

Clinical Judgment and Next Generation NCLEX-RN®

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Learning Objectives

During this session, we will:

1. Explain why NCSBN started the Next Generation NCLEX® (NGN) project.
2. Define clinical judgment.
3. Discuss strategies for implementing clinical judgment activities into the classroom
4. Explore the types of questions being piloted through the NGN project and how they can be utilized in the classroom.

Next Generation NCLEX®

Research

NCSBN® is presently conducting research projects to determine the ability of current and potential innovative items to assess Nursing Clinical Judgment (NCJ).

Candidate Participation

Over the course of 18 months from July 2017 to December 2018, 304,626 NCLEX-RN candidates participated in the special research section (i.e., responding to at least one item), which is over 85% participating rate

Candidate Participation

- Ninety-five forms consisting of 884 items had been assembled for Item Type Data Collection (ITDC) with overlapping items across the forms
- The participating candidates responded to about 16 out of 20 items and **spent about one minute on each item** in the special research section

Background Info

Factors that demand sound clinical judgment among all nurses:

- Changing landscape of health care across the U.S. and Canada
- Increasing client acuity (intensity of care)
- Aging population
- New government regulations
- Increasing demand for clinical judgment skills among entry-level nurses
- Substantial number of the adverse events that clients endure may be prevented if decisions had been made using good clinical judgment

The Beginnings



**NEC* 2012: Is the
NCLEX[®] measuring
the right things?**

*NCLEX Examination Committee

**2015: Strategic
Practice Analysis
Pilot Study**



Literature Review

Errors

- 50% errors involved novice nurses
- 65% errors attributed to poor clinical decision making
- 20% employers satisfied with clinical decision making skills of novice nurses

Recent Evidence to Support NGN Research

2012 Functional Job Analysis (RN's)

- 2,522 SMEs
- 24 Practice Settings
- All 4 Geographic Regions
- 50 States and/or U.S. Territories
- Tenure ranges 0 – 45 years

2015 Strategic Job Analysis (RN's)

- 90 SMEs
- 20 Practice Settings
- All 4 Geographic Regions
- 33 States
- Tenure ranges 2 – 45 years

Top 3 Areas Identified:

1. Clinical Judgment
2. Professional Communications
3. Active Listening

Evaluation of Current Item Types

Item Formats

Multiple choice

Multiple response

Drag and drop

Hot spot

Audio

Graphics

Exhibit

Clinical Judgment Skills

Cue recognition

Hypothesis generation

Communication

Consequences/risks

Task complexity

Time pressure

Distractions/interruptions

Current NCLEX® Item Bank:

Clinical Judgment Domain Distribution

	Cue Recognition	Hypothesis Generation	Communication	Consequences and Risk	Task Complexity	Time Pressure	Distractions and Interruption
Multiple Choice	Yellow	Yellow	Yellow	Yellow	Yellow	Orange	Orange
Multiple Response	Yellow	Yellow	Yellow	Green	Yellow	Orange	Orange
Drag and Drop	Yellow	Yellow	Orange	Yellow	Yellow	Orange	Orange
Hot Spot	Yellow	Yellow	Orange	Yellow	Orange	Orange	Orange
Audio	Green	Yellow	Yellow	Orange	Orange	Yellow	Orange
Graphic	Yellow	Yellow	Orange	Orange	Yellow	Orange	Yellow
Exhibit	Green	Orange	Orange	Orange	Orange	Orange	Orange

NCSBN Findings

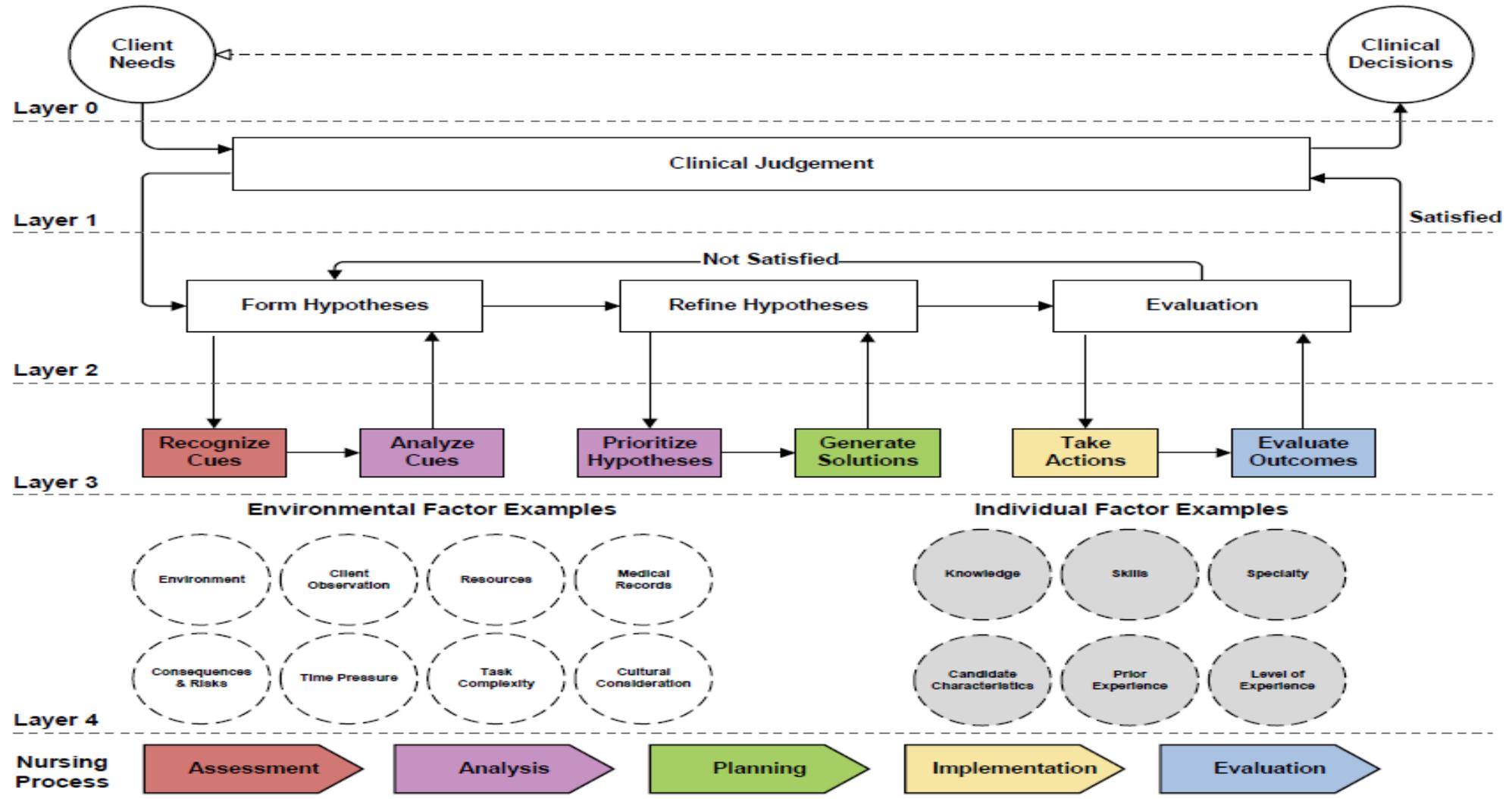
Clinical Judgment (CJ)

- Necessary skill for novice nurses
- Better care & reduction of errors can occur with improved CJ
- Assessing CJ is a goal of NCLEX[®]
- Currently CJ is indirectly tested

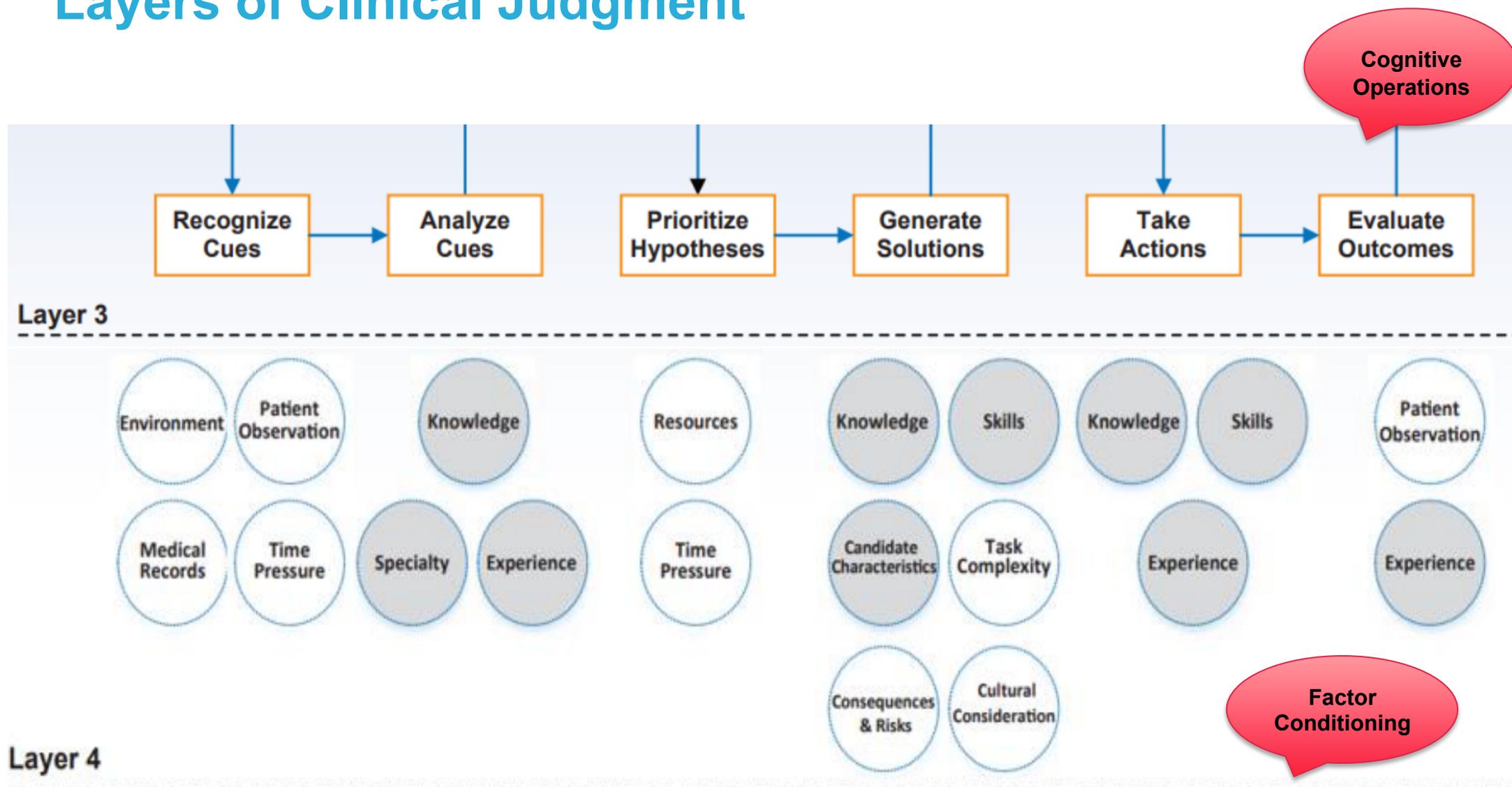
Clinical Judgment (CJ) is Defined As

- “the observed outcome of critical thinking and decision-making”
- It is an **iterative process** that **uses nursing knowledge** to **observe** and **assess** presenting situations, **identify a prioritized** client concern and **generate** the best possible evidence-based solutions in order to **deliver** safe client care.

NCSBN Clinical Judgment Model



Layers of Clinical Judgment



Definitions within CJ Model



Recognizing Cues:

- filter information (assess)

Analyzing Cues:

- organize and link information to client's appearance, what are the client needs/problems

Prioritizing Hypothesis:

- evaluate and rank hypotheses (urgent, risk)

Generating Solutions:

- identify interventions

Taking Action:

- implement solutions for highest priorities

Evaluating Outcomes:

- compare observed outcomes to expected outcomes

NCSBN Question Types

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X
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E
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D
E
D

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-N-

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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

Cloze (DropDown) Item

The nurse is admitting a 58-year-old female client to an inpatient substance abuse rehabilitation facility. The client provides the nurse with a handwritten list of the medications she takes at home. The list is difficult to read, and the client is unable to provide any additional information. The nurse transcribes the part of the information that is clearly legible.

Choose the most likely option for the missing information in the table below by choosing from the lists of options.

Medication	Dose, Route, Frequency	Drug Class	Indication
Select... ▼	500 mg, p.o., twice daily	biguanide	management of type 2 diabetes mellitus
sertraline	50 mg, p.o., daily	selective serotonin reuptake inhibitor	Select... ▼
verapamil	119 mg, p.o., daily	Select... ▼	treatment of hypertension
Select... ▼	21 mg, transdermal, daily	ganglionic cholinergic agonist	smoking deterrent
alendronate	Select... ▼	bisphosphonate	prevention of osteoporosis

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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, nonessential, or contraindicated for the client.

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

- 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.

Highlight Item

Read the case study below, then refer to the case study to answer the question.

The nurse is assessing a male client who has chronic renal failure and was admitted one day ago with bacterial pneumonia. The client's findings are listed below.

	Current	8 hours ago	24 hours ago
Blood pressure	136/84	138/86	134/82
Pulse	72	58	68
Respirations	16	14	12
Oral temperature	102.6° F (39.2° C)	100.3° F (37.9° C)	101.1° F (38.4° C)

Hemoglobin	11.5 g/dL (115 mmol/L)	12.8 g/dL (128 mmol/L)	13.5 g/dL (135 mmol/L)
Hematocrit	32 (0.32)	36 (0.36)	42 (0.42)
Platelet count	221,000/mm ³ (221 x 10 ⁹ /L)	223,400/mm ³ (223.4 x 10 ⁹ /L)	220,800/mm ³ (220.8 x 10 ⁹ /L)
White blood cell count	15,200/mm ³ (15.2 x 10 ⁹ /L)	15,300/mm ³ (15.3 x 10 ⁹ /L)	15,300/mm ³ (15.3 x 10 ⁹ /L)
Prothrombin time	12.1 seconds	12.2 seconds	12.3 seconds
Partial thromboplastin time	28 seconds	27 seconds	25 seconds

Serum potassium	5.3 mEq/L (5.3 mmol/L)	4.8 mEq/L (4.8 mmol/L)	4.5 mEq/L (4.5 mmol/L)
Serum sodium	142 mEq/L (142 mmol/L)	140 mEq/L (140 mmol/L)	143 mEq/L (143 mmol/L)
Blood urea nitrogen	52 mg/dL (18.6 mmol/L)	55 mg/dL (19.6 mmol/L)	51 mg/dL (18.2 mmol/L)
Serum creatinine	8.0 mg/dL (707.2 µmol/L)	8.2 mg/dL (724.9 µmol/L)	8.1 mg/dL (716.0 µmol/L)

Weight	210 lb (95.5 kg)	209 lb (95 kg)	206 lb (93.6 kg)
Edema	1+ pitting pedal	2+ pitting pedal	2+ pitting pedal
Urine output	23 mL/h	21 mL/h	24 mL/h

Which of the findings would be essential to follow up?

Click row(s) to highlight the finding(s) that would be essential to follow-up. Highlight only row(s) that require follow-up. To deselect a row, click the row again.

Next Generation Questions – newest form - prototype

The client has a temperature of 102.1°F (38.9°C) at this time. The nurse notes that the FHR is 170 with minimal variability and no accelerations present. Contractions are every 7 minutes, and last 50 seconds with moderate intensity. A category II FHR tracing is noted.

- Drag words from the choices below to fill in each blank found in the following sentence:

The best outcomes for the client would be to and . To achieve optimal outcomes, the nurse should and .

Word Choices

Reduce maternal temperature

Facilitate labor progression

Improve fetal well-being

Prepare for cesarean section

Perform intrauterine resuscitation

Administer intravenous antibiotics

Discontinue intravenous oxytocin

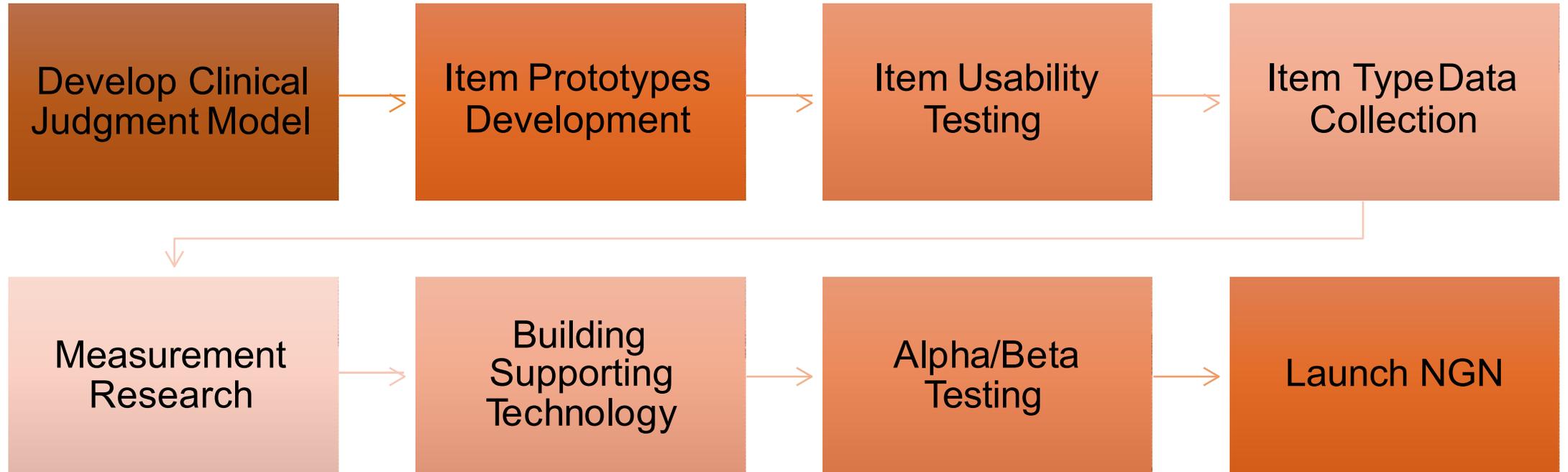
New NGN Item Types: Clinical Judgment Model Domain Distribution

	Cue Recognition	Hypothesis Generation	Communication	Consequences and Risk	Task Complexity
Enhanced Hot Spot	Green	Red	Yellow	Yellow	Yellow
Extended Multiple Response	Green	Yellow	Yellow	Green	Green
Extended Drag and Drop	Green	Yellow	Green	Green	Yellow
SBAR	Green	Green	Green	Green	Yellow
Cloze Items	Green	Yellow	Green	Green	Green
Constructed Response	Green	Green	Green	Green	Green
Rich Media Scenarios	Green	Green	Green	Green	Green
Dynamic Exhibits	Green	Green	Green	Green	Green

Current NCLEX® Item Bank: Clinical Judgment Domain Distribution

	Cue Recognition	Hypothesis Generation	Communication	Consequences and Risk	Task Complexity	Time Pressure	Distractions and Interruption
Multiple Choice	Yellow	Yellow	Yellow	Yellow	Yellow	Orange	Orange
Multiple Response	Yellow	Yellow	Yellow	Green	Yellow	Orange	Orange
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Graphic	Yellow	Yellow	Orange	Orange	Yellow	Orange	Yellow
Exhibit	Green	Orange	Orange	Orange	Orange	Orange	Orange

Next Generation NCLEX[®] (NGN) Project Flowchart



Kaplan Prototypes



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Multiple Selection Item

The nurse provides care for a client who is diagnosed with a brain tumor. The health care provider diagnoses the client with central diabetes insipidus.

Vital Signs

Blood pressure	126/82 mm Hg
Heart rate	104 beats/minute
Respirations	17 breaths/minute
Oxygen saturation	96% on room air
Temperature	99.2 °F (37.3 °C)

Urine output 1800 mL over past 4 hours

Urine specific gravity 1.003

Serum sodium level 150 mEq/L (150 mmol/L)

Blood urea nitrogen (BUN) 37 mg/dL (13.2 mmol/L)

Hematocrit 56% (0.56)

Mucous membranes dry

Client reporting thirst

➤ Which action does the nurse take?

Select all that apply.

- 1. Infuse dextrose 5% in water (D₅W).
- 2. Prepare the client for dialysis.
- 3. Administer furosemide 20 mg IV.
- 4. Obtain serial urine specific gravity measurements.
- 5. Administer desmopressin 0.4 mL intranasally.
- 6. Initiate seizure precautions.
- 7. Assess the client's level of consciousness frequently.
- 8. Provide client with PO fluids, including caffeinated beverages.

Highlight Item

Read the following case study, then refer to the case study to answer the questions.

The nurse provides care for a client who is diagnosed with liver cirrhosis. The client's assessment findings are listed below.

	Current	12 hours ago	24 hours ago	Which finding(s) require(s) follow-up by the nurse?
Blood pressure	167/82 mm Hg	155/91 mm Hg	182/102 mm Hg	
Blood pressure	167/82 mm Hg	155/91 mm Hg	182/102 mm Hg	To deselect a row, click the row again.
Pulse	88 beats/minute	77 beats/minute	92 beats/minute	
Respirations	24 breaths/minute	23 breaths/minute	26 breaths/minute	
Oral temperature	99 °F (37.2 °C)	98.8 °F (37.1 °C)	99.1 °F (37.3 °C)	
Sodium	135 mEq/L (135 mmol/L)	135 mEq/L (135 mmol/L)	135 mEq/L (135 mmol/L)	
Potassium	3.2 mEq/L (3.2 mmol/L)	3.3 mEq/L (3.3 mmol/L)	3.1 mEq/L (3.1 mmol/L)	
Albumin	3.1 g/dL (31 g/L)	3.2 g/dL (32 g/L)	3.1 g/dL (31 g/L)	
Asterixis	present	absent	absent	
Lung sounds	diminished	diminished	diminished	
Glasgow Coma Scale	score: 12	score: 13	score: 14	
Pupils	3 mm, round, reactive to light	2.5 mm, round, reactive to light	3 mm, round, reactive to light	
Abdominal	right upper quadrant tenderness	right upper quadrant tenderness	right upper quadrant tenderness	
Skin color	Jaundiced skin with spider angiomas	Jaundiced skin with spider angiomas	Jaundiced skin with spider angiomas	

Highlight Item

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	Current	12 hours ago	24 hours ago	
Blood pressure	167/82 mm Hg	155/91 mm Hg	182/102 mm Hg	Which finding(s) require(s) follow-up by the nurse?
White blood cell count	9000/mm ³ (9 × 10 ⁹ /L)	9600/mm ³ (9.6 × 10 ⁹ /L)	9100/mm ³ (9.1 × 10 ⁹ /L)	
Red blood cell count	3.7 million/mm ³ (3.7 × 10 ¹² /L)	3.8 million/mm ³ (3.8 × 10 ¹² /L)	3.8 million/mm ³ (3.9 × 10 ¹² /L)	
Hemoglobin	6.8 g/dL (68 g/L)	6.9 g/dL (69 g/L)	6.9 g/dL (69 g/L)	
Hematocrit	28% (0.28)	30% (0.30)	30% (0.30)	
Platelets	98,000/mm ³ (98 × 10 ⁹ /L)	93,000/mm ³ (93 × 10 ⁹ /L)	96,000/mm ³ (96 × 10 ⁹ /L)	
Sodium	135 mEq/L (135 mmol/L)	135 mEq/L (135 mmol/L)	135 mEq/L (135 mmol/L)	
Potassium	3.2 mEq/L (3.2 mmol/L)	3.3 mEq/L (3.3 mmol/L)	3.1 mEq/L (3.1 mmol/L)	
Albumin	3.1 g/dL (31 g/L)	3.2 g/dL (32 g/L)	3.1 g/dL (31 g/L)	
Lung sounds	diminished	diminished	diminished	
Glasgow Coma Scale	score: 12	score: 13	score: 14	
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Pulse	88 beats/minute	77 beats/minute	92 beats/minute
Respirations	24 breaths/minute	23 breaths/minute	26 breaths/minute
Oral temperature	99 °F (37.2 °C)	98.8 °F (37.1 °C)	99.1 °F (37.3 °C)
White blood cell count	9000/mm ³ (9 × 10 ³ /L)	9600/mm ³ (9.6 × 10 ³ /L)	9100/mm ³ (9.1 × 10 ³ /L)
Red blood cell count	3.7 million/mm ³ (3.7 × 10 ⁶ /L)	3.8 million/mm ³ (3.8 × 10 ⁶ /L)	3.8 million/mm ³ (3.9 × 10 ⁶ /L)
Hemoglobin	6.8 g/dL (68 g/L)	6.9 g/dL (69 g/L)	6.9 g/dL (69 g/L)
Hematocrit	28% (0.28)	30% (0.30)	30% (0.30)
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Potassium	3.2 mEq/L (3.2 mmol/L)	3.3 mEq/L (3.3 mmol/L)	3.1 mEq/L (3.1 mmol/L)
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Abdominal	right upper quadrant tenderness	right upper quadrant tenderness	right upper quadrant tenderness
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Which finding(s) require(s) follow-up by the nurse?

Click row(s) to highlight the current finding(s) that would be essential to follow-up on.

Highlight only row(s) that require follow-up.

To deselect a row, click the row again.

Cloze Item

The nurse provides care for a young adult client who reports polyuria, polydipsia, and nausea/vomiting. The client's blood glucose is 486 mg/dL (27 mmol/L) and BP is 88/50 mm Hg.

Based on the client's condition, choose the most likely option for the missing information in the table below.

Health Care Provider's Prescription	Dose or Rate	Indication
regular insulin infusion	0.1 units/kg/hr	to lower blood sugar
regular insulin infusion		
isophane insulin infusion	over 1 hour	increase intravascular volume
glargine insulin infusion	over 1 hour	
detemir insulin infusion	over 4 hours	verify ketonuria
ondansetron	over 8 hours	verify ketonuria
ondansetron	over 12 hours	verify hematuria
promethazine	20 mEq IV over 2 hours	verify glycosuria
metoclopramide		verify myoglobinuria
prochlorperazine	250 mL/hr	once blood glucose drops to 250 mg/dL (13.9 mmol/L)
sodium		once blood glucose drops to 250 mg/dL (13.9 mmol/L)
calcium		once client develops signs of hypoglycemia
		once blood pressure is within normal limits
		once polyuria and polydipsia have resolved

Matrix Item

Read the following case study, then refer to the case study to answer the questions.

The nurse provides care for a client with a diagnosis of myocardial infarction. The client's progress is documented in the following progress notes.

Progress Notes

Which actions should the nurse prepare to take?

For each action below, click to specify whether the action would be:

Progress Notes

18:15 Client presents to the emergency department with a report of chest pain and nausea/vomiting. The client reports taking three sublingual nitroglycerine tablets without relief.

18:19 Electrocardiogram obtained that reveals ST-segment elevation in leads II, III, and aVF. Client's vital signs are BP 88/50 mm Hg, pulse 114 beats/minute, respirations 18 breaths/minute, T 99.2 °F (37.3 °C), SpO₂ 97%. Health care provider notified.

18:15 Client presents to the emergency department with a report of chest pain and nausea/vomiting. The client reports taking three sublingual nitroglycerine tablets without relief.

18:19 Electrocardiogram obtained that reveals ST-segment elevation in leads II, III, and aVF. Client's BP is 88/50 mm Hg, pulse 114 beats/minute, respirations 18 breaths/minute, T 99.2 °F (37.3 °C), SpO₂ 97%. Health care provider notified.

icated

Matrix Item

Read the following case study, then refer to the case study to answer the questions.

The nurse provides care for a client who is diagnosed with an acute myocardial infarction. The client's progress notes are listed below.

Progress Notes

18:15 Client presents to the emergency department with a report of chest pain and nausea/vomiting. The client reports taking three sublingual nitroglycerine tablets without relief.

18:19 Electrocardiogram obtained that reveals ST-segment elevation in leads II, III, and aVF. Client's BP is 88/50 mm Hg, pulse 114 beats/minute, respirations 18 breaths/minute, T 99.2 °F (37.3 °C), SpO₂ 97%. Health care provider notified.

Determine if the client smokes cigarettes, and if so, how many cigarettes per day

medication

Which actions should the nurse prepare to take?

For each action below, click to specify whether the action would be:

Indicated - an action that the nurse should take to resolve the problem

Non-essential - an action that the nurse could take without harming the client, but the action would not be likely to address the client's acute problem

Contraindicated - an action that could harm the client and should not be taken

Action	Indicated	Non-essential	Contraindicated
Ask client to rate pain using a numeric pain rating scale	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obtain baseline levels of total cholesterol, high-density lipoproteins (HDLs), and low-density lipoproteins (LDLs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administer metoprolol tartrate 5 mg IV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prepare the client for percutaneous coronary intervention (PCI) by administering alteplase, a thrombolytic medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administer aspirin 325 mg PR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Determine if the client smokes cigarettes, and if so, how many cigarettes per day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Drag-and-Drop Item

From the box on the left, drag the best initial nursing action for the selected condition to the box on the right.

Potential actions to take
Eliminate activities that will provoke or overstimulate the client.
Apply bilateral soft wrist restraints.
Tell the client, "Everyone feels sad sometimes."
Assist the client in leading a discussion with other clients on mental health awareness.
Interrupt repetitive behaviors and provide distraction.
Determine if client has suicidal ideations.
Encourage exercise, such as running or weight lifting.
Provide reality orientation.
Instruct client to take slow, deep breaths, especially during periods of hyperventilation.

Condition	Best initial action to take
Obsessive-compulsive disorder	Obsessive-compulsive disorder
Bipolar mania	Bipolar mania
Major depression	Major depression
Panic attacks	Panic attacks
Schizophrenia	Schizophrenia

Exploring Scoring Methods

The nurse is assessing a 52-year-old male client with esophageal cancer who is receiving continuous enteral nutrition at 63 mL/h via a percutaneous gastrostomy tube.

Time: 0730

Vital signs:

blood pressure	98/72
heart rate	112
respirations	18
oxygen saturation	
temperature	

Throat pain rated 2 on a scale of 0 to 10

Abdomen soft

Bowel sounds active x 4

Dry mucous membranes of mouth

Urine output 100 mL over the past 2 hours

Laboratory test results:

serum potassium	3.8 mEq/L
serum sodium	147 mEq/L
blood urea nitrogen	24 mg/dL
hematocrit	50%

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

- Check the client's pupils for equality of size
- Check the client's weight and compare to prior findings.
- Check the client's skin turgor.
- Request a prescription to administer additional water via the feeding tube.
- Request a prescription to obtain a stool culture.
- Request a change from enteral nutrition to parenteral nutrition.

	Top 9 Freqs	Pattern	Dich	Subset	Plus/Minus
1		B*C*D	1	3	3-0 = 3
2		B*C	0	2	2-0 = 2
3		B*C*F	0	0	2-1 = 1
4		A*B*C	0	0	2-1 = 1
5		B*C*D*F	0	0	3-1 = 2
6		A*B*C*D	0	0	3-1 = 2
7		C*D	0	2	2-0 = 2
8		C*D*F	0	0	2-1 = 1
9		B*C*E	0	0	2-1 = 1

Clinical Judgment Activities

Turn every classroom into clinical

- Give a patient scenario related to the days topic and ask what are the top 3 priorities? Why? (r/t NCSBN Cloze)
- What are 3 things you can delegate and why? What 3 things can you not delegate and why?
- Lab value exercise – which lab values indicate a patient is improving/declining? Can do the same with VS.
- Offer information tables and have the students highlight what information supports a clinical decision/judgment? (r/t NCSBN highlight question)

Clinical Judgment Activities

- Unfolding Case Studies
- Mid-fidelity virtual simulation
- NGN Item practice – in class; with case studies
- Task Models

Task Model

Layer 3



Layer 4



Cognitive Operation	Factor Conditioning	Expected Behavior
Recognize Cues	<p>Environmental Cues:</p> <ul style="list-style-type: none"> • Set <i>location</i> to <i>emergency room</i> • Show <i>the presence of parent</i> <p>Patient Observation Cues:</p> <ul style="list-style-type: none"> • Show <i>age</i> to 8-10 • Show <i>dehydration symptoms</i> (e.g., dry mucous membranes appear, cool extremities, cap refill 3-4 seconds) • Show/Imply <i>lethargy</i> <p>Medical Record Cues:</p> <ul style="list-style-type: none"> • Show <i>dehydration symptoms</i> (e.g., a lower-grade temperature, diarrhea, a poor appetite) • Show/Imply <i>history of diabetes</i> • Show/Imply <i>vital signs</i> <p>Time Pressure Cue:</p> <ul style="list-style-type: none"> • Set <i>time pressure</i> to <i>varying with onset of symptoms and current lethargy</i> 	<ul style="list-style-type: none"> • Recognize <i>abnormal vital signs</i> • Recognize <i>symptoms of dehydration</i> • Identify <i>the history of diabetes</i> • Hypothesize <i>dehydration</i> • Hypothesize <i>diabetes</i>
Analyze Cues	<ul style="list-style-type: none"> • Require <i>knowledge of dehydration symptoms</i> • Require <i>knowledge of diabetes symptoms</i> 	
Prioritize Hypotheses	<ul style="list-style-type: none"> • Give <i>vital sign monitors</i> as <i>resources</i> • Set <i>time pressure</i> to <i>vary with vital signs</i> 	<ul style="list-style-type: none"> • Prioritize <i>dehydration</i> • Address <i>dehydration</i> • Avoid <i>glucose</i>
Generate Solutions	<ul style="list-style-type: none"> • Require <i>knowledge of dehydration treatment and intervention</i> • Require <i>knowledge of diabetes treatment and intervention</i> 	
Evaluate Outcomes	<p>Experience:</p> <ul style="list-style-type: none"> • Require <i>experience of administering isotonic fluid</i> <p>Patient Observation Cue:</p> <ul style="list-style-type: none"> • Show <i>patient awaking and talking</i> • Imply <Set <i>vital signs</i> to <i>varying with action</i>> 	<ul style="list-style-type: none"> • Check <i>vital signs</i> • Check <i>lethargy</i>

Cognitive Function	Conditioning Factor(s)	Expected Behaviors
<p>Task Model Template</p> <p>Recognize Cues</p>	Environment Cues:	Recognize abnormal vs normal
	Patient Observation Cues:	Recognize signs and symptoms
	Medical Record Cues:	
	Time Pressure Cues:	Identify history of
Analyze Cues	Requires knowledge of signs and symptoms of...	
Prioritize Hypothesis	<p>Can give vital signs as resource</p> <p>Can add time pressure for context of vital signs</p>	Requires prioritization of condition... Address condition of...
Generate Solutions	<p>Knowledge of conditions</p> <p>Knowledge of treatment for conditions with nursing intervention</p>	
Take Actions	Experience:	Nursing Intervention...
Evaluate Outcomes	Experience:	Follow-up on labs, vital signs, assessment etc- determine improvement or worsening of condition being treated
	Patient Observation Cue:	

Case Study: SBAR

Situation, Background, Assessment, Recommendation

S = Nursing Handoff Communication at 1900.

B = Mr. Smith, 75 years old, is hospitalized for a compound fracture of the right femur.

A = Skeletal traction, lactovegetarian. Vital signs at 1900: T 101°F (38.3°C), P 110, R 28, BP 130/84 mm Hg, SpO₂ 94%. IV 0.9% NaCl infusing at 75 mL/hr in the left forearm with 500 mL left in the IV bag. He is restless, had difficulty sleeping the night before, and didn't sleep today. Shortness of breath was reported when he used the trapeze bar to move in bed.

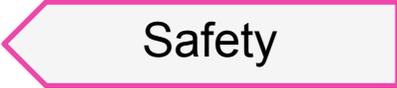
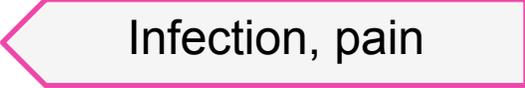
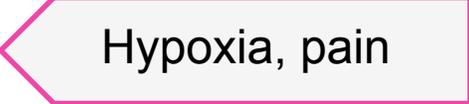
R =

Evaluate shortness of breath, increased breathing pattern/ breath sounds, I&O, fever, heart rate, elevated BP, pain, difficulty sleeping.

Case Study: Developing the Plan of Care

Consider the abnormal findings.

What are the priority concerns in care?

- Skeletal traction  Safety
- SOB upon movement in the bed with the trapeze bar  Fat emboli syndrome
- Temperature = T 101°F (38.3°C), P 110, R 28, BP 130/84 mm Hg  Infection, pain
- Restlessness and difficulty sleeping  Hypoxia, pain

Health Record Information

Medication Record

<u>Routine</u>	<u>Time Due</u>
Cefazolin 1g IVPB every 8 hours	0000
Tobramycin 5 mg/kg IVPB daily	2000
Td 0.5 mL IM	2000
Acetaminophen 650 mg PO q 4h PRN	
Morphine PCA (morphine sulfate - 1 mg/hr)	
Promethazine 25 mg IV/IM q 6h PRN	

Intake and Output (I&O)

<u>Intake</u>	<u>Output</u>
1/8 cup of milk	Urine = 1500 mL
10 oz of soup	Vomitus = 100 mL
1/4 cup ice cream	
IV = 500 mL	

I&O noted,
vomiting present

Receiving pain medication

NCLEX® Practice

Alternate Question Type: Fill in the Blank

The nurse supervises care for a client on the medical-surgical unit. The nurse evaluates the client's intake and output.

Intake:

1/8 cup of milk

10 oz of soup

1/4 cup ice cream

IV 500 mL

Output:

1500 mL urine

100 mL vomitus

**How many milliliters should the nurse record as intake?
Calculate and record the number in the box.**

Do not round.

890	mL
-----	----

Topic: Amount of intake in milliliters

Case Study: Developing the Plan of Care

Consider additional information needed from the outgoing nurse:

What are the trends and patterns of temperature, heart rate, blood pressure, and respirations throughout the day?

Slight increase throughout the day

What type of skeletal traction is being used?

Balanced suspension (Thomas splint/Pearson attachment)

Did the client receive pain medication today?

Yes, client used the PCA twice today

Was the health care provider notified about the abnormal findings?

No

Case Study: Priority Actions in the Plan

Assessment Priority Actions

Assessment

- Respiratory: lung sounds, investigate shortness of breath.
- Level of consciousness: mental status changes related to the restlessness.
- Recheck vital signs and correlate trends: continuing to elevate or decrease.
- Hydration status: check IV integrity and rate of flow, I&O, investigate vomiting.
- Pain and comfort level: PCA status and usage, positioning.
- Skin integrity: IV insertion site, pin sites, early signs of decubitus ulcer formation.
- Traction: “traction, line of pull, and countertraction.”

Assessment: You gather the data, you organize it, you analyze it, and then you develop a plan of care.

Case Study: Analyze Your Findings

Recognize Cues

- Oriented to person, place, time, and situation. Lung sounds clear and equal bilaterally, rate unchanged, but client verbalizes getting short of breath when moving in the bed because of the pain. Vital signs T 101°F (38.3°C), P 108, R 24, BP 128/82 mm Hg.
- IV infusing at appropriate rate and without difficulty. Intake of 860 mL, output of 1600 mL from previous shift. Denies N/V. IV insertion site and pin sites without redness, warmth, or edema. No signs of skin breakdown. Ropes and pulleys in alignment, weights hanging freely for line of pull, and client positioned appropriately for countertraction.
- Client reports constant, dull, aching pain radiating throughout affected leg with intermittent, sharp muscle spasms. Reports inability to get comfortable or sleep. Rates pain 10/10.

What is the priority for the client's care after analyzing the data?

The persistent pain can be causing many of the problems the client is experiencing.

Case Study: Priority Actions in the Plan

Implementation Priority Actions

Pain control and comfort measures:

- Educate client on use of PCA, encourage client to reposition self using trapeze bar, and assist the client to reposition at least every 2 hours.
- Encourage incentive spirometer use every hour while awake.
- Encourage PO fluid intake (if client is not short of breath and does not have nausea/vomiting).
- Notify health care provider:
 - Abnormal vitals signs
 - Shortness of breath upon movement
 - Intake and output
 - Increased pain and muscle spasms

Case Study: Evaluate the Plan

Outcomes After 1 hour

Pain control and comfort measures:

- Client utilized the PCA three times within past hour.
- Verbalizes pain rating as 2/10.
- Vital signs T 100.5°F (38.1°C), P 88, R 18, BP 120/78 mm Hg, SpO₂ 94%.
- Encourage and continue incentive spirometer use every hour while awake.
 - Client utilized incentive spirometer five times within past hour.
- Notify health care provider.
 - New prescriptions implemented for PCA: Loading dose 2–4 mg, 1.5 mg every 10–15 minutes, 1 hour limit: 6–9 mg/hr and PRN medication for muscle spasms.
 - Encourage PO fluids and increase IV rate to 100 mL/hr.
 - New prescriptions implemented: chest X-ray, complete blood count (CBC).

NCLEX® Practice

Multiple Choice Question

The nurse cares for an elderly client diagnosed with a fractured right femur. The nurse is **most** concerned if which observation is made?

- 1. ~~The right foot large toe remains pale for 3 seconds after pressure is applied to the nail.~~
- 2. ~~The client is incontinent of urine and stool.~~
- 3. ~~The client reports “slight shortness of breath” while moving in bed.~~
- 4. The client plucks at the bed covers and is confused about the current date and location.

Topic: priority complication for femur fracture

NCLEX® Practice

Multiple Choice Question

A client is treated for a fracture of the right femur using skeletal traction with balanced suspension through the use of a Thomas splint and a Pearson attachment. The nurse should intervene if which is observed?

- ~~1. The client grasps the overhead trapeze with the right arm to lift the body.~~
- 2. The client turns to the right side to answer the telephone.
- ~~3. The client contracts and relaxes the right quadriceps and gluteal muscles for 5 minutes four times a day.~~
- ~~4. The client flexes the left leg and pushes up in bed.~~

Topic: Intervention, skeletal traction with balanced suspension

NGN Updates and Resources

- <https://www.ncsbn.org/next-generation-nclex.htm>



Thank You For Attending This Session



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