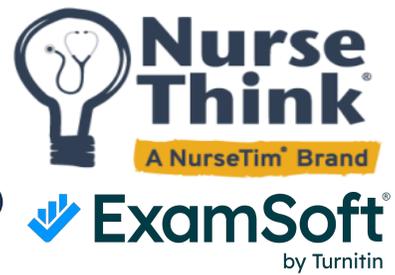


Clinical Judgment Exams



From Traditional to Next Gen NCLEX®



The NurseThink® Clinical Judgment Exams (CJEs) are designed using the foundation of the Clinical Judgment Measurement Model (CJMM) from the National Council of State Boards of Nursing (NCSBN). As the NCSBN transitions to the Next Gen NCLEX® (NGN) guided by their extensive research, NurseThink® has also adopted the new NGN item types to include alongside traditional item types on each CJE. These before and after samples highlight the ways the NGN item types elevate test items to gauge how well students can apply their nursing education to multiple steps of the CJMM in realistic client-care scenarios.

Item 1: Before (Select all that apply)

The nurse cares for a client in the early post-operative phase of a kidney transplant. Which assessment findings indicate blood supply to the new kidney may not be established? **Select all that apply.**

1. *Creatinine level change from 3.6 mg/dL to 4.0 mg/dL.
2. *Blood urea nitrogen (BUN) change from 28 mg/dL to 34 mg/dL.
3. *50 mL of concentrated urine in the past two hours.
4. Urine output decreased from 950 mL/hour to 880 ml/hour.
5. *Sudden decrease in urine output from 780 mL/hour to 300 mL/hour.

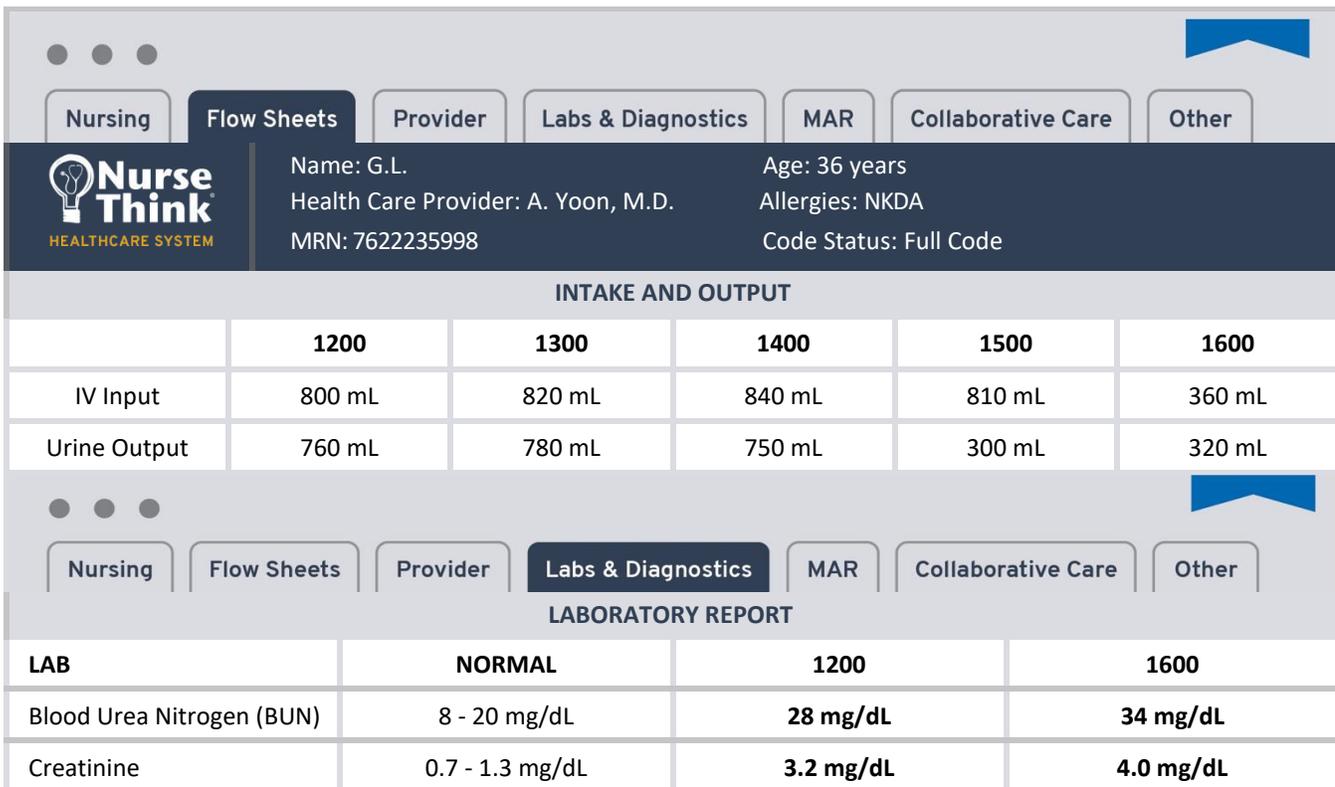
System: Genitourinary **Concept:** Elimination **Concept Exemplar-Disease:** Kidney Transplant **Subtopic:** Graft Dysfunction **Bloom's Taxonomy:** Applying **NCLEX® Client Needs:** Management of Care **QSEN Competencies:** Patient-Centered Care **Nursing Process:** Evaluation **Clinical Judgment Measurement Model:** Evaluate Outcomes

Item 1: After (Cloze)

Review the electronic health record. Use the drop-down lists to complete the sentences.

The nurse cares for a client in the early postoperative phase of kidney transplantation. The

nurse recognizes the signs of { *graft dysfunction
acute rejection
normal graft function
renal infection } and responds by { continuing to monitor.
*calling the provider.
collecting a urine sample.
increasing the rate of IV fluids. }



Nurse Think HEALTHCARE SYSTEM

Name: G.L. Age: 36 years
Health Care Provider: A. Yoon, M.D. Allergies: NKDA
MRN: 7622235998 Code Status: Full Code

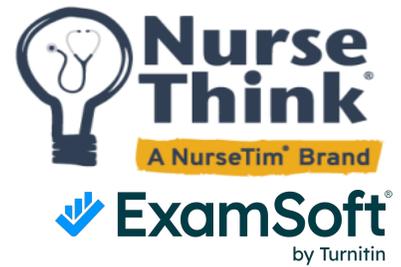
INTAKE AND OUTPUT					
	1200	1300	1400	1500	1600
IV Input	800 mL	820 mL	840 mL	810 mL	360 mL
Urine Output	760 mL	780 mL	750 mL	300 mL	320 mL

LABORATORY REPORT

LAB	NORMAL	1200	1600
Blood Urea Nitrogen (BUN)	8 - 20 mg/dL	28 mg/dL	34 mg/dL
Creatinine	0.7 - 1.3 mg/dL	3.2 mg/dL	4.0 mg/dL

Debriefing: In the first 12-24 hours after a kidney transplant, blood supply to the kidney should be reestablished and the kidney should start working well. The client may have up to one liter per hour of urine output. The client's creatinine and BUN levels start returning to normal and the urine output starts to gradually decrease. This client's BUN and creatinine levels are increasing which indicate the new kidney is not working well. The sudden drastic decrease in the client's urine output would also be major cause for concern in this early postoperative phase. There is not enough information to determine if acute rejection or infection are the cause of the graft dysfunction. The provider should be notified so diagnostic tests may be prescribed. The rate of IV fluids in the immediate postoperative phase is usually 60 mL/hr plus the previous hour's urine output; the nurse should not increase the rate. The provider may prescribe a urine test, but the nurse needs to first contact them. **Clinical Tip:** With renal transplantation, the nurse must monitor the client carefully for complications of transplantation, such as organ rejection or infection.

Item 2: Before (Multiple Choice)



A client arrives at the hospital with complaints of chest pain. The health care provider prescribes intravenous nitroglycerin. Which data is most important for the nurse to assess prior to administering the medication?

1. A numeric pain rating.
2. *Client's blood pressure.
3. Client's oxygen saturation.
4. Electrocardiogram results.

System: Cardiovascular **Concept:** Pain Concept **Exemplar-Disease:** Acute Pain **Subtopic:** Nitroglycerin Administration **Bloom's Taxonomy:** Applying **NCLEX® Client Needs:** Pharmacological and Parenteral Therapies **QSEN Competencies:** Safety **Nursing Process:** Analysis **Clinical Judgment Measurement Model:** Prioritize Hypotheses

Item 2: After (Continued)

Debriefing: Primary adverse effects of nitroglycerin are hypotension and reflex tachycardia. The prescription indicates it should only be given if the systolic blood pressure is > 90 mmHg, so the nurse should not administer a third dose. Supplemental oxygen is not indicated as the client is not hypoxic. Transcutaneous pacing is indicated for profound and symptomatic bradycardia unresponsive to medications and is not appropriate for this client. Cardiac catheterization is often utilized for clients with myocardial infarction and the nurse should prepare the client for this likely intervention. In the meantime, the nurse should ensure the client has a continuous cardiac monitor in place. **Clinical Tip:** The nurse must ensure the client has patent peripheral venous access to prepare for possible adverse effects when administering nitroglycerin.

Item 3: Before (Select all that apply)

The nurse cares for a client experiencing hypovolemic shock. Which signs and symptoms does the nurse expect to find on assessment? **Select all that apply.**

1. *Tachycardia
2. Cheyne-Stokes respirations.
3. *Confusion.
4. *Generalized pallor.
5. Bounding pulse.

System: Cardiovascular **Concept:** Perfusion Concept **Exemplar-Disease:** Hypovolemic Shock **Subtopic:** Assessment Findings **Bloom's Taxonomy:** Analyzing **NCLEX® Client Needs:** Physiological Adaptation **QSEN Competencies:** Patient-Centered Care **Nursing Process:** Analysis **Clinical Judgment Measurement Model:** Analyze Cues

Item 3: After (Drag and Drop)

The nurse participates in a humanitarian aid trip, providing care to residents of a tent city in Haiti. What additional signs and symptoms is the nurse likely to find and document at 0900? Drag and drop each expected finding into the Expected Findings box.



Name: W.C. Age: 37 years

Health Care Provider: M. Pierre, M.D. Allergies: NKDA

MRN: 7622235993 Code Status: Full Code

VITAL SIGN RECORD

Time	Blood Pressure (mmHg)	Heart Rate (beats/minute)	Respirations (breaths/minute)	Temperature (°F/°C)	Oxygen Saturation (%)
0530	115/72	98	16	98.8/37.1	99
0700	106/84	110	22	98.6/37.1	98
0900	78/42	125	30	98.2/36.8	92

NURSING NOTES

0530: Client presented to the clinic after waking up with diarrhea. Watery diarrhea x3 before arrival. Knows of a neighbor who was sick yesterday but denies illness of household members. Provided oral rehydration serum.

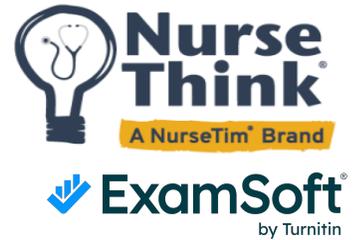
0700: Rice-water diarrhea x2, about 300 mL each. Client reports nausea and mild abdominal cramping. Continues to take frequent small sips of oral rehydration serum.

0900: Continues to have rice-water diarrhea, increasing in quantity and frequency. Also vomited x1. Peripheral venous access device inserted.

Possible Findings
Warm, dry skin
Confusion
Pallor
Weakness
Pain with defecation
Muscle cramping
Sunken eyes
Cheyne-Stokes respirations
Bounding Pulse

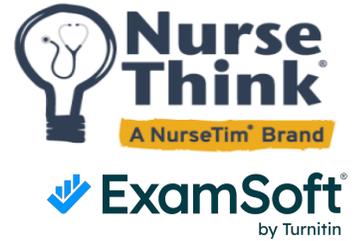
Expected Findings

Item 3: After (Continued)



Debriefing: The client is most likely experiencing hypovolemic shock due to cholera infection. Cholera causes very rapid dehydration and electrolyte imbalances. Diarrhea with cholera has a characteristic rice-water appearance that often smells of fish and is not painful; adult clients can lose up to one liter of fluid per hour. The client would be pale, clammy, weak, confused, with sunken eyes, rapid respirations, and a thready pulse. Hypokalemia and hypocalcemia may cause muscle cramping. **Clinical Tip:** There are several types of shock, each with differing signs and symptoms. The nurse must be aware of the differences in order to implement the appropriate nursing interventions.

Item 4: Before (Multiple Choice)



A client with end-stage renal disease is prescribed epoetin alfa. The nurse plans the teaching the client will need to safely administer the medication at home. Which information should the nurse include in the client's instructions?

1. Methods to administer the oral medication.
2. *To be aware of adverse reactions such as myocardial infarction.
3. The activity restrictions associated with the medication.
4. The need for protective isolation while taking the medication.

System: Renal **Concept:** Fluid & Electrolytes Concept **Exemplar-Disease:** End-stage Renal Disease **Subtopic:** Epoetin Alfa **Bloom's Taxonomy:** Applying **NCLEX® Client Needs:** Reduction of Risk Potential **QSEN Competencies:** Safety **Nursing Process:** Planning **Clinical Judgment Measurement Model:** Generate Solutions

Item 4: After (Hot Spot)

The nurse reviews the teaching plan in the electronic health record for a client with end-stage renal disease using epoetin alfa. Which part of the teaching plan does the nurse question?

Nursing		Flow Sheets	Provider	Labs & Diagnostics	MAR	Collaborative Care	Other
		Name: M.T. Health Care Provider: M. Dixon, M.D. MRN: 2300516894		Age: 48 years Allergies: NKDA Code Status: Full Code			
CLIENT EDUCATION							
June 12 0745	Client with end-stage renal disease to discharge home today with epoetin alfa Client instructions: <ul style="list-style-type: none"> • Monitor iron and hematocrit levels regularly (as specified by provider) • Avoid large crowds and fresh fruits and vegetables • Monitor blood pressure • Call 911 with chest pain or shortness of breath 						

Debriefing: Epoetin alfa is a subcutaneous injection that increases red blood cell production. Treatment is not without serious side effects including myocardial infarction and thromboembolic disease. The client's blood pressure, hematocrit, and iron level need to be monitored regularly. Activity restrictions and protective isolation are not indicated with this medication. **Clinical Tip:** Clients with chronic renal failure lack endogenous erythropoietin. Exogenous epoetin alfa provides significant positive outcomes for clients.