NCSBN
Leading Regulatory Excellence

NCLEX®

NCLEX-RN® Test Plan

Effective April 2023

NCSBN
Leading Regulatory Excellence

Mission Statement

NCSBN empowers and supports nursing regulators in their mandate to protect the public.

Purpose and Functions

The purpose of NCSBN is to provide an organization through which nursing regulatory bodies act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

The major functions of NCSBN include developing the NCLEX-RN® and NCLEX-PN® Examinations, performing policy analysis and promoting uniformity in relationship to the regulation of nursing practice, disseminating data related to NCSBN's purpose and serving as a forum for information exchange for NCSBN members.

Address inquiries in writing to NCSBN Permissions, 111 E. Wacker Drive, Suite 2900, Chicago, IL 60601-4277. Suggested Citation: National Council of State Boards of Nursing. (2023). 2023 NCLEX-RN® Test Plan. Chicago: Author.

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I. Background

The test plan for the National Council Licensure Examination for Registered Nurses (NCLEX-RN®) was developed by the National Council of State Boards of Nursing, Inc. (NCSBN®). The purpose of this document is to provide detailed information about the content areas tested in the NCLEX-RN Examination.

This booklet contains:

- The *2023 NCLEX-RN® Test Plan;*
- Information on testing requirements and sample examination questions (items);
- Item writing tips; and
- References.

About the NCLEX-RN® Test Plan

The test plan is reviewed and approved by the NCLEX® Examination Committee (NEC) every three years. Multiple resources are used, including the recent practice analysis of registered nurses (RNs) and expert opinions of the NEC, NCSBN staff and boards of nursing/regulatory bodies, to ensure that the test plan is consistent with nurse practice acts. Following the endorsement of proposed revisions by the NEC, the test plan document is presented for approval to the Delegate Assembly, which is the decision-making body of NCSBN.

The test plan serves a variety of purposes. It is used to guide candidates preparing for the examination, to direct item writers in the development of items and to facilitate the classification of examination items. This document offers a comprehensive listing of content for each Client Needs category and subcategory outlined in the test plan. Sample items are provided at the end of each category that are specific to the Client Needs category in that section. There are item writing tips that provide nurse educators with guidelines on writing well-designed test items.

For up-to-date information on the NCLEX-RN Examination, visit the NCSBN website at NCLEX.com.

II. 2023 NCLEX-RN® Test Plan

Test Plan for the National Council Licensure Examination for Registered Nurses (NCLEX-RN®)

Introduction

Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of Nursing (NCSBN®) member board jurisdictions (state, commonwealth, province and territorial boards of nursing). To ensure public protection, each jurisdiction requires candidates for licensure to meet set requirements that include passing an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse (RN). NCSBN develops a licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN®), which is used by member board jurisdictions and most Canadian nursing regulatory bodies, to assist in making licensure decisions.

Several steps occur in the development of the NCLEX-RN Test Plan. The first step is conducting a practice analysis that is used to collect data on the current practice of the entry-level nurse *(Report of Findings from the 2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* [NCSBN®, 2022]). Twenty-four thousand newly licensed RNs are asked about the frequency, importance and clinical judgment relevancy of performing nursing care activities. Nursing care activities are then analyzed in relation to the frequency of performance, impact on maintaining client safety and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes fundamental to the practice of nursing. Clinical judgment is one of the fundamental processes found to possess a high level of relevance and importance in the delivery of safe, effective nursing at the entry level.

Entry-level nurses are required to make increasingly complex decisions while delivering client care. These increasingly complex decisions often require the use of clinical judgment to support client safety. It is essential to note that clinical judgment applied in this dynamic supports the entry-level nurse to make effective decisions inside the nursing scope of practice, which provides a foundation for client safety. NCSBN has conducted several years of research and study to understand and isolate the individual factors that contribute to the process of nursing clinical judgment. These isolated factors are represented in the NCLEX-RN Test Plan and subsequently delivered as examination items. A more detailed description of clinical judgment can be found in the Integrated Processes section.

The second step is the development of the NCLEX-RN Test Plan, which guides the selection of content and behaviors to be tested. The NCLEX-RN Test Plan provides a concise summary of the content and scope of the licensing examination. It serves as a guide for examination development as well as candidate preparation. The NCLEX® assesses the knowledge, skills, abilities and clinical judgment that are essential for the entry-level nurse to use in order to meet the needs of clients requiring the promotion, maintenance or restoration of health. The following sections describe beliefs about people and nursing that are integral to the examination, cognitive abilities that will be tested in the examination and specific components of the NCLEX-RN Test Plan.

Beliefs

Beliefs about people and nursing underlie the NCLEX-RN Test Plan. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living reflecting their values, motives and lifestyles. People have the right to make decisions regarding their health care needs and to participate in meeting those needs. The profession of nursing makes a unique contribution

in helping clients (individual, family or group) achieve an optimal level of health in a variety of settings. For the purposes of the NCLEX, a client is defined as the individual, family, or group, which includes significant others and population.

Nursing is both an art and a science, founded on a professional body of knowledge that integrates concepts from the liberal arts and the biological, physical, psychological and social sciences. It is a learned profession based on knowledge of the human condition across the life span and the relationships of an individual with others and within the environment. Nursing is a dynamic, continuously evolving discipline that employs critical thinking and clinical judgment to integrate increasingly complex knowledge, skills, technologies and client care activities into evidence-based nursing practice. The goal of nursing for client care is preventing illness and potential complications; protecting, promoting, restoring and facilitating comfort; health; and dignity in dying.

The RN provides a unique, comprehensive assessment of the health status of the client, applying principles of ethics, client safety, health promotion and the nursing process. The RN then develops and implements an explicit plan of care considering unique cultural and spiritual client preferences, the applicable standard of care and legal considerations. The RN assists clients to promote health, cope with health problems, adapt to and/or recover from the effects of disease or injury, and support the right to a dignified death. The RN is accountable for abiding by all applicable member board jurisdiction statutes related to nursing practice.

Classification of Cognitive Levels

Bloom's taxonomy for the cognitive domain is used as a basis for writing and coding items for the examination (Bloom, et al., 1956; Anderson & Krathwohl, 2001). Since the practice of nursing requires application of knowledge, skills, abilities and clinical judgment, the majority of items are written at the application or higher levels of cognitive ability, which require more complex thought processing.

Test Plan Structure

The framework of Client Needs was selected for the examination because it provides a universal structure for defining nursing actions and competencies and focuses on clients in all settings.

Client Needs

The content of the NCLEX-RN Test Plan is organized into four major Client Needs categories. Two of the four categories are divided into subcategories.

Safe and Effective Care Environment

- Management of Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity

- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

Integrated Processes

The following processes are fundamental to the practice of nursing and are integrated throughout the Client Needs categories and subcategories.

- Caring – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.
- Clinical judgment – the observed outcome of critical thinking and decision-making. It is an iterative process with multiple steps 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 (detail description of the steps below).
- Communication and documentation – verbal and nonverbal interactions between the nurse and the client, the client's significant others and the other members of the health care team. Events and activities associated with client care are recorded in written and/or electronic records that demonstrate adherence to the standards of practice and accountability in the provision of care.
- Culture and spirituality – interaction of the nurse and the client (individual, family or group, including significant others and populations) that recognizes and considers the client-reported, self-identified, unique and individual preferences to client care, the applicable standard of care and legal considerations.
- Nursing process – a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation and evaluation.
- Teaching/learning – facilitation of the acquisition of knowledge, skills and abilities promoting a change in behavior.

Clinical Judgment

The nurse engages in this iterative multistep 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. Clinical judgment content may be represented as a case study or as an individual stand-alone item. A case study contains six items that are associated with the same client presentation, share unfolding client information and address the following steps in clinical judgment.

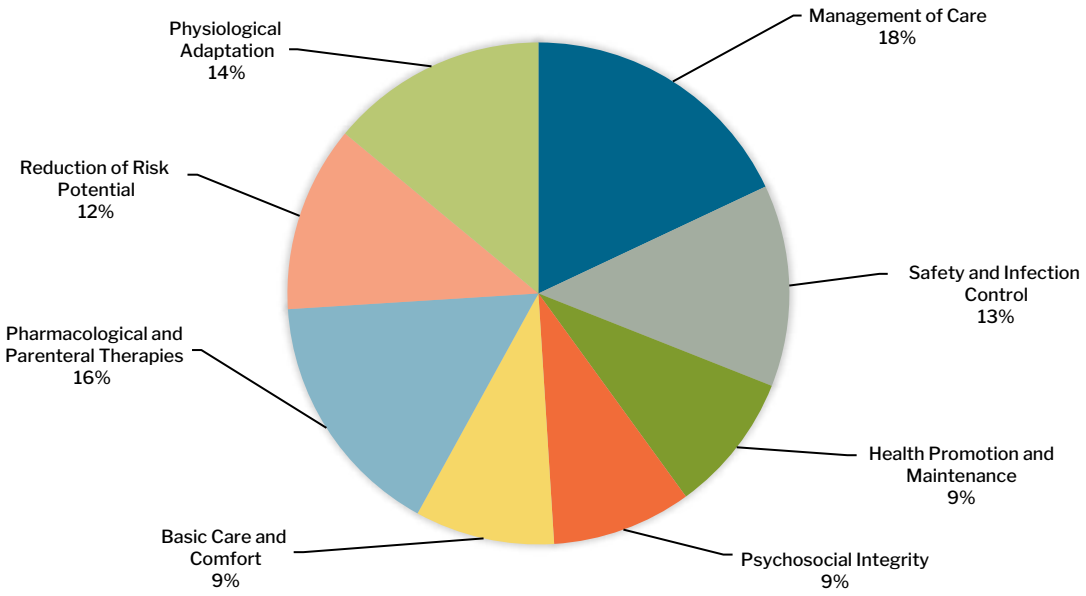
- Recognize cues – identify relevant and important information from different sources (e.g., medical history, vital signs).
- Analyze cues – organize and connect the recognized cues to the client's clinical presentation.
- Prioritize hypotheses – evaluate and prioritize hypotheses (urgency, likelihood, risk, difficulty, time constraints, etc.).
- Generate solutions – identify expected outcomes and use hypotheses to define a set of interventions for the expected outcomes.
- Take action – implement the solution(s) that address the highest priority.
- Evaluate outcomes – compare observed outcomes to expected outcomes.

Distribution of Content

The percentage of test questions assigned to each Client Needs category and subcategory of the NCLEX-RN Test Plan is based on the results of the *Report of Findings from the 2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* (NCSBN, 2022) and expert judgment provided by members of the NCLEX Examination Committee (NEC). In addition to the Client Needs categories and subcategories listed below, clinical judgment processes are explicitly measured by 18 case study items (i.e., three item sets) and approximately 10% stand-alone items, which will be selected depending on exam length.

Client Needs	Percentage of Items from Each Category/Subcategory
Safe and Effective Care Environment	
· Management of Care	15–21%
· Safety and Infection Control	10–16%
Health Promotion and Maintenance	6–12%
Psychosocial Integrity	6–12%
Physiological Integrity	
· Basic Care and Comfort	6–12%
· Pharmacological and Parenteral Therapies	13–19%
· Reduction of Risk Potential	9–15%
· Physiological Adaptation	11–17%

DISTRIBUTION OF CONTENT FOR THE NCLEX-RN® TEST PLAN



NCLEX-RN Examinations are administered adaptively in variable-length format to target candidate-specific ability. To accommodate possible variations in examination length, content area distributions of the individual examinations may differ up to ±3% in each category.

Overview of Content

The activity statements used in the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* (NCSBN, 2022) preface each of the eight content categories and are identified throughout the test plan by an asterisk(*). NCSBN performs an analysis of those activities used frequently and identified as important by entry-level nurses to ensure client safety. This is called a practice analysis; it provides data to support the NCLEX as a reliable, valid measure of competent, entry-level nursing practice. The practice analysis is conducted every three years. Due to COVID-19, the practice analysis was delayed from 2020 to 2021.

In addition to the practice analysis, NCSBN conducts a knowledge, skills and abilities (KSA) survey. The primary purpose of this study is to identify the knowledge needed by newly licensed registered nurses (RNs) in order to practice safe and effective care. Findings from both the 2021 RN Practice Analysis and the 2021 RN KSA survey can be found at: www.ncsbn.org/1235.htm. Both documents are used in the development of the NCLEX-RN Test Plan as well as to inform item development.

All task statements in the *2023 NCLEX-RN® Test Plan* require the nurse to apply the fundamental principles of clinical decision-making and critical thinking to nursing practice. The test plan also assumes that the nurse integrates concepts from the following bodies of knowledge:

- Social sciences (psychology and sociology)
- Biological sciences (anatomy, physiology, biology and microbiology)
- Physical sciences (chemistry and physics)

In addition, the following concepts are applied throughout the four major Client Needs categories and subcategories of the test plan:

- Caring
- Clinical judgment
- Communication and documentation
- Culture and spirituality
- Nursing process
- Teaching/learning

Appendix A of this document includes detailed examples of content for each NCLEX-RN Test Plan category.

Please note: *There are certain inconsistencies throughout this document related to word usage and punctuation. Sentences or phrases marked by an asterisk (*) are activity statements taken directly from the* 2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice. *In order to provide proper attribution to the original survey, these statements have not been altered to fit the overall grammatical style of this document. In addition, the term "client" refers to the individual, family or group, which includes significant others and populations. "Clients" are the same as "residents" or "patients." In general, if the age or age category of the client is not stated in an item, it can be understood that the client is an adult. Any ethnicity or cultural or spiritual belief attributed to a client should be considered self-reported by that client. NCLEX items are developed based on a variety of practice settings such as acute care, long-term care/rehabilitation care, outpatient care and community-based/home care settings.*

Safe and Effective Care Environment

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients and health care personnel.

Management of Care

- Providing and directing nursing care that enhances the care delivery setting to protect the client and health care personnel.

Management of Care Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Integrate advance directives into client plan of care
• Delegate and supervise care of client provided by others (e.g., LPN/VN, assistive personnel, other RNs)
• Organize workload to manage time effectively
• Practice and advocate for cost effective care
• Initiate, evaluate and update client plan of care
• Provide education to clients and staff about client rights and responsibilities
• Advocate for client rights and needs
• Collaborate with multi-disciplinary team members when providing client care (e.g., physical therapist, nutritionist, social worker)
• Manage conflict among clients and health care staff
• Maintain client confidentiality and privacy
• Provide and receive hand off of care (report) on assigned clients
• Use approved terminology when documenting care
• Perform procedures necessary to safely admit, transfer and/or discharge a client
• Prioritize the delivery of client care based on acuity
• Recognize and report ethical dilemmas
• Practice in a manner consistent with the nurses' code of ethics
• Verify the client receives education and client consents for care and procedures
• Receive, verify and implement health care provider orders
• Utilize resources to promote quality client care (e.g., evidence-based research, information technology, policies and procedures)
• Recognize limitations of self and others and utilize resources
• Report client conditions as required by law (e.g., abuse/neglect and communicable diseases)
• Provide care within the legal scope of practice
• Participate in performance improvement projects and quality improvement processes
• Assess the need for referrals and obtain necessary orders

Safety and Infection Control

- Protecting clients and health care personnel from health and environmental hazards.

Safety and Infection Control Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assess client for allergies and intervene as needed • Assess client care environment • Promote staff safety • Protect client from injury • Properly identify client when providing care • Verify appropriateness and accuracy of a treatment order • Participate in emergency planning and response • Use ergonomic principles when providing care • Follow procedures for handling biohazardous and hazardous materials • Educate client on safety issues • Acknowledge and document practice errors and near misses • Report, intervene, and/or escalate unsafe practice of health care personnel (e.g., substance abuse, improper care, staffing practices) • Facilitate appropriate and safe use of equipment • Follow security plan and procedures (e.g., newborn security, violence, controlled access) • Apply principles of infection prevention (e.g., hand hygiene, aseptic technique, isolation, sterile technique, universal/standard enhanced barrier precautions) • Educate client and staff regarding infection prevention measures • Follow requirements when using restraints

Health Promotion and Maintenance

The nurse provides and directs nursing care of the client that incorporates the knowledge of expected growth and development principles, prevention and/or early detection of health problems, and strategies to achieve optimal health.

Health Promotion and Maintenance Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Provide care and education for the newborn, infant, and toddler client from birth through 2 years • Provide care and education for the preschool, school age and adolescent client ages 3 through 17 years • Provide care and education for the adult client ages 18 through 64 years • Provide care and education for the adult client ages 65 years and over • Provide prenatal care and education • Provide care and education to an antepartum client or a client in labor • Provide post-partum care and education • Assess and educate clients about health risks based on family, population, and community • Assess client's readiness to learn, learning preferences, and barriers to learning • Plan and/or participate in community health education • Educate client about preventative care and health maintenance recommendations • Provide resources to minimize communication barriers • Perform targeted screening assessments (e.g., vision, nutrition, depression) • Educate client about prevention and treatment of high risk health behaviors • Assess client ability to manage care in home environment and plan care accordingly • Perform comprehensive health assessments

Psychosocial Integrity

The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client experiencing stressful events as well as clients with acute or chronic mental illness.

Psychosocial Integrity Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assess client for abuse or neglect and report, intervene, and/or escalate • Incorporate behavioral management techniques when caring for a client • Assess client for substance abuse and/or toxicities and intervene as appropriate (e.g., dependency, withdrawal) • Assess client's ability to cope with life changes and provide support • Assess the potential for violence and use safety precautions • Incorporate client cultural practices and beliefs when planning and providing care • Provide end-of-life care and education to clients • Assess client support system to aid in plan of care • Provide care for a client experiencing grief or loss • Provide care and education for acute and chronic psychosocial health issues (e.g., addictions/dependencies, depression, dementia, eating disorders) • Assess psychosocial factors influencing care and plan interventions (e.g., occupational, spiritual, environmental, financial) • Provide appropriate care for a client experiencing visual, auditory, and/or cognitive alterations • Recognize non-verbal cues to physical and/or psychological stressors • Use therapeutic communication techniques • Promote a therapeutic environment

Physiological Integrity

The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

Basic Care and Comfort

- Providing comfort and assistance in the performance of activities of daily living.

Basic Care and Comfort Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assist client to compensate for a physical or sensory impairment (e.g., assistive devices, positioning) • Assess and manage client with an alteration in bowel and bladder elimination • Perform irrigations (e.g., of bladder, ear, eye) • Perform skin assessment and implement measures to maintain skin integrity • Apply, maintain, or remove orthopedic devices • Implement measures to promote circulation (e.g., active or passive range of motion, positioning and mobilization) • Assess client for pain and intervene as appropriate • Recognize complementary therapies and identify potential benefits and contraindications (e.g., aromatherapy, acupressure, supplements) • Provide non-pharmacological comfort measures • Evaluate the client's nutritional status and intervene as needed • Provide client nutrition through tube feedings • Evaluate client intake and output and intervene as needed • Assess client performance of activities of daily living and assist when needed • Perform post-mortem care • Assess client sleep/rest pattern and intervene as needed

Pharmacological and Parenteral Therapies

- Providing care related to the administration of medications and parenteral therapies.

Pharmacological and Parenteral Therapies Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Administer blood products and evaluate client response
• Access and/or maintain central venous access devices
• Perform calculations needed for medication administration
• Evaluate client response to medication
• Educate client about medications
• Prepare and administer medications using rights of medication administration
• Review pertinent data prior to medication administration (e.g., contraindications, lab results, allergies, potential interactions)
• Participate in medication reconciliation process
• Titrate dosage of medication based on assessment and ordered parameters
• Dispose of medications safely
• Handle and maintain medication in a safe and controlled environment
• Evaluate appropriateness and accuracy of medication order for client
• Handle and administer high-risk medications safely
• Monitor intravenous infusion and maintain site
• Administer medications for pain management
• Handle and administer controlled substances within regulatory guidelines
• Administer parenteral nutrition and evaluate client response

Reduction of Risk Potential

- Reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

Reduction of Risk Potential Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assess and respond to changes and trends in client vital signs
• Perform testing within scope of practice (e.g., electrocardiogram, glucose monitoring)
• Monitor the results of diagnostic testing and intervene as needed
• Obtain blood specimens
• Obtain specimens other than blood for diagnostic testing
• Insert, maintain, or remove a nasal/oral gastrointestinal tube
• Insert, maintain, or remove a urinary catheter
• Insert, maintain, or remove a peripheral intravenous line
• Maintain percutaneous feeding tube
• Apply and/or maintain devices used to promote venous return (e.g., anti-embolic stockings, sequential compression devices)
• Use precautions to prevent injury and/or complications associated with a procedure or diagnosis
• Evaluate client responses to procedures and treatments
• Recognize trends and changes in client condition and intervene as needed
• Perform focused assessments
• Educate client about treatments and procedures
• Provide preoperative and postoperative education
• Provide preoperative care
• Manage client during a procedure with moderate sedation
• Manage client following a procedure with moderate sedation

Physiological Adaptation

- Managing and providing care for clients with acute, chronic or life-threatening physical health conditions.

Physiological Adaptation Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assist with invasive procedures (e.g., central line, thoracentesis, bronchoscopy)
• Implement and monitor phototherapy
• Maintain optimal temperature of client
• Monitor and care for clients on a ventilator
• Monitor and maintain devices and equipment used for drainage (e.g., surgical wound drains, chest tube suction, negative pressure wound therapy)
• Perform and manage care of client receiving peritoneal dialysis
• Perform suctioning
• Perform wound care and dressing change
• Provide ostomy care and education (e.g., tracheal, enteral)
• Provide pulmonary hygiene (e.g., chest physiotherapy, incentive spirometry)
• Provide postoperative care
• Manage the care of the client with a fluid and electrolyte imbalance
• Monitor and maintain arterial lines
• Manage the care of a client with a pacing device
• Manage the care of a client on telemetry
• Manage the care of a client receiving hemodialysis or continuous renal replacement therapy
• Manage the care of a client with alteration in hemodynamics, tissue perfusion, and hemostasis
• Educate client regarding an acute or chronic condition
• Manage the care of a client with impaired ventilation/oxygenation
• Evaluate the effectiveness of the treatment plan for a client with an acute or chronic diagnosis
• Perform emergency care procedures
• Identify pathophysiology related to an acute or chronic condition
• Recognize signs and symptoms of client complications and intervene

III. Administration of the NCLEX-RN®

The NCLEX-RN® is administered to candidates by computerized adaptive testing (CAT). CAT is a method of delivering examinations that uses computer technology and measurement theory. With CAT, each candidate's examination is unique because it is assembled interactively as the examination proceeds. Computer technology selects items that match the candidate's ability. The items, which are stored in a large item pool, have been classified by test plan category and level of difficulty as well as clinical judgment steps. After the candidate answers an item, the computer calculates an ability estimate based on all of the candidate's previous answers. The next item administered is chosen based on that ability estimate and is selected from an appropriate test plan category. This process is repeated for each item, creating an examination tailored to the candidate's knowledge and skills while fulfilling all NCLEX-RN Test Plan requirements. The examination continues with items selected and administered in this way until a pass or fail decision is made.

Examination Length

All registered nurse (RN) candidates must answer a minimum of 85 items. The maximum number of items that an RN candidate may answer is 150 during the allotted five-hour period. Of the minimum-length examination, 52 of the items will come from the eight content areas listed above in the stated percentages. Eighteen of the items will comprise three clinical judgment case studies. Case studies are item sets composed of six items that measure each of the six domains of the NCSBN Clinical Judgment Measurement Model (NCJMM) mentioned earlier: recognizing cues, analyzing cues, prioritizing hypotheses, generating solutions, taking action and evaluating outcomes. Since clinical judgment is an integrated process, the case studies will span any number of content areas and are therefore counted independently of the content-area-specific items. The remaining 15 items will be unscored pretest items. The five-hour limit to complete the examination includes all breaks.

The length of the examination is determined by the candidate's responses to the items. Depending upon the particular pattern of correct and incorrect responses, candidates will receive different numbers of items and therefore use varying amounts of time. The candidate should select and maintain a reasonable pace that will allow them to complete the examination within the allotted time should the maximum number of items be administered. In general, it is recommended that the candidate spend approximately one to two minutes per item in order to maintain this pace.

Each candidate is given an examination that adheres to the test plan and is therefore given the opportunity to demonstrate their ability. The length of the candidate's examination is not an indication of a pass or fail result. A candidate may pass or fail regardless of the length of the examination. Additional information on passing and failing rules is included in further detail in this section.

The Passing Standard

The NCSBN® Board of Directors (BOD) reevaluates the passing standard once every three years. The criterion that the BOD uses to set the standard is the minimum level of ability required for safe and effective entry-level nursing practice. Due to COVID-19, the passing standard was reevaluated in 2022.

To assist the BOD in making this decision, they are provided information on:

1. The results of a standard-setting exercise performed by a panel of experts with the assistance of psychometricians;
2. The historical record of the passing standard with summaries of the candidate performance associated with those standards; and
3. Information describing the educational readiness of high school graduates who express an interest in nursing.

Once the passing standard is set, it is applied uniformly to every examination according to the procedures laid out in the Scoring the NCLEX section. To pass the NCLEX, a candidate must perform at or above the passing standard. There is no fixed percentage of candidates that pass or fail each examination.

Similar Items

Occasionally, a candidate may receive an item that seems to be very similar to an item received earlier in the examination. This may happen for a variety of reasons. Items may contain content pertaining to similar symptoms, diseases or disorders, yet address different phases of the nursing process. Alternatively, a pretest (unscored) item may contain content similar to an operational (scored) item. Candidates should not assume they received a second item similar in content to a previously administered item because the candidate answered the first item incorrectly. The candidate is instructed to always select the answer believed to be correct for each item administered.

Reviewing Answers and Guessing

Examination items are presented to the candidate one at a time on a computer screen. There is no time limit for a candidate to spend on each individual item. Once an answer to an item is selected, the candidate is able to consider the answer and change it, if necessary. However, once the candidate confirms the answer and proceeds to the next item by pressing the <NEXT> button, the candidate will no longer be able to return to a previous item. Every item must be answered even if the candidate is not sure of the correct answer. If the candidate is unsure of the correct answer, the candidate should consider all response options and provide their best answer in order to proceed to the next item. The computer will not allow the candidate to proceed to the next item without answering the current item on the screen. The best advice is to maintain a reasonable pace (one item every minute or two) and carefully read and consider each item before answering.

Scoring the NCLEX®

Computerized Adaptive Testing

The NCLEX is different from a traditional fixed-length examination, which administers the same items to every candidate. Fixed-length examinations ensure that the difficulty of the examination is constant for every candidate; therefore, the percentage correct is the indicator of the candidate's ability. This approach requires high-ability candidates to answer all easy items on the examination and low-ability candidates to guess on difficult items. This method provides less accurate information about the candidate's true ability.

The NCLEX uses CAT to administer items. CAT is able to produce results that are more precise and efficient, using fewer items by targeting items to the candidate's ability. The computer (i.e., CAT scoring algorithm) estimates the ability of the candidate in relation to the passing standard. Every time the candidate answers an item, the computer re-estimates the candidate's ability. With each additional answered item, the ability estimate becomes more precise.

Each item that the candidate receives is selected from a large pool of items using three criteria.

1. The item is limited to the content area that will produce the best match to the test plan percentages. CAT ensures that each candidate's exam contains enough items from each content area to match the required test plan percentages. Regarding clinical judgment items, three case study sets and approximately 10% stand-alone items will be selected depending on the exam length.
2. An item is selected that the candidate is expected to find challenging. The computer estimates the candidate's ability based on all previous answers and the difficulty of those items and then selects an item that the candidate should have a 50% chance of answering correctly. This ensures the next item

should not be too easy or too difficult and the examination can obtain maximum information about the candidate's ability from the item.

3. Items are excluded that a repeat candidate has seen in the current item pool.

For more information on CAT, visit NCLEX.com.

Pretest Items

For CAT to function properly, the difficulty of each item must be known in advance. The degree of difficulty is determined by administering the items as pretest items to a large sample of NCLEX candidates. Since the difficulty of pretest items is unknown in advance, these items are not included when estimating the candidate's ability and subsequently making pass-fail decisions. When enough responses are collected, the pretest items are statistically analyzed and calibrated. If the pretest items meet the NCLEX statistical standards, they can be administered on future examinations as operational items. There are 15 pretest items on every NCLEX-RN. Pretest items appear identical to operational items; therefore, it is recommended that candidates give their best effort for every item.

Passing and Failing

The decision as to whether a candidate passes or fails the NCLEX is governed by three scenarios.

Scenario #1: The 95% Confidence Interval Rule

This scenario is the most common for NCLEX candidates. The computer will stop administering items when it is 95% certain that the candidate's ability is either clearly above or clearly below the passing standard.

Scenario #2: Maximum-Length Exam

Some candidates' ability levels will be very close to the passing standard. When this is the case, the computer continues to administer items until the maximum number of items is reached. At this point, the computer disregards the 95% confidence interval rule and considers only the final ability estimate.

- If the final ability estimate is at or above the passing standard, the candidate passes.
- If the final ability estimate is below the passing standard, the candidate fails.

Scenario #3: Run-Out-of-Time Rule (R.O.O.T.)

If a candidate runs out of time before reaching the maximum number of items and the computer has not determined with 95% certainty whether the candidate has passed or failed, alternate criteria are used.

- If the candidate has not answered the minimum number of required items, the candidate automatically fails.
- If at least the minimum number of required items were answered, then the final ability estimate will be based on all responses given before the exam time expired. If the score is at or above the passing standard, the candidate will pass; otherwise, the candidate will fail.

Scoring Items

NCLEX items have multiple item formats. There is partial credit scoring for items for which more than one key exists. There will be three methods for scoring items for partial credit: plus/minus, zero/one, and rationale scoring.

For information on scoring NCLEX items, be sure to access NCSBN.org for newsletters and articles, particularly the newsletter on Next Generation NCLEX: Scoring Models.

Types of Items on the NCLEX-RN®

Candidates may be administered stand-alone items and case studies as well as items written in alternate formats. All item types may include multimedia such as charts, tables and graphics. All items undergo an extensive review process before being used as items on the examination.

NCLEX® Terminology

Client: Individual, family or group, which includes significant others and populations.

Order: Intervention, remedy or treatment as directed by an authorized primary health care provider.

Prescription: Intervention as it relates to medication specifically as directed by an authorized primary health care provider.

Primary Health Care Provider: Members of the health care team who are licensed and authorized to formulate prescriptions and orders on behalf of the client, as well as receive notifications of client status, are referred as primary health care provider, medical physician (or other specialty, e.g., surgeon, nephrologist) or an advanced practice nurse.

Unlicensed Assistive Personnel (UAP): Any unlicensed personnel trained to function in a supportive role, regardless of title, to whom a nursing responsibility may be delegated.

Please note: *Order and Prescription terminology has been updated for the 2023 Test Plan.*

Examination Security and Confidentiality

Any candidate who violates test center regulations or rules or engages in irregular behavior, misconduct and/or does not follow a test center administrator's warning to discontinue inappropriate behavior may be dismissed from the test center. Additionally, examination results may be withheld or canceled and the licensing board may take other disciplinary action such as denial of a license and/or disqualifying the candidate from future registrations for licensure. Refer to the current candidate bulletin at NCLEX.com.

Candidates should be aware and understand that the disclosure of examination items before, during or after the examination is a violation of law. Violations of confidentiality and/or candidates' rules can result in criminal prosecution or civil liability and/or disciplinary actions by the licensing agency including the denial of licensure. Disclosure of examination materials includes but is not limited to discussing examination items with faculty, friends, family, or others.

Tutorial

Each NCLEX-RN candidate is provided information on how to answer examination items. A tutorial is available to all candidates prior to examination day. The tutorial explains the various item formats that candidates may see on the examination. More detailed information about the NCLEX examination, including information on the Next Generation NCLEX, CAT methodology, the candidate bulletin and tutorials, can be found at the website NCLEX.com. A more detailed description of the item types can be found in the NCLEX Tutorial section on the website.

Appendix A

Sample Content

This section includes sample content and items for each of the eight test plan categories. To view additional sample items and item types, visit NCLEX.com.

Safe and Effective Care Environment

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients and health care personnel.

Management of Care

- Providing and directing nursing care that enhances the care delivery setting to protect the client and health care personnel.

Management of Care Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Integrate advance directives into client plan of care • Delegate and supervise care of client provided by others (e.g., LPN/VN, assistive personnel, other RNs) • Organize workload to manage time effectively • Practice and advocate for cost effective care • Initiate, evaluate and update client plan of care • Provide education to clients and staff about client rights and responsibilities • Advocate for client rights and needs • Collaborate with multi-disciplinary team members when providing client care (e.g., physical therapist, nutritionist, social worker) • Manage conflict among clients and health care staff • Maintain client confidentiality and privacy • Provide and receive hand off of care (report) on assigned clients • Use approved terminology when documenting care • Perform procedures necessary to safely admit, transfer and/or discharge a client • Prioritize the delivery of client care based on acuity • Recognize and report ethical dilemmas • Practice in a manner consistent with the nurses' code of ethics • Verify the client receives education and client consents for care and procedures • Receive, verify and implement health care provider orders • Utilize resources to promote quality client care (e.g., evidence-based research, information technology, policies and procedures) • Recognize limitations of self and others and utilize resources • Report client conditions as required by law (e.g., abuse/neglect and communicable diseases) • Provide care within the legal scope of practice • Participate in performance improvement projects and quality improvement processes • Assess the need for referrals and obtain necessary orders

Related content includes but is **not limited** to:

Advance Directives/Self-Determination/Life Planning

- Assess client and/or staff member knowledge of advance directives (e.g., living will, health care agent/proxy, power of attorney for health care)
- Integrate advance directives into client plan of care*
- Provide client with information about advance directives, self-care determination, life planning

Advocacy

- Discuss identified treatment options with client and respect their decisions
- Provide information on advocacy to staff members
- Act in the role of client advocate
- Use advocacy resources appropriately (e.g., social worker, chain of command, interpreter)

Assignment, Delegation and Supervision

- Identify tasks for assignment or delegation based on client needs
- Delegate and assign appropriate tasks based on client needs to personnel with competency to perform tasks
- Delegate and supervise care of client provided by others (e.g., LPN/VN, assistive personnel, other RNs)*
- Communicate tasks to be completed and report client concerns immediately
- Organize workload to manage time effectively*
- Utilize the rights of delegation (e.g., right task, right circumstances, right person, right direction/communication, right supervision/evaluation)
- Evaluate delegated tasks to ensure correct completion of activity
- Evaluate ability of staff members to perform assigned tasks considering personnel's allowable tasks/duties, competency and ability to use sound judgment and decision-making
- Evaluate effectiveness of staff members' time management skills

Case Management

- Explore resources available to assist client with achieving or maintaining independence
- Assess client's need for materials and equipment (e.g., oxygen, suction machine, wound care supplies)
- Practice and advocate for cost effective care*
- Plan individualized care for client based on need (e.g., client diagnosis, self-care ability, prescribed treatments)
- Provide client with information on discharge procedures to home or community setting
- Initiate, evaluate and update client plan of care*

**Activity statement used in the 2021 RN practice analysis*

Client Rights

- Recognize client's right to refuse treatment/procedures
- Discuss treatment options/decisions with client
- Provide education to clients and staff about client rights and responsibilities*
- Evaluate client and staff understanding of client rights
- Advocate for client rights and needs*

Collaboration with Multidisciplinary Team

- Identify the need for interdisciplinary conferences
- Identify significant information to report to other disciplines (e.g., health care provider, pharmacist, social worker, respiratory therapist)
- Review plan of care to ensure continuity across disciplines
- Collaborate with multi-disciplinary team members when providing client care (e.g., physical therapist, nutritionist, social worker)*
- Serve as resource person to other staff

Concepts of Management

- Identify roles and responsibilities of health care team members
- Plan overall strategies to address client problems
- Act as liaison between client and others (e.g., coordinate or manage care)
- Manage conflict among clients and health care staff*
- Evaluate management outcomes

Confidentiality/Information Security

- Assess staff member and client understanding of confidentiality requirements
- Maintain client confidentiality and privacy*
- Intervene appropriately when staff members have breached confidentiality

Continuity of Care

- Provide and receive hand off of care (report) on assigned clients*
- Use documents to record and communicate client information (e.g., medical record, referral/transfer form)
- Use approved terminology when documenting care*
- Perform procedures necessary to safely admit, transfer and/or discharge a client*
- Follow up on unresolved issues regarding client care (e.g., laboratory results, client requests)

**Activity statement used in the 2021 RN practice analysis*

Establishing Priorities

- Apply knowledge of pathophysiology when establishing priorities for interventions with multiple clients
- Prioritize the delivery of client care based on acuity*
- Evaluate plan of care for multiple clients and revise plan of care as needed

Ethical Practice

- Recognize and report ethical dilemmas*****
- Inform client and staff members of ethical issues affecting client care
- Practice in a manner consistent with the nurses' code of ethics*****
- Evaluate outcomes of interventions to promote ethical practice

Informed Consent

- Identify appropriate person to provide informed consent for client
- Provide written materials in client's spoken language, when possible
- Describe components of informed consent
- Participate in obtaining informed consent
- Verify the client receives education and client consents for care and procedures*

Information Technology

- Receive, verify and implement health care provider orders*
- Apply knowledge of facility regulations when accessing client records
- Access data for client through online databases and journals
- Enter computer documentation accurately, completely and in a timely manner
- Utilize resources to promote quality client care (e.g., evidence-based research, information technology, policies and procedures)*

Legal Rights and Responsibilities

- Identify legal issues affecting the client (e.g., refusing treatment)
- Identify and manage client's valuables according to facility/agency policy
- Recognize limitations of self and others and utilize resources*****
- Review facility policy and legal considerations prior to agreeing to serve as an interpreter for staff or primary health care provider
- Educate client and staff on legal issues
- Report client conditions as required by law (e.g., abuse/neglect and communicable diseases)*****
- Provide care within the legal scope of practice*****

**Activity statement used in the 2021 RN practice analysis*

Performance Improvement (Quality Improvement)

- Define performance improvement/quality assurance activities
- Participate in performance improvement projects and quality improvement processes*
- Report identified client care issues to appropriate personnel
- Utilize research and other references for performance improvement actions
- Evaluate the impact of performance improvement measures on client care and resource use

Referrals

- Assess the need to refer clients for assistance with existing or potential problems (e.g., physical therapy, speech therapy)
- Assess the need for referrals and obtain necessary orders*
- Identify community resources for the client (e.g., respite care, social services, shelters)
- Identify which documents to include when referring a client (e.g., medical record, referral form)

Sample Item

The nurse has been made aware of the following client situations. The nurse should **first** assess the client

1. with diverticulitis who is reporting left lower quadrant (LLQ) pain
2. with chronic obstructive pulmonary disease (COPD) who is reporting hemoptysis
3. who had an evacuation of a subdural hematoma 8 hours ago and has become agitated **(key)**
4. who had a total knee replacement 8 hours ago and whose affected extremity is internally rotated

(Key) is used throughout this document to denote the correct answer(s) for the exam item.

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Safety and Infection Control

- Protecting clients and health care personnel from health and environmental hazards.

Safety and Infection Control Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assess client for allergies and intervene as needed • Assess client care environment • Promote staff safety • Protect client from injury • Properly identify client when providing care • Verify appropriateness and accuracy of a treatment order • Participate in emergency planning and response • Use ergonomic principles when providing care • Follow procedures for handling biohazardous and hazardous materials • Educate client on safety issues • Acknowledge and document practice errors and near misses • Report, intervene, and/or escalate unsafe practice of health care personnel (e.g., substance abuse, improper care, staffing practices) • Facilitate appropriate and safe use of equipment • Follow security plan and procedures (e.g., newborn security, violence, controlled access) • Apply principles of infection prevention (e.g., hand hygiene, aseptic technique, isolation, sterile technique, universal/standard enhanced barrier precautions) • Educate client and staff regarding infection prevention measures • Follow requirements when using restraints

Related content includes but is **not limited** to:

Accident/Error/Injury Prevention

- Assess client for allergies and intervene as needed*
- Assess client care environment*
- Determine client and staff member knowledge of safety procedures
- Identify factors that influence accident and injury prevention (e.g., age, developmental stage, lifestyle, mental status)

**Activity statement used in the 2021 RN practice analysis*

- Identify deficits that may impede client safety (e.g., visual, hearing, sensory/perceptual)
- Identify and verify orders for treatments that may contribute to an accident or injury (does not include medication)
- Identify and facilitate correct use of infant and child car seats
- Promote staff safety*
- Provide client with appropriate method to signal staff members
- Protect client from injury*
- Review necessary modifications with client to reduce stress on specific muscle or skeletal groups (e.g., frequent changing of position; routine stretching of the shoulders, neck, arms, hands, fingers)
- Implement seizure precautions for at-risk clients
- Make appropriate room assignments for cognitively impaired clients
- Properly identify client when providing care*
- Verify appropriateness and accuracy of a treatment order*

Emergency Response Plan

- Determine which client(s) to recommend for discharge in a disaster situation
- Identify nursing roles in disaster planning
- Use clinical decision-making/critical thinking for emergency response plan
- Participate in emergency planning and response*****
- Participate in disaster planning activities/drills

Ergonomic Principles

- Assess client ability to balance, transfer and use assistive devices prior to planning care (e.g., crutches, walker)
- Provide instruction and information to client about body positions that eliminate potential for repetitive stress injuries
- Use ergonomic principles when providing care*****

Handling Hazardous and Infectious Materials

- Identify biohazardous, flammable and infectious materials
- Follow procedures for handling biohazardous and hazardous materials*
- Demonstrate safe handling techniques to staff and client
- Ensure safe implementation of internal radiation therapy

**Activity statement used in the 2021 RN practice analysis*

Home Safety

- Assess need for client home modifications (e.g., lighting, handrails, kitchen safety)
- Apply knowledge of client pathophysiology to home safety interventions
- Educate client on safety issues*
- Encourage client to use protective equipment when using devices that can cause injury
- Evaluate client care environment for fire and environmental hazards

Reporting of Incident/Event/Irregular Occurrence/Variance

- Identify need/situation where reporting of incident/event/irregular occurrence/variance is appropriate
- Acknowledge and document practice errors and near misses*****
- Evaluate response to error/event/occurrence
- Report, intervene, and/or escalate unsafe practice of health care personnel (e.g., substance abuse, improper care, staffing practices)*****

Safe Use of Equipment

- Inspect equipment for safety hazards (e.g., frayed electrical cords, loose/missing parts)
- Teach client about safe use of equipment needed for health care
- Facilitate appropriate and safe use of equipment*****
- Remove malfunctioning equipment from client care area and report the problem to appropriate personnel

Security Plan

- Use clinical decision-making/critical thinking in situations related to security planning
- Apply principles of triage and evacuation procedures and protocols
- Follow security plan and procedures (e.g., newborn security, violence, controlled access)*****

Standard Precautions/Transmission-Based Precautions/Surgical Asepsis

- Assess client care area for sources of infection
- Understand communicable diseases and the modes of organism transmission (e.g., airborne, droplet, contact)
- Apply principles of infection prevention (e.g., hand hygiene, aseptic technique, isolation, sterile technique, universal/standard enhanced barrier precautions)*****
- Follow correct policy and procedures when reporting a client with a communicable disease
- Educate client and staff regarding infection prevention measures*****
- Use appropriate precautions for immunocompromised clients
- Use appropriate technique to set up a sterile field/maintain asepsis
- Evaluate infection control precautions implemented by staff members
- Evaluate whether aseptic technique is performed correctly

**Activity statement used in the 2021 RN practice analysis*

Use of Restraints/Safety Devices

- Assess appropriateness of the type of restraint/safety device used
- Follow requirements when using restraints*
- Monitor/evaluate client response to restraints/safety device

Sample Item

The nurse is assigning unlicensed assistive personnel (UAP) to assist the following clients to ambulate. It would be **most** important for the nurse to review safety precautions with the UAP prior to ambulating the

1. 44-year-old client with Ménière's disease **(key)**
2. 59-year-old client with a unilateral cataract
3. 62-year-old client with presbycusis
4. 65-year-old client with sinusitis

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Health Promotion and Maintenance

The nurse provides and directs nursing care of the client that incorporates the knowledge of expected growth and development principles, prevention and/or early detection of health problems, and strategies to achieve optimal health.

Health Promotion and Maintenance Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Provide care and education for the newborn, infant, and toddler client from birth through 2 years • Provide care and education for the preschool, school age and adolescent client ages 3 through 17 years • Provide care and education for the adult client ages 18 through 64 years • Provide care and education for the adult client ages 65 years and over • Provide prenatal care and education • Provide care and education to an antepartum client or a client in labor • Provide post-partum care and education • Assess and educate clients about health risks based on family, population, and community • Assess client's readiness to learn, learning preferences, and barriers to learning • Plan and/or participate in community health education • Educate client about preventative care and health maintenance recommendations • Provide resources to minimize communication barriers • Perform targeted screening assessments (e.g., vision, nutrition, depression) • Educate client about prevention and treatment of high risk health behaviors • Assess client ability to manage care in home environment and plan care accordingly • Perform comprehensive health assessments

**Activity statement used in the 2021 RN practice analysis*

Related content includes but is **not limited** to:

Aging Process

- Assess client's reactions to expected age-related changes
- Provide care and education for the newborn, infant, and toddler client from birth through 2 years*
- Provide care and education for the preschool, school age and adolescent client ages 3 through 17 years*
- Provide care and education for the adult client ages 18 through 64 years*
- Provide care and education for the adult client ages 65 years and over*

Ante-/Intra-/Postpartum and Newborn Care

- Assess client's psychosocial response to pregnancy (e.g., support systems, perception of pregnancy, coping mechanisms)
- Assess client for symptoms of postpartum complications (e.g., hemorrhage, infection)
- Calculate expected delivery date
- Check fetal heart rate during routine prenatal exams
- Assist client with learning and performing newborn care (e.g., feeding)
- Provide prenatal care and education*
- Provide care and education to an antepartum client or a client in labor*
- Provide post-partum care and education*
- Provide discharge instructions (e.g., postpartum and newborn care)
- Evaluate client's ability to care for the newborn

Developmental Stages and Transitions

- Identify expected physical, cognitive and psychosocial stages of development
- Identify expected body image changes associated with client developmental age (e.g., aging, pregnancy)
- Identify family structures and roles of family members (e.g., nuclear, blended, adoptive)
- Compare client development to expected age/developmental stage and report any deviations
- Assess impact of change on family system (e.g., one-parent family, divorce, ill family member)
- Assist client to cope with life transitions (e.g., attachment to newborn, parenting, puberty, retirement)
- Modify approaches to care in accordance with client developmental stage (use age-appropriate explanations of procedures and treatments)
- Provide education to client and staff members about expected age-related changes and age-specific growth and development (e.g., developmental stages)
- Evaluate client's achievement of expected developmental level (e.g., developmental milestones)
- Evaluate impact of expected body image changes on client and family

**Activity statement used in the 2021 RN practice analysis*

Health Promotion/Disease Prevention

- Assess and educate clients about health risks based on family, population, and community*
- Assess client's readiness to learn, learning preferences, and barriers to learning*
- Plan and/or participate in community health education*
- Educate client on actions to promote and maintain health and prevent disease (e.g., smoking cessation, diet, weight loss)
- Integrate complementary therapies into health promotion activities for the well client
- Educate client about preventative care and health maintenance recommendations*
- Provide follow-up to client following participation in health promotion program (e.g., diet counseling)
- Provide resources to minimize communication barriers*
- Assist client in maintaining an optimal level of health
- Evaluate client understanding of health promotion behaviors/activities (e.g., weight control, exercise actions)

Health Screening

- Apply knowledge of pathophysiology to health screening
- Perform health history/health and risk assessments (e.g., lifestyle, family and genetic history)
- Perform targeted screening assessments (e.g., vision, nutrition, depression)*
- Use appropriate procedures and interviewing techniques when taking client health history

High-Risk Behaviors

- Assess client lifestyle practice risks that may impact health (e.g., excessive sun exposure, lack of regular exercise)
- Assist client to identify behaviors/risks that may impact health
- Educate client about prevention and treatment of high risk health behaviors*

Lifestyle Choices

- Assess client's lifestyle choices
- Assess client's attitudes/perceptions on sexuality
- Assess client's need/desire for contraception
- Identify contraindications to chosen contraceptive method (e.g., smoking, adherence, medical conditions)
- Identify expected outcomes for family planning methods
- Recognize client who is socially or environmentally isolated
- Educate client on sexuality issues (e.g., family planning, safer sex practices, menopause, impotence)
- Evaluate client alternative or homeopathic health care practices (e.g., massage therapy, acupuncture, herbal medicine and minerals)

**Activity statement used in the 2021 RN practice analysis*

Self-Care

- Assess client ability to manage care in home environment and plan care accordingly*
- Consider client self-care needs before developing or revising care plan
- Assist primary caregivers working with the client to meet self-care goals

Techniques of Physical Assessment

- Apply knowledge of nursing procedures and psychomotor skills to techniques of physical assessment
- Choose physical assessment equipment and technique appropriate for the client (e.g., age of client, measurement of vital signs)
- Perform comprehensive health assessments*

Sample Item

The nurse is teaching clients at a community health fair about risk factors for developing cancer. The nurse should recognize that at **highest** risk is the

1. 30-year-old client who consumes a diet high in selenium and has a history of an ovarian cyst
2. 49-year-old client who drinks 2 or 3 cups of coffee daily and has a family history of fibrocystic breast conditions
3. 51-year-old client who has hypertension and teaches an aerobic exercise program
4. 62-year-old client who consumes 5 or 6 alcoholic beverages daily and is an opera singer **(key)**

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Psychosocial Integrity

The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client experiencing stressful events as well as clients with acute or chronic mental illness.

Psychosocial Integrity Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assess client for abuse or neglect and report, intervene, and/or escalate • Incorporate behavioral management techniques when caring for a client • Assess client for substance abuse and/or toxicities and intervene as appropriate (e.g., dependency, withdrawal) • Assess client's ability to cope with life changes and provide support • Assess the potential for violence and use safety precautions • Incorporate client cultural practices and beliefs when planning and providing care • Provide end-of-life care and education to clients • Assess client support system to aid in plan of care • Provide care for a client experiencing grief or loss • Provide care and education for acute and chronic psychosocial health issues (e.g., addictions/dependencies, depression, dementia, eating disorders) • Assess psychosocial factors influencing care and plan interventions (e.g., occupational, spiritual, environmental, financial) • Provide appropriate care for a client experiencing visual, auditory, and/or cognitive alterations • Recognize non-verbal cues to physical and/or psychological stressors • Use therapeutic communication techniques • Promote a therapeutic environment

Related content includes but is **not limited** to:

Abuse or Neglect

- Assess client for abuse or neglect and report, intervene and/or escalate*
- Identify risk factors for domestic, child and elder abuse or neglect and sexual abuse
- Plan interventions for victims/suspected victims of abuse
- Counsel victims/suspected victims of abuse and their families on coping strategies

**Activity statement used in the 2021 RN practice analysis*

- Provide a safe environment for the abused or neglected client
- Evaluate client response to interventions

Behavioral Interventions

- Assess client's appearance, mood and psychomotor behavior and identify/respond to inappropriate/abnormal behavior
- Assist client with achieving and maintaining self-control of behavior (e.g., behavior modification)
- Assist client to develop and use strategies to decrease anxiety
- Orient the client to reality
- Participate in group sessions (e.g., support groups)
- Incorporate behavioral management techniques when caring for a client*
- Evaluate client's response to treatment plan

Chemical and Other Dependencies/Substance Use Disorder

- Assess client's reactions to the diagnosis and treatment of substance-related disorder
- Assess client for substance abuse and/or toxicities and intervene as appropriate (e.g., dependency, withdrawal)*
- Plan and provide care to clients experiencing substance-related withdrawal or toxicity (e.g., nicotine, opioid, sedative)
- Educate client on substance use diagnosis and treatment plan
- Provide care and/or support for a client with non-substance-related dependencies (e.g., gambling, sex addiction)
- Provide symptom management for clients experiencing withdrawal or toxicity
- Encourage client to participate in support groups
- Evaluate client's response to a treatment plan and revise as needed

Coping Mechanisms

- Assess client's support systems and available resources
- Assess client's ability to adapt to temporary and permanent role changes
- Assess client's reaction to a diagnosis of acute or chronic mental illness (e.g., rationalization, hopefulness, anger)
- Assess client's ability to cope with life changes and provide support*
- Identify situations that may necessitate role changes for a client (e.g., spouse with chronic illness, death of parent)
- Provide support to client with unexpected altered body image (e.g., alopecia, amputation, burns)
- Evaluate client's constructive use of defense mechanisms
- Evaluate whether client has successfully adapted to situational role changes (e.g., accept dependency on others)

**Activity statement used in the 2021 RN practice analysis*

Crisis Intervention

- Assess the potential for violence and use safety precautions*
- Identify the client in crisis
- Use crisis intervention techniques to assist the client in coping
- Apply knowledge of client psychopathology to crisis intervention
- Guide the client to resources for recovery from crisis (e.g., social supports)

Cultural Awareness/Cultural Influences on Health

- Assess importance of client self-reported culture/ethnicity when planning/providing/evaluating care
- Incorporate client cultural practices and beliefs when planning and providing care*
- Respect client self-reported cultural background and practices
- Evaluate and document how client language needs were met

End-of-Life Care

- Assess client's ability to cope with end-of-life interventions
- Identify end-of-life needs of the client (e.g., financial concerns, fear, loss of control, role changes)
- Recognize the need for and provide psychosocial support to the family/caregiver
- Assist client in resolution of end-of-life issues
- Provide end-of-life care and education to clients*

Family Dynamics

- Assess barriers and stressors that impact family functioning (e.g., meeting client care needs, divorce)
- Assess client support system to aid in plan of care*
- Assess parental techniques related to discipline
- Encourage the client's participation in group/family therapy
- Assist client to integrate new members into family structure (e.g., new infant, blended family)
- Evaluate resources available to assist family functioning

Grief and Loss

- Provide care for a client experiencing grief or loss*
- Support the client in anticipatory grieving
- Inform the client of expected reactions to grief and loss (e.g., denial, fear)
- Provide the client with resources to adjust to loss/bereavement (e.g., individual counseling, support groups)
- Evaluate the client's coping and fears related to grief and loss

**Activity statement used in the 2021 RN practice analysis*

Mental Health Concepts

- Identify signs and symptoms of impaired cognition (e.g., memory loss, poor hygiene)
- Recognize signs and symptoms of acute and chronic mental illness (e.g., schizophrenia, depression, bipolar disorder)
- Recognize client use of defense mechanisms
- Assess client adherence to treatment plan
- Assess client for alterations in mood, judgment, cognition and reasoning
- Apply knowledge of client psychopathology to mental health concepts applied in individual/group/family therapy
- Provide care and education for acute and chronic psychosocial health issues (e.g., addictions/dependencies, depression, dementia, eating disorders)*
- Evaluate client's ability to adhere to treatment plan
- Evaluate client's abnormal response to the aging process (e.g., depression)

Religious and Spiritual Influences on Health

- Identify the client emotional problems or needs that are related to self-reported religious/spiritual beliefs (e.g., spiritual distress, conflict between recommended treatment and beliefs)
- Assess psychosocial factors influencing care and plan interventions (e.g., occupational, spiritual, environmental, financial)*
- Assess and plan interventions that meet client emotional and self-reported spiritual needs
- Evaluate whether client's self-reported religious/spiritual needs are met

Sensory/Perceptual Alterations

- Identify time, place and stimuli surrounding the appearance of symptoms
- Assist client to develop strategies for dealing with sensory and thought disturbances
- Provide appropriate care for a client experiencing visual, auditory and/or cognitive alterations*
- Provide care in a nonthreatening and nonjudgmental manner
- Provide reality-based diversions

Stress Management

- Recognize non-verbal cues to physical and/or psychological stressors*
- Assess stressors, including environmental, that affect client care (e.g., noise, fear, uncertainty, change, lack of knowledge)
- Implement measures to reduce environmental stressors (e.g., noise, temperature)
- Provide information to client on stress management techniques (e.g., relaxation techniques, exercise, meditation)
- Evaluate client's use of stress management techniques

**Activity statement used in the 2021 RN practice analysis*

Support Systems

- Assist family to plan care for client with impaired cognition (e.g., Alzheimer's disease)
- Encourage client's involvement in the health care decision-making process
- Evaluate client's feelings about the diagnosis and treatment plan

Therapeutic Communication

- Assess verbal and nonverbal client communication needs
- Respect the client's personal values and beliefs
- Allow time to communicate with the client
- Use therapeutic communication techniques*
- Encourage client to verbalize feelings (e.g., fear, discomfort)
- Evaluate the effectiveness of communications with the client

Therapeutic Environment

- Identify external factors that may interfere with client recovery (e.g., stressors, family dynamics)
- Make client room assignments that support the therapeutic milieu
- Promote a therapeutic environment*

Sample Item

The nurse is talking with a client who had a colostomy created 2 days ago. Which of the following statements by the client would indicate ineffective coping? **Select all that apply.**

1. "I am not touching that disgusting bag." **(key)**
2. "I am glad I can still go to the gym just as I used to."
3. "I really like raw vegetables, and it will be hard for me to limit them."
4. "I understand the need for the colostomy, but I am afraid that the bag will leak."
5. "I do not understand why I cannot have a nurse perform the colostomy bag changes for me." **(key)**

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Physiological Integrity

The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

Basic Care and Comfort

- Providing comfort and assistance in the performance of activities of daily living.

Basic Care and Comfort Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assist client to compensate for a physical or sensory impairment (e.g., assistive devices, positioning)
• Assess and manage client with an alteration in bowel and bladder elimination
• Perform irrigations (e.g., of bladder, ear, eye)
• Perform skin assessment and implement measures to maintain skin integrity
• Apply, maintain, or remove orthopedic devices
• Implement measures to promote circulation (e.g., active or passive range of motion, positioning and mobilization)
• Assess client for pain and intervene as appropriate
• Recognize complementary therapies and identify potential benefits and contraindications (e.g., aromatherapy, acupressure, supplements)
• Provide non-pharmacological comfort measures
• Evaluate the client's nutritional status and intervene as needed
• Provide client nutrition through tube feedings
• Evaluate client intake and output and intervene as needed
• Assess client performance of activities of daily living and assist when needed
• Perform post-mortem care
• Assess client sleep/rest pattern and intervene as needed

Related content includes but is **not limited** to:

Assistive Devices

- Assess client for actual/potential difficulty with communication and speech/vision/hearing problems
- Assess client's use of assistive devices (e.g., prosthetic limbs, hearing aid)
- Assist client to compensate for a physical or sensory impairment (e.g., assistive devices, positioning)*
- Manage client who uses assistive devices or prostheses (e.g., eating utensils, telecommunication devices, dentures)
- Evaluate the correct use of assistive devices by client

**Activity statement used in the 2021 RN practice analysis*

Elimination

- Assess and manage client with an alteration in bowel and bladder elimination*
- Perform irrigations (e.g., of bladder, ear, eye)*
- Provide skin care to clients who are incontinent (e.g., wash frequently, barrier creams/ointments)
- Use alternative methods to promote voiding
- Evaluate whether client's ability to eliminate is restored/maintained

Mobility/Immobility

- Identify complications of immobility (e.g., skin breakdown, contractures)
- Assess the client for mobility, gait, strength and motor skills
- Perform skin assessment and implement measures to maintain skin integrity*
- Apply knowledge of nursing procedures and psychomotor skills when providing care to clients with immobility
- Apply, maintain, or remove orthopedic devices*
- Educate immobilized client regarding proper methods used when being repositioned
- Maintain client's correct body alignment
- Maintain/correct the adjustment of client's traction device (e.g., external fixation device, halo traction, skeletal traction)
- Implement measures to promote circulation (e.g., active or passive range of motion, positioning and mobilization)*
- Evaluate client's response to interventions to prevent complications from immobility

Nonpharmacological Comfort Interventions

- Assess client's need for alternative and/or complementary therapy
- Assess client's need for palliative care/symptom management or noncurative treatments
- Assess client for pain and intervene as appropriate*
- Recognize differences in client perception and response to pain
- Apply knowledge of pathophysiology to nonpharmacological comfort/palliative care interventions
- Incorporate alternative/complementary therapies into client plan of care (e.g., music therapy, relaxation therapy)
- Recognize complementary therapies and identify potential benefits and contraindications (e.g., aromatherapy, acupressure, supplements)*
- Counsel client regarding palliative care/symptom management and noncurative treatments
- Respect client palliative care/symptom management or noncurative treatment choices
- Assist client in receiving appropriate end-of-life physical symptom management
- Plan measures to provide comfort interventions to client with anticipated or actual impaired comfort
- Provide non-pharmacological comfort measures*

**Activity statement used in the 2021 RN practice analysis*

- Evaluate the client's response to nonpharmacological interventions (e.g., pain rating scale, verbal reports)
- Evaluate outcomes of alternative and/or complementary therapy practices
- Evaluate outcomes of palliative care/symptom management or noncurative treatments

Nutrition and Oral Hydration

- Assess client ability to eat (e.g., chew, swallow)
- Assess client for actual and potential specific food-medication interactions
- Consider client choices regarding meeting nutritional requirements and/or maintaining dietary restrictions, including mention of specific food items
- Monitor client hydration status (e.g., edema, signs and symptoms of dehydration)
- Initiate calorie counts for client
- Apply knowledge of mathematics to client nutrition (e.g., body mass index)
- Evaluate the client's nutritional status and intervene as needed*
- Promote client's independence in eating
- Provide and maintain special diets based on client diagnosis/nutritional needs and self-reported cultural considerations (e.g., low sodium, high protein, calorie restrictions)
- Provide nutritional supplements as needed (e.g., high-protein drinks)
- Provide client nutrition through tube feedings*
- Evaluate side effects of client tube feedings and intervene as needed (e.g., diarrhea, dehydration)
- Evaluate client intake and output and intervene as needed*
- Evaluate the impact of disease/illness on nutritional status of a client

Personal Hygiene

- Assess client for personal hygiene habits/routine
- Assess client performance of activities of daily living and assist when needed*
- Provide information to client on required adaptations for performing activities of daily living (e.g., shower chair, handrails)
- Perform post-mortem care*

Rest and Sleep

- Assess client sleep/rest pattern and intervene as needed*
- Apply knowledge of client pathophysiology to rest and sleep interventions
- Schedule client care activities to promote adequate rest

**Activity statement used in the 2021 RN practice analysis*

Sample Item

The nurse is teaching a client who had a subtotal gastrectomy about ways to prevent dumping syndrome. Which of the following foods would be appropriate for the nurse to recommend eliminating from the client's diet?

1. cheese
2. red meat
3. ice cream **(key)**
4. yellow vegetables

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Pharmacological and Parenteral Therapies

- Providing care related to the administration of medications and parenteral therapies.

Pharmacological and Parenteral Therapies Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Administer blood products and evaluate client response
• Access and/or maintain central venous access devices
• Perform calculations needed for medication administration
• Evaluate client response to medication
• Educate client about medications
• Prepare and administer medications using rights of medication administration
• Review pertinent data prior to medication administration (e.g., contraindications, lab results, allergies, potential interactions)
• Participate in medication reconciliation process
• Titrate dosage of medication based on assessment and ordered parameters
• Dispose of medications safely
• Handle and maintain medication in a safe and controlled environment
• Evaluate appropriateness and accuracy of medication order for client
• Handle and administer high-risk medications safely
• Monitor intravenous infusion and maintain site
• Administer medications for pain management
• Handle and administer controlled substances within regulatory guidelines
• Administer parenteral nutrition and evaluate client response

Related content includes but is **not limited** to:

Adverse Effects/Contraindications/Side Effects/Interactions

- Identify a contraindication to the administration of a medication to a client
- Identify actual and potential incompatibilities of prescribed client medications
- Identify symptoms/evidence of an allergic reaction to medications
- Assess client for actual and potential side effects and adverse effects of medications (e.g., prescribed, over-the-counter, herbal supplements, preexisting condition)
- Provide information to client on common side effects/adverse effects/potential interactions of medications and inform client when to notify primary health care provider

**Activity statement used in the 2021 RN practice analysis*

- Notify primary health care provider of side effects, adverse effects and contraindications of medications and parenteral therapy
- Document side effects and adverse effects of medications and parenteral therapy
- Monitor for anticipated interactions among client's prescribed medications and fluids (e.g., oral, topical, subcutaneous, intramuscular, intravenous)
- Evaluate and document client's response to actions taken to counteract side effects and adverse effects of medications and parenteral therapy

Blood and Blood Products

- Identify client according to facility/agency policy prior to administration of red blood cells/blood products (e.g., order for administration, correct type, correct client, crossmatching complete, consent obtained)
- Check the client for appropriate venous access for red blood cell/blood product administration (e.g., correct needle gauge, integrity of access site)
- Document necessary information on the administration of red blood cells/blood products
- Administer blood products and evaluate client response*

Central Venous Access Devices

- Educate client on the reason for and care of a venous access device
- Access and/or maintain central venous access devices*
- Provide care for client with a central venous access device

Dosage Calculations

- Perform calculations needed for medication administration*
- Use clinical decision-making/critical thinking when calculating dosages

Expected Actions/Outcomes

- Obtain information on a client's prescribed medications (e.g., review formulary, consult pharmacist)
- Use clinical decision-making/critical thinking when addressing expected effects/outcomes of medications (e.g., oral, intradermal, subcutaneous, intramuscular, topical)
- Evaluate client's use of medications over time (e.g., prescription, over-the-counter, home remedies)
- Evaluate client response to medication*

Medication Administration

- Educate client about medications*
- Educate client on medication self-administration procedures
- Prepare and administer medications using rights of medication administration*
- Review pertinent data prior to medication administration (e.g., contraindications, lab results, allergies, potential interactions)*
- Mix medications from two vials when necessary
- Administer and document medications given by common routes (e.g., oral, topical)

**Activity statement used in the 2021 RN practice analysis*

- Administer and document medications given by parenteral routes (e.g., intravenous, intramuscular, subcutaneous)
- Participate in medication reconciliation process*
- Titrate dosage of medication based on assessment and ordered parameters*
- Dispose of medications safely*
- Handle and maintain medication in a safe and controlled environment*
- Evaluate appropriateness and accuracy of medication order for client*
- Handle and administer high-risk medications safely*

Parenteral/Intravenous Therapies

- Identify appropriate veins that should be accessed for various therapies
- Educate client on the need for intermittent parenteral fluid therapy
- Apply knowledge and concepts of mathematics/nursing procedures/psychomotor skills when caring for a client receiving intravenous therapy
- Prepare client for intravenous catheter insertion
- Monitor the use of an infusion pump (e.g., intravenous, patient-controlled analgesia device)
- Monitor intravenous infusion and maintain site*
- Evaluate the client's response to intermittent parenteral fluid therapy

Pharmacological Pain Management

- Assess client need for administration of a PRN pain medication (e.g., oral, topical, subcutaneous, intramuscular, intravenous)
- Administer and document pharmacologic pain management appropriate for client age and diagnoses (e.g., pregnancy, children, older adults)
- Administer medications for pain management*
- Handle and administer controlled substances within regulatory guidelines*
- Evaluate and document client's use and response to pain medications

Total Parenteral Nutrition

- Identify side effects and adverse events related to total parenteral nutrition (TPN) and intervene as appropriate (e.g., hyperglycemia, fluid imbalance, infection)
- Educate client on the need for and use of TPN
- Apply knowledge of nursing procedures and psychomotor skills when caring for a client receiving TPN
- Apply knowledge of client pathophysiology and mathematics to TPN interventions
- Administer parenteral nutrition and evaluate client response*

**Activity statement used in the 2021 RN practice analysis*

Sample Item

The nurse is preparing to administer prescribed otic drops to a 1-year-old client. Which of the following actions should the nurse take?

1. Gently pull the pinna upward and straight back to straighten the auditory canal.
2. Administer the drops immediately after removing them from the refrigerator to minimize the risk of bacterial growth.
3. Direct the drops along the side of the ear canal to avoid instilling the medication directly onto the eardrum. **(key)**
4. Gently massage the area immediately posterior to the ear after instilling the drops to facilitate distribution of the medication.

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Reduction of Risk Potential

- Reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

Reduction of Risk Potential Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assess and respond to changes and trends in client vital signs
• Perform testing within scope of practice (e.g., electrocardiogram, glucose monitoring)
• Monitor the results of diagnostic testing and intervene as needed
• Obtain blood specimens
• Obtain specimens other than blood for diagnostic testing
• Insert, maintain, or remove a nasal/oral gastrointestinal tube
• Insert, maintain, or remove a urinary catheter
• Insert, maintain, or remove a peripheral intravenous line
• Maintain percutaneous feeding tube
• Apply and/or maintain devices used to promote venous return (e.g., anti-embolic stockings, sequential compression devices)
• Use precautions to prevent injury and/or complications associated with a procedure or diagnosis
• Evaluate client responses to procedures and treatments
• Recognize trends and changes in client condition and intervene as needed
• Perform focused assessments
• Educate client about treatments and procedures
• Provide preoperative and postoperative education
• Provide preoperative care
• Manage client during a procedure with moderate sedation
• Manage client following a procedure with moderate sedation

Related content includes but is **not limited** to:

Changes/Abnormalities in Vital Signs

- Assess and respond to changes and trends in client vital signs*
- Apply knowledge needed to perform related nursing procedures and psychomotor skills when assessing vital signs
- Apply knowledge of client pathophysiology when measuring vital signs
- Evaluate invasive monitoring data (e.g., pulmonary artery pressure, intracranial pressure)

**Activity statement used in the 2021 RN practice analysis*

Diagnostic Tests

- Apply knowledge of related nursing procedures and psychomotor skills when caring for clients undergoing diagnostic testing
- Compare client diagnostic findings with pre-test results
- Perform testing within scope of practice (e.g., electrocardiogram, glucose monitoring)*
- Perform fetal heart monitoring
- Monitor results of maternal and fetal diagnostic tests (e.g., nonstress test, amniocentesis, ultrasound)
- Monitor the results of diagnostic testing and intervene as needed*

Laboratory Values

- Compare client laboratory values to normal laboratory values
- Educate client about the purpose and procedure of ordered laboratory tests
- Obtain blood specimens*
- Obtain specimens other than blood for diagnostic testing*
- Monitor client laboratory values (e.g., glucose testing results for client with diabetes)
- Notify primary health care provider about laboratory test results

Potential for Alterations in Body Systems

- Identify client potential for aspiration (e.g., feeding tube, sedation, swallowing difficulties)
- Identify client potential for skin breakdown (e.g., immobility, nutritional status, incontinence)
- Identify client with increased risk for insufficient vascular perfusion (e.g., immobilized limb, postsurgery, diabetes)
- Educate client on methods to prevent complications associated with activity level/diagnosed illness/disease (e.g., contractures, foot care for client with diabetes)
- Compare current client data to baseline client data (e.g., symptoms of illness/disease)
- Monitor client output for changes from baseline (e.g., nasogastric tube, emesis, stool, urine)

Potential for Complications of Diagnostic Tests/Treatments/Procedures

- Assess client for an abnormal response following a diagnostic test/procedure (e.g., dysrhythmia following cardiac catheterization)
- Apply knowledge of nursing procedures and psychomotor skills when caring for a client with potential for complications
- Monitor client for signs of bleeding
- Position client to prevent complications following tests/treatments/procedures (e.g., elevate head of bed, immobilize extremity)
- Insert, maintain, or remove a nasal/oral gastrointestinal tube*
- Insert, maintain, or remove a urinary catheter*
- Insert, maintain, or remove a peripheral intravenous line*

**Activity statement used in the 2021 RN practice analysis*

- Maintain tube patency (e.g., nasogastric tube for decompression, chest tubes)
- Maintain percutaneous feeding tube*
- Apply and/or maintain devices used to promote venous return (e.g., anti-embolic stockings, sequential compression devices)*
- Use precautions to prevent injury and/or complications associated with a procedure or diagnosis*
- Provide care for client undergoing electroconvulsive therapy (e.g., monitor airway, assess for side effects, teach client about procedure)
- Intervene to manage potential circulatory complications (e.g., hemorrhage, embolus, shock)
- Intervene to prevent aspiration (e.g., check nasogastric tube placement)
- Intervene to prevent potential neurologic complications (e.g., foot drop, numbness, tingling)
- Evaluate client responses to procedures and treatments*

Potential for Complications from Surgical Procedures and Health Alterations

- Apply knowledge of pathophysiology to monitoring for complications (e.g., recognize signs of thrombocytopenia)
- Evaluate client's response to postoperative interventions to prevent complications (e.g., prevent aspiration, promote venous return, promote mobility)

System-Specific Assessments

- Assess client for abnormal peripheral pulses after a procedure or treatment
- Assess client for abnormal neurologic status (e.g., level of consciousness, muscle strength, mobility)
- Assess client for peripheral edema
- Assess client for signs of hypoglycemia or hyperglycemia
- Identify factors that result in delayed wound healing
- Recognize trends and changes in client condition and intervene as needed*
- Perform a risk assessment (e.g., sensory impairment, potential for falls, level of mobility, skin integrity)
- Perform focused assessments*

Therapeutic Procedures

- Assess client response to recovery from local, regional or general anesthesia
- Apply knowledge of related nursing procedures and psychomotor skills when caring for clients undergoing therapeutic procedures
- Educate client about treatments and procedures*
- Educate client about home management of care
- Use precautions to prevent further injury when moving a client with a musculoskeletal condition (e.g., log-rolling, abduction pillow)
- Monitor client before and after a procedure/surgery (e.g., casted extremity)

**Activity statement used in the 2021 RN practice analysis*

- Monitor effective functioning of therapeutic devices (e.g., chest tube, drainage tubes, wound drainage devices, continuous bladder irrigation)
- Provide preoperative and postoperative education*
- Provide preoperative care*
- Manage client during a procedure with moderate sedation*
- Manage client following a procedure with moderate sedation*

Sample Item

The nurse is caring for a client who is scheduled for a lumbar puncture. It would be **most** important for the nurse to assess the client for

1. bowel and bladder function
2. presence of Trousseau's sign
3. signs of increased intracranial pressure (ICP) **(key)**
4. circulation, movement, and sensation of the legs

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Physiological Adaptation

- Managing and providing care for clients with acute, chronic or life-threatening physical health conditions.

Physiological Adaptation Related Activity Statements from the *2021 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*
• Assist with invasive procedures (e.g., central line, thoracentesis, bronchoscopy)
• Implement and monitor phototherapy
• Maintain optimal temperature of client
• Monitor and care for clients on a ventilator
• Monitor and maintain devices and equipment used for drainage (e.g., surgical wound drains, chest tube suction, negative pressure wound therapy)
• Perform and manage care of client receiving peritoneal dialysis
• Perform suctioning
• Perform wound care and dressing change
• Provide ostomy care and education (e.g., tracheal, enteral)
• Provide pulmonary hygiene (e.g., chest physiotherapy, incentive spirometry)
• Provide postoperative care
• Manage the care of the client with a fluid and electrolyte imbalance
• Monitor and maintain arterial lines
• Manage the care of a client with a pacing device
• Manage the care of a client on telemetry
• Manage the care of a client receiving hemodialysis or continuous renal replacement therapy
• Manage the care of a client with alteration in hemodynamics, tissue perfusion, and hemostasis
• Educate client regarding an acute or chronic condition
• Manage the care of a client with impaired ventilation/oxygenation
• Evaluate the effectiveness of the treatment plan for a client with an acute or chronic diagnosis
• Perform emergency care procedures
• Identify pathophysiology related to an acute or chronic condition
• Recognize signs and symptoms of client complications and intervene

**Activity statement used in the 2021 RN practice analysis*

Related content includes but is **not limited** to:

Alterations in Body Systems

- Assess adaptation of a client to health alteration, illness and/or disease
- Assess tube drainage during the time client has an alteration in body systems (e.g., amount, color)
- Assess client for signs and symptoms of adverse effects of radiation therapy
- Identify signs of potential prenatal complications
- Identify signs, symptoms and incubation periods of infectious diseases
- Apply knowledge of nursing procedures, pathophysiology and psychomotor skills when caring for a client with an alteration in body systems
- Educate client about managing health problems (e.g., chronic illness)
- Assist with invasive procedures (e.g., central line, thoracentesis, bronchoscopy)*
- Implement and monitor phototherapy*
- Implement interventions to address side/adverse effects of radiation therapy (e.g., dietary modifications, avoid sunlight)
- Maintain optimal temperature of client*
- Monitor and care for clients on a ventilator*
- Monitor wounds for signs and symptoms of infection
- Monitor and maintain devices and equipment used for drainage (e.g., surgical wound drains, chest tube suction, negative pressure wound therapy)*
- Perform and manage care of client receiving peritoneal dialysis*
- Perform suctioning*
- Perform wound care and dressing change*
- Promote client progress toward recovery from an alteration in body systems
- Provide ostomy care and education (e.g., tracheal, enteral)*
- Provide care to client who has experienced a seizure
- Provide care to client with an infectious disease
- Provide pulmonary hygiene (e.g., chest physiotherapy, incentive spirometry)*
- Provide care for client experiencing complications of pregnancy/labor and/or delivery (e.g., eclampsia, precipitous labor, hemorrhage)
- Provide care for client experiencing increased intracranial pressure
- Provide postoperative care*
- Remove sutures or staples
- Evaluate client response to surgery
- Evaluate achievement of client treatment goals

**Activity statement used in the 2021 RN practice analysis*

- Evaluate client response to treatment for an infectious disease (e.g., acquired immune deficiency syndrome [AIDS], tuberculosis [TB])
- Evaluate and monitor client response to radiation therapy

Fluid and Electrolyte Imbalances

- Identify signs and symptoms of client fluid and/or electrolyte imbalance
- Apply knowledge of pathophysiology when caring for the client with fluid and electrolyte imbalances
- Manage the care of the client with a fluid and electrolyte imbalance*
- Evaluate client's response to interventions to correct fluid or electrolyte imbalance

Hemodynamics

- Assess client for decreased cardiac output (e.g., diminished peripheral pulses, hypotension)
- Identify cardiac rhythm strip abnormalities (e.g., sinus bradycardia, premature ventricular contractions, ventricular tachycardia, atrial fibrillation, ventricular fibrillation)
- Apply knowledge of pathophysiology to interventions in response to client abnormal hemodynamics
- Provide client with strategies to manage decreased cardiac output (e.g., frequent rest periods, limit activities)
- Intervene to improve client cardiovascular status (e.g., initiate protocol to manage cardiac arrhythmias, monitor pacemaker functions)
- Monitor and maintain arterial lines*
- Manage the care of a client with a pacing device*
- Manage the care of a client on telemetry*
- Manage the care of a client receiving hemodialysis or continuous renal replacement therapy*
- Manage the care of a client with alteration in hemodynamics, tissue perfusion, and hemostasis*

Illness Management

- Identify client data that needs to be reported immediately
- Apply knowledge of client pathophysiology to illness management
- Educate client regarding an acute or chronic condition*
- Educate client about managing illness
- Implement interventions to manage client's recovery from an illness
- Perform gastric lavage
- Promote and provide continuity of care in illness management activities
- Manage the care of a client with impaired ventilation/oxygenation*
- Evaluate the effectiveness of the treatment plan for a client with an acute or chronic diagnosis*

**Activity statement used in the 2021 RN practice analysis*

Medical Emergencies

- Apply knowledge of pathophysiology when caring for a client experiencing a medical emergency
- Apply knowledge of nursing procedures and psychomotor skills when caring for a client experiencing a medical emergency
- Explain emergency interventions to a client
- Notify primary health care provider about unexpected client response/emergency situation
- Perform emergency care procedures*
- Provide emergency care for wound disruption (e.g., dehiscence)
- Evaluate and document client's response to emergency interventions (e.g., restoration of breathing, pulse)

Pathophysiology

- Identify pathophysiology related to an acute or chronic condition*
- Understand general principles of pathophysiology (e.g., injury and repair, immunity, cellular structure)

Unexpected Response to Therapies

- Assess client for unexpected adverse response to therapy (e.g., increased intracranial pressure, hemorrhage)
- Recognize signs and symptoms of client complications and intervene*
- Promote recovery of a client from unexpected response to therapy (e.g., urinary tract infection)

Sample Item

The nurse is assessing a client with viral meningitis. Which of the following findings would the nurse expect to observe? **Select all that apply.**

1. nausea **(key)**
2. vomiting **(key)**
3. piloerection
4. bradycardia
5. photophobia **(key)**

Visit NCLEX.com for additional resources and sample items, including sample clinical judgment case studies and stand-alone items.

**Activity statement used in the 2021 RN practice analysis*

Appendix B

Item Writing Tips

The following tips are designed to provide nurse educators with information on writing NCLEX-style items. Refer to NCLEX.com for answers to frequently asked questions and for additional information on item formats and sample items.

NCSBN has created a repository of resources related to Next Generation NCLEX development. For information on developing clinical judgment items, be sure to access NCSBN.org for newsletters and articles, particularly the newsletters on the NGN Clinical Judgment Measurement Model and Action Model, the NGN Case Study and Stand-alone Items.

Steps to Item Writing

A well-designed item or case study consists of four main components: client data (clinical scenario/exhibits such as vital signs), a stem (asks a question or poses a statement that requires completion), key(s) (the correct answer/s) and distractors (incorrect options). The following steps are provided to assist in creating a well-designed item or case study.

Step 1. Select a nursing concept for focus of the item or case study (test plan category or integrated process).

Step 2. Use the concept to build the client data (clinical scenario/exhibits) and stem.

Step 3. Write a key or keys to represent important information the entry-level nurse should know.

Step 4. Identify common errors, misconceptions or irrelevant information.

Step 5. Use the previous information and write the distractors.

Step 6. Complete the item using the client data (clinical scenario/exhibits), stem, key(s) and distractors.

Step 7. Write a rationale supporting the keys and distractors.

Appendix C

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