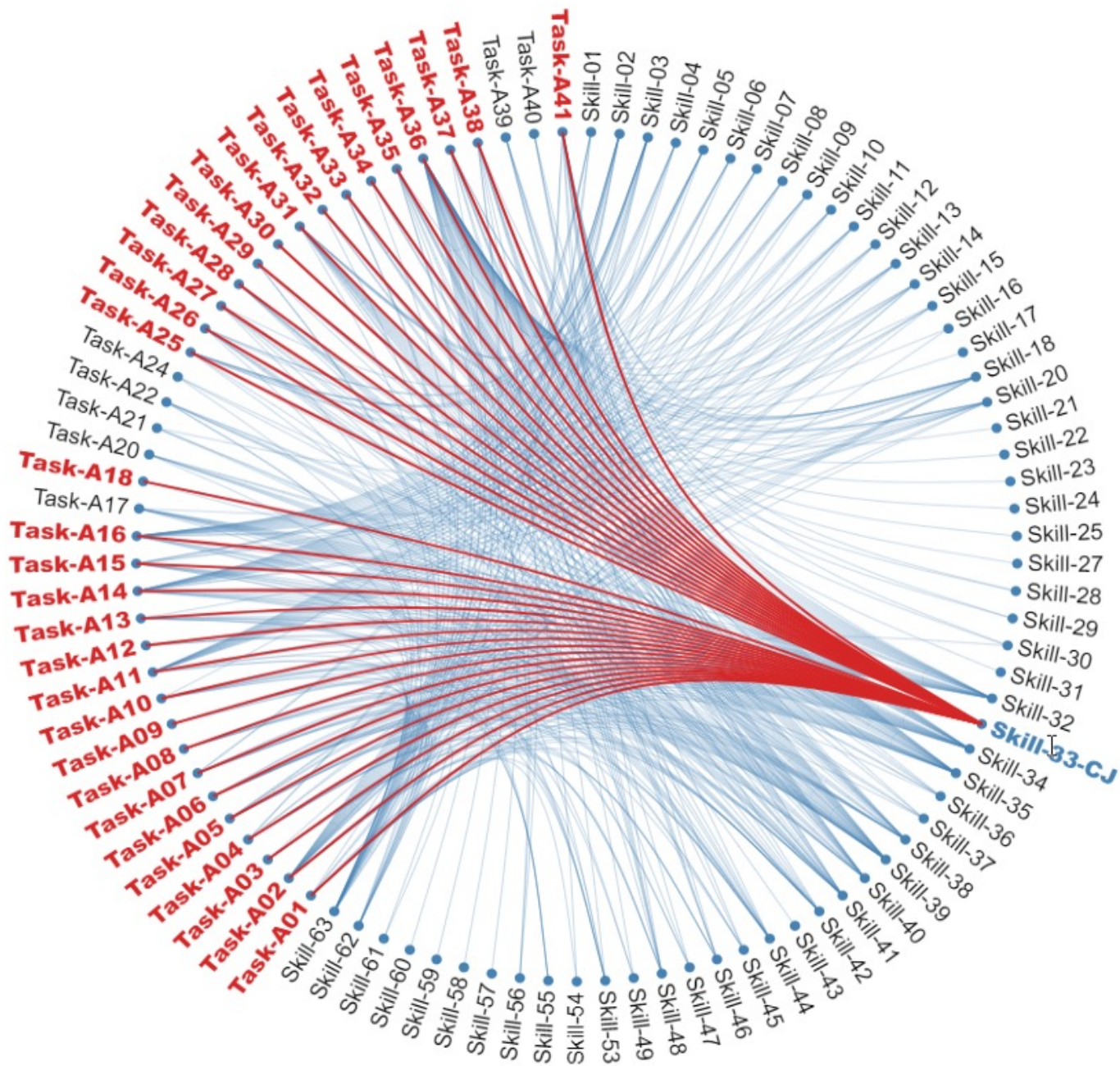
- Literature review
- Strategic Practice Analysis

Literature Review Findings

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



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



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



Measuring Clinical Judgment

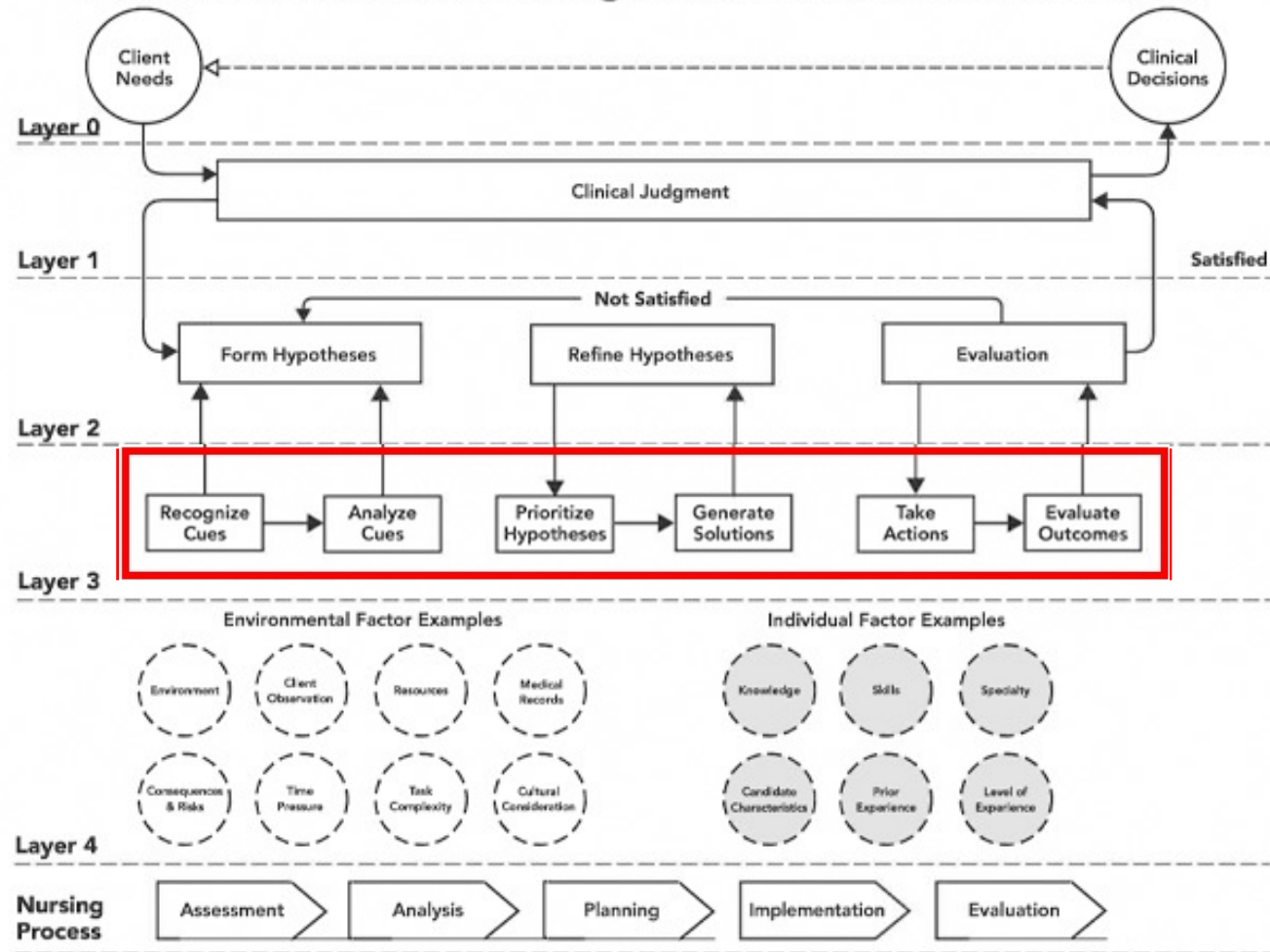


NGN News - Winter 2019

Topic: The NGN Clinical Judgment Measurement Model

2019 | PUBLICATION

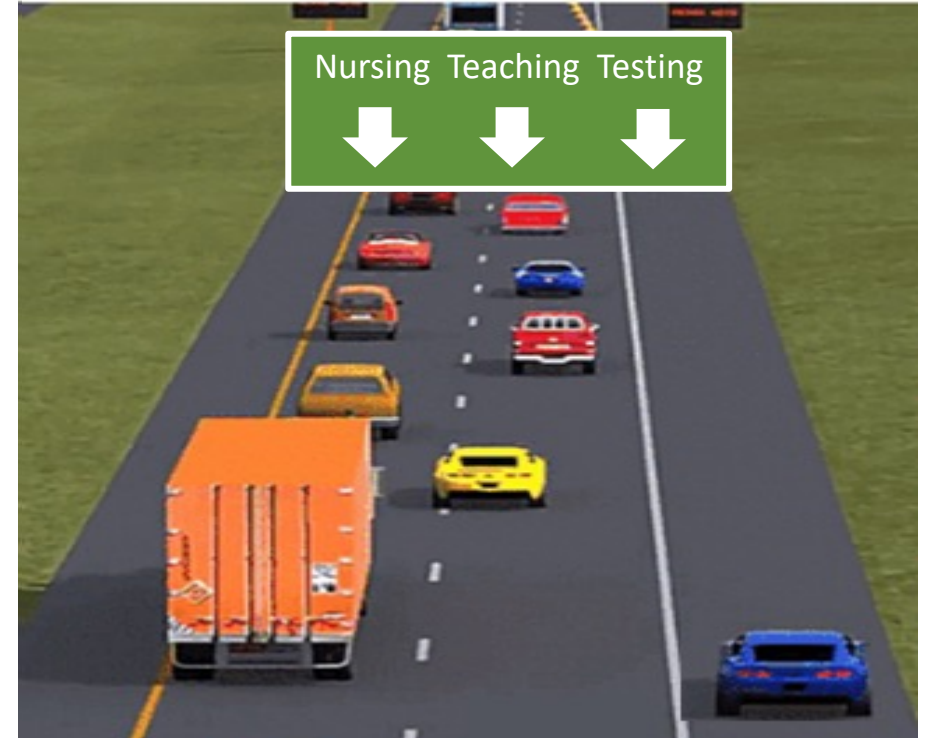
The NCSBN Clinical Judgment Measurement Model



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NCSBN Clinical Judgment Measurement Model (NCJMM)

- Designed to test clinical judgment and decision-making in a **large-scale, high-stakes** setting
- Supports **item development** for the Next Generation NCLEX
- Does **not** replace established models of **practice** or **pedagogy**

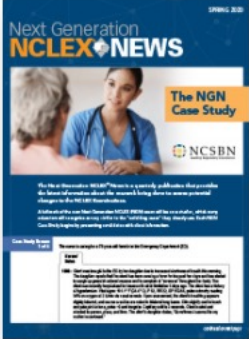


NGN Content

Two ways to measure clinical judgment

- **Case studies** – A real-world nursing scenario accompanied by several related test items
- **Bowtie/Trend items** – Two new “standalone” item types targeting clinical judgment

NGN Case Study



NGN News – Spring 2020

Topic: The NGN Case Study

2020 | PUBLICATION

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 arthroscopic 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.

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)
- O₂ saturation 98% on room air



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)	9g/dL (19.0 x 10 ⁹ /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/mm ³ (19.0 x 10 ⁹ /L)	5,000–10,000/mm ³ (5–10 x 10 ⁹ /L)

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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The nurse is reviewing the client's health history and medical record.

- Drag each potential issue that the client is at risk for to the box on the right.

Potential Issues
stroke
hemothorax
bowel perforation
splenic laceration
pulmonary embolism
abdominal aortic aneurysm

Risk to the Client

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.



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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 followed by the client's .

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

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	<input type="radio"/>	<input type="radio"/>
intravenous fluids	<input type="radio"/>	<input type="radio"/>
abdominal ultrasound	<input type="radio"/>	<input type="radio"/>
preparation for surgery	<input type="radio"/>	<input type="radio"/>
serum type and screen	<input type="radio"/>	<input type="radio"/>
chest percussion therapy	<input type="radio"/>	<input type="radio"/>
insertion of a nasogastric (NG) tube	<input type="radio"/>	<input type="radio"/>
administration of prescribed pain medication	<input type="radio"/>	<input type="radio"/>

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.

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.



- 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. Tiding 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.

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.



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Case Study – Key Features

- Real-world situations
- Some information the candidate will **not** need
- Progression through time **and** steps of NCJMM Layer 3
- Range of content knowledge
- Various new item types

Case Study – Let's try one together!

- Based on sample from Spring 2020 NGN Newsletter
- Type your ideas into the chat!
- “Like” or comment on each other's ideas

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."

Recognize cues – “what matters most?”

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.”

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

Client Findings

Top 4 Findings



Analyze cues – “what could it mean?”

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.”

➤ 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
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[Redacted]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Prioritize hypotheses – “Where do I start?”

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.”

➤ Complete the following sentence by choosing from the lists of options.

The client is at highest risk for developing as evidenced by the client's

vital signs
neurologic assessment
respiratory assessment
cardiovascular assessment
hypoxia
stroke
dysrhythmias
a pulmonary embolism

Generate solutions – “what might 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 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
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>

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:

-
-
-
-
-



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
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Trend and Bowtie Items

- Additional measurement of clinical judgment
- Individual “standalone” items
- Typically target multiple clinical judgment elements from NCJMM Layer 3



NGN News – Spring 2021

Topic: Stand-alone Items

2021 | PUBLICATION

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.

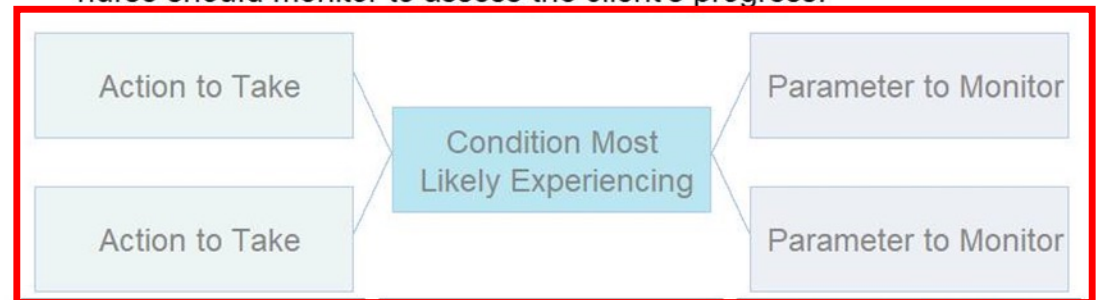
Nurses' Notes

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.



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

Test Design



**NGN News - Winter
2022**

Topic: NGN Test Design
2022 | PUBLICATION

NGN Test Design

- How many questions are on the test?
- How long will candidates have to take the test?
- How many case studies will there be?
- How many NGN standalone items will there be?
- Will computer adaptive testing still be used?
- Etc.

How different is the NGN from NCLEX?

How different is the NGN from NCLEX?



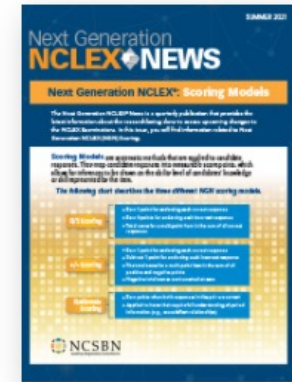
Approved NGN Test Design

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**	52 – 117**
Unscored (Pretest) Items	15	15

* Items within a Case Study are static, not adaptive

** Range possible due to variable length CAT

Scoring



NGN News – Summer
2021

Topic: Scoring Models

2021 | PUBLICATION

A new approach to scoring

- NCLEX today – A candidate response to an item is either correct or incorrect—i.e., **dichotomous** scoring
 - Points possible: 0 or 1
- NGN CJ items – A candidate response may be partially correct and receive partial credit—i.e., **polytomous** scoring
 - Points possible: 0, 1, 2, 3, etc.
- **Three** ways to assign partial credit on NGN

Method #1

Partial credit can be assigned in three different ways—

- Candidates receive a point for correct responses and **lose a point** for incorrect responses. We call this **+/-** scoring.
- Note that any negative overall scores are “rounded up” to zero.

Which of these countries are in North America?
Select all that apply.

- France
- Mexico
- Canada
- New Zealand
- United States

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Method #1

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

Which of these countries are in North America?
Select all that apply.

- | | | | |
|-------------------------------------|---------------|-----------|----------|
| <input checked="" type="checkbox"/> | France | incorrect | -1 point |
| <input checked="" type="checkbox"/> | Mexico | correct | +1 point |
| <input checked="" type="checkbox"/> | Canada | correct | +1 point |
| <input type="checkbox"/> | New Zealand | | |
| <input type="checkbox"/> | United States | | |

Using +/- scoring this candidate earns $2 - 1 = 1$ point out of a maximum of 3 points possible (Mexico, Canada, United States).

Method #2

Partial credit can be assigned in three different ways—

- Candidates receive a point for correct responses but **do not lose points** for incorrect responses. We call this **0/1** scoring.

Which **three** of these countries are in North America?

- France
- Mexico
- Canada
- New Zealand
- United States

Method #2

Partial credit can be assigned in three different ways—

- Candidates receive a point for correct responses but **do not lose points** for incorrect responses. We call this **0/1** scoring.

Which **three** of these countries are in North America?

- France
- Mexico
- Canada
- New Zealand
- United States

Method #2

Partial credit can be assigned in three different ways—

- Candidates receive a point for correct responses but **do not lose points** for incorrect responses. We call this **0/1** scoring.

Which **three** of these countries are in North America?

<input checked="" type="checkbox"/> France	incorrect	0 points
<input checked="" type="checkbox"/> Mexico	correct	+1 point
<input checked="" type="checkbox"/> Canada	correct	+1 point
<input type="checkbox"/> New Zealand		
<input type="checkbox"/> United States		

*Using **0/1** scoring this candidate earns **2 points** out of a maximum of 3 points possible (Mexico, Canada, United States).*

Method #3

Partial credit can be assigned in three different ways—

- Candidates receive “all or nothing” credit for **paired information** within an item.
- Sometimes called **rationale scoring**.
- Nursing examples--
 - “The nurse should question the order for X because of Y.”
 - “The client is at highest risk of X as evidenced by Y.”

Drag and drop the tokens below to complete the statements. No token may be used more than once.

TOKENS

Japan	Cairo	Egypt
Paris	Okinawa	Tokyo
Rome	France	Madrid

STATEMENTS

The capital of [] is [] .
The capital of [] is [] .

Method #3

Partial credit can be assigned in three different ways—

- Candidates receive “all or nothing” credit for **paired information** within an item.
- Sometimes called **rationale scoring**.
- Nursing examples--
 - “The nurse should question the order for X because of Y.”
 - “The client is at highest risk of X as evidenced by Y.”

Drag and drop the tokens below to complete the statements. No token may be used more than once.

TOKENS

Japan	Cairo	Egypt
Paris	Okinawa	Tokyo
Rome	France	Madrid

STATEMENTS

The capital of **France** is .
The capital of is .

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TOKENS

Japan	Cairo	Egypt
Paris	Okinawa	Tokyo
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STATEMENTS

The capital of **France** is **Paris** .
The capital of **Egypt** is **Japan** .

Method #3

Partial credit can be assigned in three different ways—

- Candidates receive “all or nothing” credit for **paired information** within an item.
- Sometimes called **rationale scoring**.
- Nursing examples--
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 - “The client is at highest risk of X as evidenced by Y.”

Drag and drop the tokens below to complete the statements. No token may be used more than once.

TOKENS

Japan	Cairo	Egypt
Paris	Okinawa	Tokyo
Rome	France	Madrid

STATEMENTS

The capital of **France** is **Paris** .
The capital of **Egypt** is **Japan** .

*The candidate earns **1 point** for France/Paris pair but **no points** for Egypt/Japan. In this example country and city are **linked** for scoring. Total score: **1 point**.*

What are the benefits of partial credit scoring?

- Measurement precision



- Appropriateness
- Fairness

What are the benefits of partial credit scoring?

- Measurement precision



- Appropriateness
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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?

Sample candidate response

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

Assessment Findings

productive cough


intermittent left shoulder pain


ECG showing normal sinus rhythm


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


$$4 - 1 = 3$$


Assessment Findings That Require Immediate Follow-up

BP 90/50, P 116, RR 24 

slightly diminished breath sounds on the left 

T 97.8° F (36.6° C), O₂ saturation 98% on room air 

Hgb 9 g/dL (19.0 x 10⁹/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 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	<input type="radio"/>	<input type="radio"/>
intravenous fluids	<input type="radio"/>	<input type="radio"/>
abdominal ultrasound	<input type="radio"/>	<input type="radio"/>
preparation for surgery	<input type="radio"/>	<input type="radio"/>
serum type and screen	<input type="radio"/>	<input type="radio"/>
chest percussion therapy	<input type="radio"/>	<input type="radio"/>
insertion of a nasogastric (NG) tube	<input type="radio"/>	<input type="radio"/>
administration of prescribed pain medication	<input type="radio"/>	<input type="radio"/>

Sample candidate response

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	<input checked="" type="radio"/>	<input type="radio"/>	
intravenous fluids	<input checked="" type="radio"/>	<input type="radio"/>	
abdominal ultrasound	<input checked="" type="radio"/>	<input type="radio"/>	
pr	<input type="radio"/>	<input checked="" type="radio"/>	
se	<input checked="" type="radio"/>	<input type="radio"/>	
ch	<input checked="" type="radio"/>	<input type="radio"/>	
in	<input checked="" type="radio"/>	<input type="radio"/>	
administration of prescribed pain medication	<input checked="" type="radio"/>	<input type="radio"/>	

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. Tiding 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.

- 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. Tiding 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.

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

$$1 - 2 = -1 \rightarrow 0$$

NCSBN NGN Resources

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Next Generation NCLEX Project >

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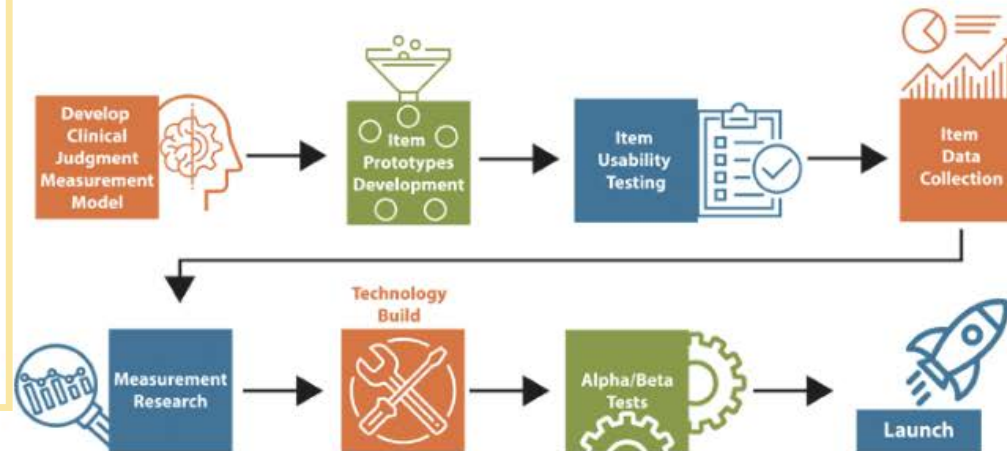
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Next Generation NCLEX Project

The 2013-2014 NCSBN Strategic Practice Analysis highlighted the increasingly complex decisions newly licensed nurses make during the course of patient care. NCSBN is conducting research to determine whether clinical judgment and decision making in nursing practice can be reliably assessed through the use of innovative item types. This objective is the Next Generation NCLEX project, or NGN.

Overview

The NGN consists of several phases of research, which are delineated in the model below. If the evidence during any individual step indicates that potential innovations will not support the rigor and quality of the NCLEX, the project will be reexamined at all levels.



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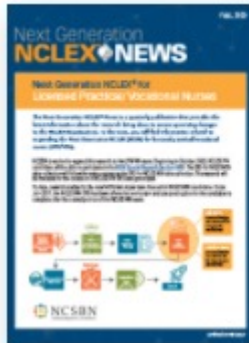
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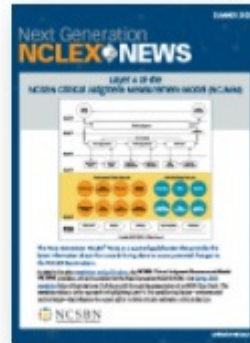
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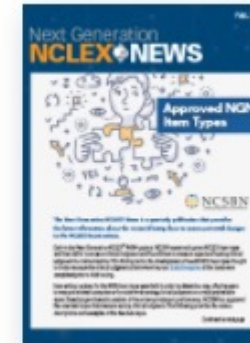
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Nursing Clinical Decision-Making: A Literature Review

The aim of this paper is to review the factors that contribute to clinical judgment and decision-making of novice nurses.

2012 | PUBLICATION



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Questions