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
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:

<table>
<thead>
<tr>
<th>Case Study</th>
<th>Stand-alone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steps from Layer 3 of NCJMM addressed</strong></td>
<td>All of the six steps</td>
</tr>
<tr>
<td><strong># of items</strong></td>
<td>Six items</td>
</tr>
<tr>
<td><strong># of clinical decisions required from the candidate</strong></td>
<td>Multiple clinical decisions</td>
</tr>
</tbody>
</table>

**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**
- vital signs
- lung sounds
- capillary refill
- client orientation
- radial pulse characteristics
- characteristics of the cough

**Top 4 Findings**
The nurse is caring for a 78-year-old female in the Emergency Department (ED).

**ANALYZE CUES**

**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.”

**PRIORITIZE HYPOTHESIS**

**Nurses' Notes**

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**GENERATE SOLUTIONS**

**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 98/62, pulse oximetry reading 91% on oxygen at 2 L/min via nasal cannula.

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**Client Findings**

<table>
<thead>
<tr>
<th>Client Findings</th>
<th>Pneumonia</th>
<th>UTI</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>confusion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>body soreness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cough and sputum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>shortness of breath</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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**Potential Intervention**

<table>
<thead>
<tr>
<th>Potential Intervention</th>
<th>Indicated</th>
<th>Contraindicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare the client for defibrillation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place client in a semi-Fowler’s position.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Request an order to increase the oxygen flow rate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Request an order to administer an intravenous fluid bolus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Request an order to insert an additional peripheral venous access device (IV2).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The nurse is caring for a 78-year-old female in the Emergency Department (ED).

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 received orders from the physician.

- 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

<table>
<thead>
<tr>
<th>RR 36</th>
<th>BP 118/68</th>
<th>Pale skin tone</th>
<th>Pulse oximetry reading 91%</th>
<th>Interacting with daughter at bedside</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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

**Potential Conditions**
- Bell’s palsy
- hypoglycemia
- ischemic stroke
- urinary tract infection (UTI)

**Parameters to Monitor**
- temperature
- urinary output
- neurologic status
- serum glucose level
- electrocardiogram (ECG) rhythm

**Actions to Take**
- Request a prescription for an oral steroid.
- Administer oxygen at 2 L/min via nasal cannula.
- Insert a peripheral venous access device (VAD).
- Obtain a urine sample for urinalysis and culture and sensitivity (C & S).
- Request an order for 50% dextrose in water to be administered intravenously.

The nurse in the emergency department (ED) is caring for a 10-day-old client who is experiencing projectile vomiting after drinking formula. 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)

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.

**Potential Conditions**
- barium enema
- abdominal x-ray
- abdominal ultrasound
- complete metabolic panel
- esophagogastroduodenoscopy (EGD)

**Parameters to Monitor**
- intake
- output
- vital signs
- urine analysis

**Actions to Take**
- Request a prescription for an oral steroid.
- Administer oxygen at 2 L/min via nasal cannula.
- Insert a peripheral venous access device (VAD).
- Obtain a urine sample for urinalysis and culture and sensitivity (C & S).
- Request an order for 50% dextrose in water to be administered intravenously.

**Flow Sheet**

<table>
<thead>
<tr>
<th>Time</th>
<th>Intake</th>
<th>Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>480 mL of formula over the past 24 hrs</td>
<td>3 small yellow stools over the past 24 hrs</td>
</tr>
<tr>
<td>1400</td>
<td>60 mL of formula over the past 4 hrs</td>
<td>40 mL of emesis 30 min after feeding</td>
</tr>
<tr>
<td>1800</td>
<td>60 mL of formula over the past 4 hrs</td>
<td>40 mL of emesis 30 min after feeding</td>
</tr>
</tbody>
</table>

**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.
NGN Resources

For more information regarding the NGN project, please visit the [NCSBN website](http://www.ncsbn.org) and our [Frequently Asked Questions](http://www.ncsbn.org), which address common questions from candidates and educators. The [NGN Resources](http://www.ncsbn.org) 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](http://www.ncsbn.org) related to the NGN.