EXPLORING NEXT GEN NCLEX(NGN) FORMAT/CONTENT WITH MARSHALL©TEST STRATEGIES AND PRACTICE QUESTIONS

Lois S. Marshall, PhD, MN, RN

Nurse Education Consultant

NCLEX/NGN Expert

Author, *Take Charge of Your Nursing Career (Sigma, 2022)*

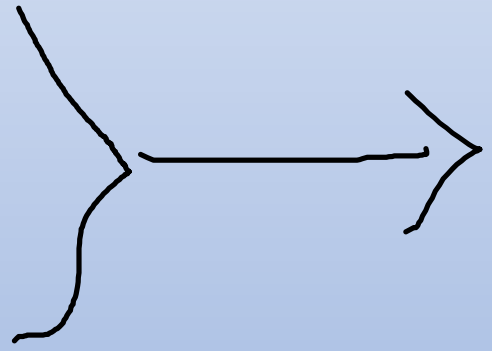
(Recipient of AJN Book Award, 2022)

Why Test Strategies?

- To assist when you are unsure of response
- To assist in eliminating obvious options to increase chances of choosing correct response
- To provide unique approach to determining NCLEX responses
- To provide means of increasing confidence in your abilities to answer questions even if you don’t know answer

How to Maximize Test Taking Abilities for NCLEX-RN©

- STUDY FOR SUCCESS
- LINKING
- CONCEPTUALIZING
- PSYCHOLOGICAL PREPARATION



Assess
Intervene
Evaluate

Marshall's© Unique Approach to NCLEX® Success

- Reading Carefully
- Process of Elimination
- Using What You Do Know To Assist You With You Might Not Know
  - LINKING/CONCEPTUALIZING

How to use (LINKING and CONCEPTUALIZATION©) to Enhance NCLEX-RN® Success

IF YOU CAN ASSESS…YOU CAN INTERVENE….YOU CAN EVALUATE

How to use (LINKING and CONCEPTUALIZATION©) to Enhance NCLEX-RN® Success

- Examples
  - Linking: Use what you know, i.e. health alterations/assessments to assist you with what you do not know/can't answer
  - Conceptualization: Use broad concepts, i.e. oxygenation, mobility, etc., to assist with linking to areas you don't know/unfamiliar with

How to use (LINKING and CONCEPTUALIZATION©) to Enhance NCLEX-RN® Success

- Respiratory Assessments…ARE ASSESSMENTS ONLY FOR RESPIRATORY CONDITIONS????... EXTEND TO INTERVENTIONS AND EVALUATION FOR EACH…
  - Dyspnea, Tachypnea, Bradypnea, Orthopnea, SOB
  - Restlessness
  - Non-productive/Productive Cough
  - Adventitious Breath Sounds: Crackles, Rhonchi, Wheezes
  - Use of Accessory Muscles
  - Retractions
  - Nasal Flaring
  - Specific to COPD: Barrel-chested, Pursed lip breathing, Clubbing nailbeds, Slight Respiratory Acidosis (Note ABG's), Periods of cyanosis
  - Specific to Infants: Grunting, Head bobbing

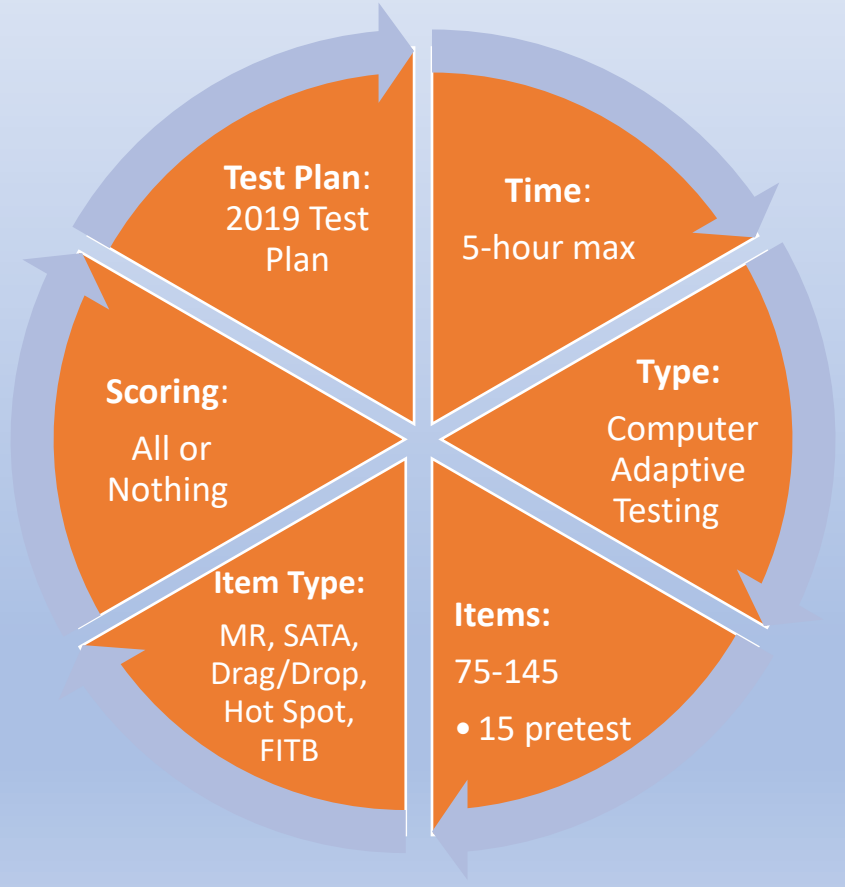
How to use (LINKING and CONCEPTUALIZATION©) to Enhance NCLEX-RN® Success

More examples:

- General preop/post op care
- Hyperthyroidism vs Hypothyroidism
- Cushings vs Addisons…and Steroid Long-Term Effects
- SIADH vs Diabetes Insipidus
- Skin Integrity and Edema
- Immobility

WHAT Is the Difference of NCLEX and NGN

Traditional NCLEX®



Next Generation NCLEX®

- Time: 5-hour max
- Type: CAT and **Not CAT**
- Items: **85-150**
  - (15 pretest)
- Item Types: Same with addition of **Unfolding cases and CJ Standalone Items (Bowtie, Trend)**
- Scoring: **Partial Credit Options**
- Test Plan: **↑ in Safety & Pharm**

NCSBN, 2019; NCSBN, 2022; NCSBN, 2023

WHAT: Test Composition

- Minimum Length Exam: 85 items
  - (3) 6-PART Clinical Judgement (CJ) Unfolding Cases: 18 questions
    - Static
  - 52 Stand-alone Questions
  - 15 Pretest Items

All Stand-alone Items

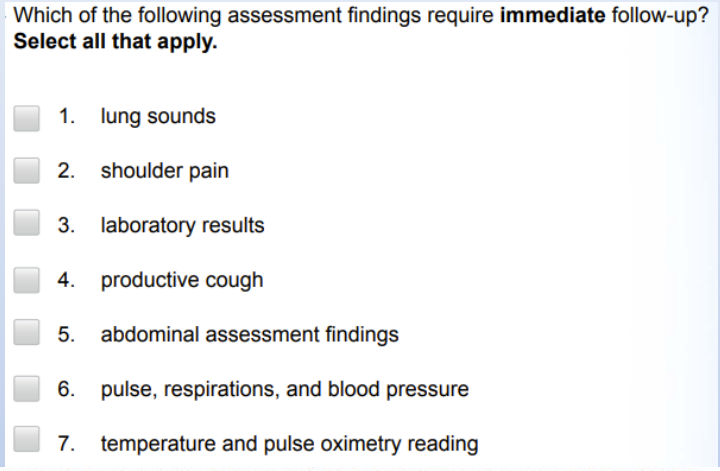
6-part Case 9 Stand-alone Items

(2) 6-part Cases 3 Stand-alone Items

- Maximum Length Exam
  - After first 85 questions: possible 65 standalone items
  - ~10% chance (6-7 questions) will be CJ standalone items

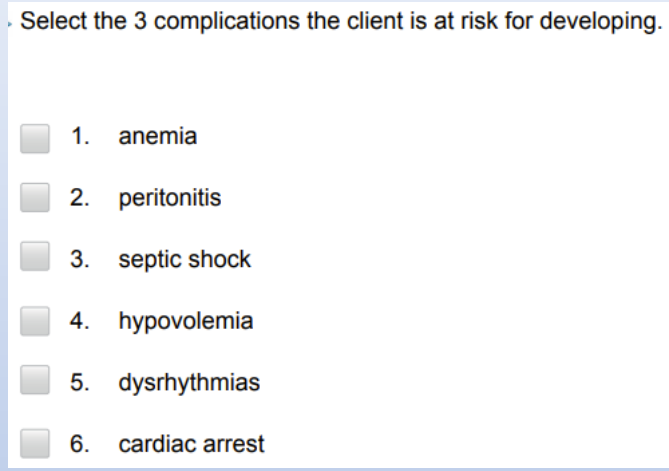
What: New Item Types

- Extended Multiple Response
  - SATA
  - Select (N)
  - Grouping
- Highlight Items
  - Text, Table



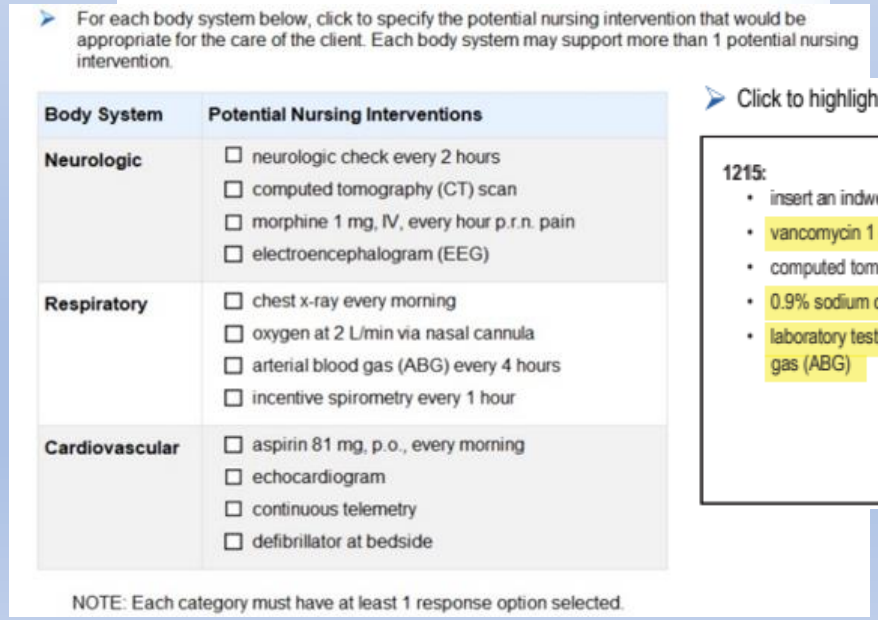
Which of the following assessment findings require **immediate** follow-up? **Select all that apply.**

1. lung sounds
2. shoulder pain
3. laboratory results
4. productive cough
5. abdominal assessment findings
6. pulse, respirations, and blood pressure
7. temperature and pulse oximetry reading



Select the 3 complications the client is at risk for developing.

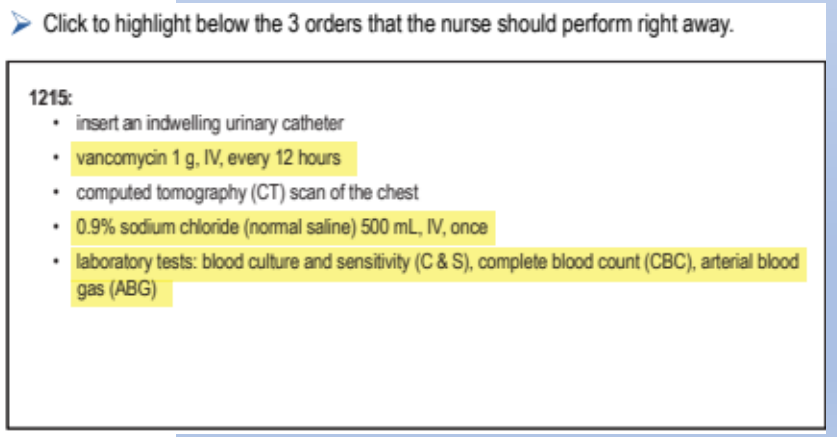
1. anemia
2. peritonitis
3. septic shock
4. hypovolemia
5. dysrhythmias
6. cardiac arrest



For each body system below, click to specify the potential nursing intervention that would be appropriate for the care of the client. Each body system may support more than 1 potential nursing intervention.

Body System	Potential Nursing Interventions
Neurologic	☐ neurologic check every 2 hours ☐ computed tomography (CT) scan ☐ morphine 1 mg, IV, every hour p.r.n. pain ☐ electroencephalogram (EEG)
Respiratory	☐ chest x-ray every morning ☐ oxygen at 2 L/min via nasal cannula ☐ arterial blood gas (ABG) every 4 hours ☐ incentive spirometry every 1 hour
Cardiovascular	☐ aspirin 81 mg, p.o., every morning ☐ echocardiogram ☐ continuous telemetry ☐ defibrillator at bedside

NOTE: Each category must have at least 1 response option selected.



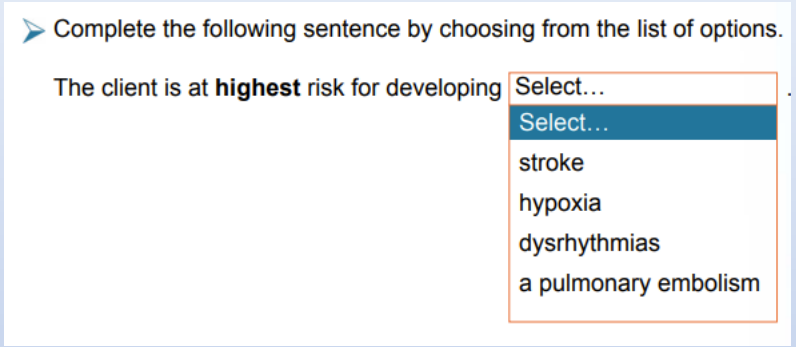
Click to highlight below the 3 orders that the nurse should perform right away.

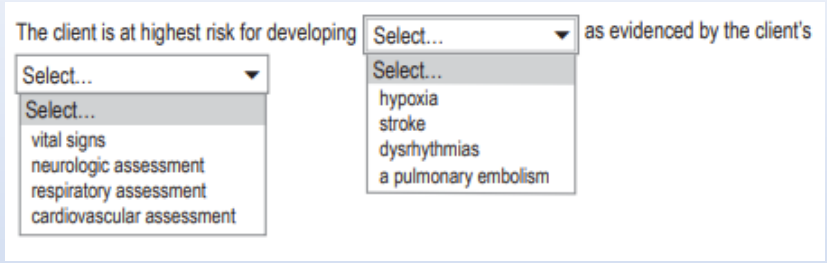
1215:

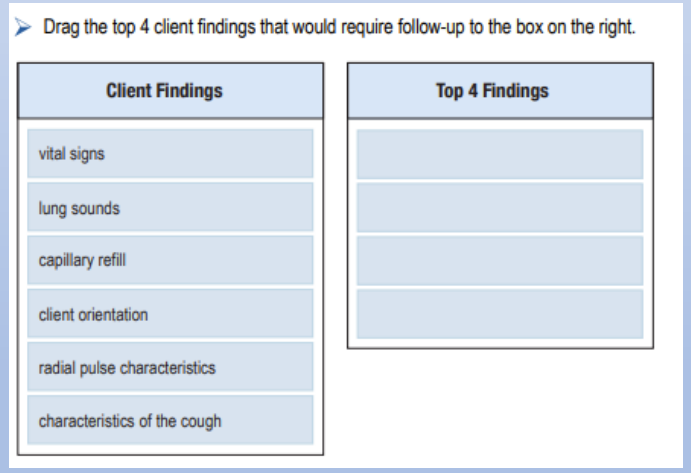
- insert an indwelling urinary catheter
- vancomycin 1 g, IV, every 12 hours
- computed tomography (CT) scan of the chest
- 0.9% sodium chloride (normal saline) 500 mL, IV, once
- laboratory tests: blood culture and sensitivity (C & S), complete blood count (CBC), arterial blood gas (ABG)

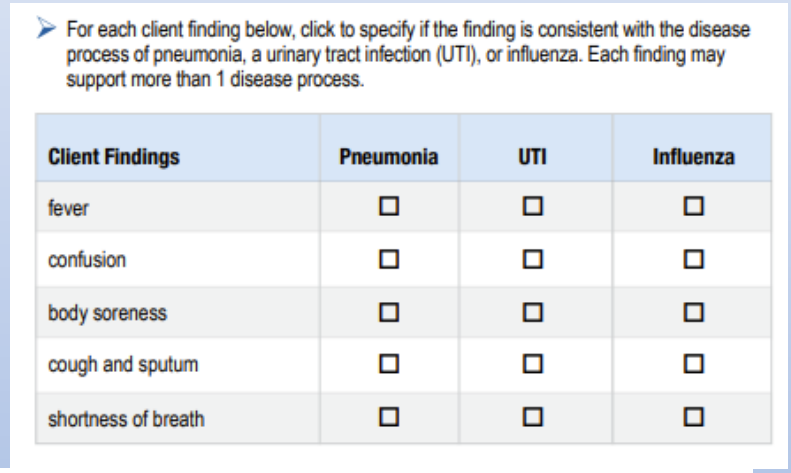
What: Item Types

- Drop Down
  - Cloze
  - Rationale
- Drag and Drop
  - Cloze
  - Rationale
- Matrix
  - MR
  - Multiple Choice

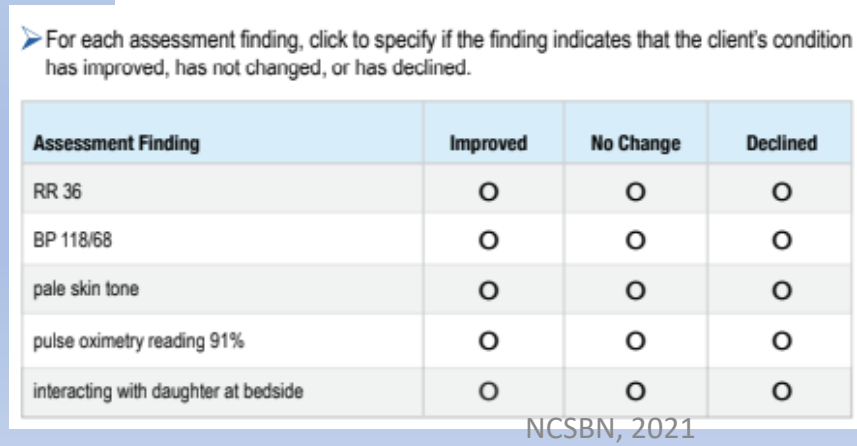








Client Findings	Pneumonia	UTI	Influenza
fever	☐	☐	☐
confusion	☐	☐	☐
body soreness	☐	☐	☐
cough and sputum	☐	☐	☐
shortness of breath	☐	☐	☐



Assessment Finding	Improved	No Change	Declined
RR 36	O	O	O
BP 118/68	O	O	O
pale skin tone	O	O	O
pulse oximetry reading 91%	O	O	O
interacting with daughter at bedside	O	O	O

NCSBN, 2021

What: Three Different Scoring Models

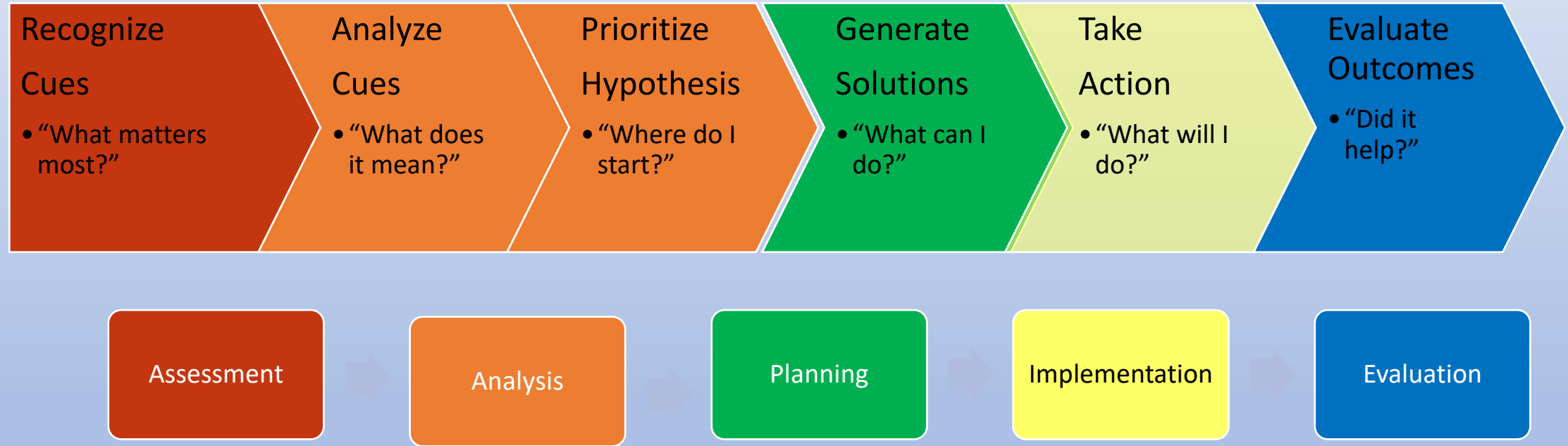
- **0/1 Scoring** (Multiple Choice/Matrix MR/Select N/Bow Tie)
  - Earn 1 point for each correct answer; 0 points for each incorrect answer

- **+/- Scoring** (Multiple Response-SATA/Matrix MR/MR Grouping/Highlight)
  - Earn 1 point for each correct answer; Subtract 1 point for each incorrect answer
  - Total score for multi point item is “right minus wrong”
  - Lowest score is 0 (no negative scores)

- **Rationale Scoring** (Drop Down/Drag and Drop Rationale; X because of Y)
  - Earn points when both answers in pair are correct
  - Applied to items that require identification of cause-and-effect relationship

Why: Clinical Judgement Model

- NCSBN Clinical Judgement Measurement Model



NCSBN, 2022

How Do We Measure CJ?

Unfolding Case Example

Recognize Cues

A nurse is caring for a client in the ED for breakthrough seizures

Nurses' Notes

Tuesday 2130: Client being seen for breakthrough seizure in college dorm. Pt states partying and drinking alcohol "and maybe other stuff" lately. Client taking Phenytoin (Dilantin) but has been "forgetting meds" because of stress of school. Eating lots of fast food; gained 10 pounds. Pt states he felt "an aura and then I blacked out. Roommate states: "he fell to floor, eyes shifted to left, became unresponsive. It lasted less than a minute, his body was jerking, and his mouth was blue". Assessment S1, S2, RRR, no injuries except evidence of tongue biting with no current bleeding. Reported to neurologist; admitted to neuro floor.

Vital Signs

T: 98.1°F; RR: 16 bpm; P: 124 bpm; BP: 120/84 mmHg; PO2: 95% on room air

What data is relevant as risk factors of a seizure? Select all that apply.

- ❑ Alcohol use
- ❑ Forgetting meds
- ❑ Stress
- ❑ Age
- ❑ Drug use
- ❑ Gender
- ❑ Diet
- ❑ Weight gain

Analyze Cues

A nurse is caring for a client in the ED for breakthrough seizures

Nurses' Notes

Tuesday 2130: Client being seen for breakthrough seizure in college dorm. Pt states partying and drinking alcohol "and maybe other stuff" lately. Client taking Phenytoin (Dilantin) but has been "forgetting meds" because of stress of school. Eating lots of fast food; gained 10 pounds. Pt states he felt "an aura and then I blacked out. Roommate states: "he fell to floor, eyes shifted to left, became unresponsive. It lasted less than a minute, his body was jerking, and his mouth was blue". Assessment S1, S2, RRR, no injuries except evidence of tongue biting with no current bleeding. Reported to neurologist; admitted to neuro floor.

Vital Signs

T: 98.1°F; RR: 16 bpm; P: 124 bpm; BP: 120/84 mmHg; PO2: 95% on room air

For each finding below, click to specify if the finding is consistent with Tonic-Clonic, absence, or Clonic seizure. Each finding may support more than one type.

Symptoms	Tonic-Clonic (Grand Mal)	Absence (Petit Mal)	Clonic
Fell to floor	X		X
Tongue biting	X		X
Became unresponsive	X	X	X
Lasted less than a minute	X	X	
Jerking muscles movements in body	X		X
His mouth looked blue	X		

Prioritize Hypothesis

A nurse is caring for a client in the ED for breakthrough seizures

Nurses' Notes

Tuesday 2130: Client being seen for breakthrough seizure in college dorm. Pt states partying and drinking alcohol "and maybe other stuff" lately. Client taking Phenytoin (Dilantin) but has been "forgetting meds" because of stress of school. Eating lots of fast food; gained 10 pounds. Pt states he felt "an aura and then I blacked out. Roommate states: "he fell to floor, eyes shifted to left, became unresponsive. It lasted less than a minute, his body was jerking, and his mouth was blue". Assessment S1, S2, RRR, no injuries except evidence of tongue biting with no current bleeding. Reported to neurologist; admitted to neuro floor.

Vital Signs

T: 98.1°F; RR: 16 bpm; P: 124 bpm; BP: 120/84 mmHg; PO2: 95% on room air

The nurse should first address: _____

education

safety

vital signs

weight gain

Generate Solutions

A nurse is caring for a client in the ED for breakthrough seizures

Nurses' Notes

Tuesday 2130: Client being seen for breakthrough seizure in college dorm. Pt states partying and drinking alcohol "and maybe other stuff" lately. Client taking Phenytoin (Dilantin) but has been "forgetting meds" because of stress of school. Eating lots of fast food; gained 10 pounds. Pt states he felt "an aura and then I blacked out. Roommate states: "he fell to floor, eyes shifted to left, became unresponsive. It lasted less than a minute, his body was jerking, and his mouth was blue". Assessment S1, S2, RRR, no injuries except evidence of tongue biting with no current bleeding. Reported to neurologist; admitted to neuro floor.

Vital Signs

T: 98.1°F; RR: 16 bpm; P: 124 bpm; BP: 120/84 mmHg; PO2: 95% on room air

For each order, indicated Whether the order is indicated or Contraindicated.

Potential Orders	Indicated	Contraindicated
Dilantin level	X	
Padded tongue blade at bedside		X
Lorazepam PO		X
Oxygen at bedside	X	
Lorazepam IVP	X	
Suction at bedside	X	

Take Action

A nurse is caring for a client in the ED for breakthrough seizures

Nurses' Notes

Tuesday 2130: Client being seen for breakthrough seizure in college dorm. Pt states partying and drinking alcohol "and maybe other stuff" lately. Client taking Phenytoin (Dilantin) but has been "forgetting meds" because of stress of school. Eating lots of fast food; gained 10 pounds. Pt states he felt "an aura and then I blacked out. Roommate states: "he fell to floor, eyes shifted to left, became unresponsive. It lasted less than a minute, his body was jerking, and his mouth was blue". Assessment S1, S2, RRR, no injuries except evidence of tongue biting with no current bleeding. Reported to neurologist; admitted to neuro floor.

Vital Signs

T: 98.1°F; RR: 16 bpm; P: 124 bpm; BP: 120/84 mmHg; PO2: 95% on room air

Provider Orders

Tuesday 2200:

Dilantin levels	Neuro checks as routine
Insert IV ;NS at KVO	Seizure precautions
stat EEG	Lorazepam 4mg IV if status epilepticus occurs

There are new provider orders.

Which (3) orders should the nurse complete first?

- ❑ Dilantin levels
- ❑ Stat EEG
- ❑ Seizure precautions
- ❑ Neuro checks as routine
- ❑ Insert IV ;NS at KVO
- ❑ Administer lorazepam if status epilepticus occurs

Evaluate Outcomes

Tuesday 2230

Lab Result	Reference Range
Phenytoin Level 7 mcg/mL	10-20 mcg/mL

Nurses' Notes

Tuesday 2300: Tonic-Clonic seizure occurred. No safety issues/injuries occurred during seizure. Postictally the client slept for 2 hours and upon awakening had no memory of seizure. New doctor's order for increased phenytoin dosage. New increased dose of phenytoin 300 mg PO given.

Thursday 1100: Client had an uneventful hospital stay. No further seizure activity. Phenytoin level at 1000 this mornings 11 mcg/mL.

Vital Signs

Temp: 98.8 F; P: 88; B/P:110/84; O2 sat: 98% on room air. Patient remained on Phenytoin 300 mg bid PO. Patient ready for discharge.

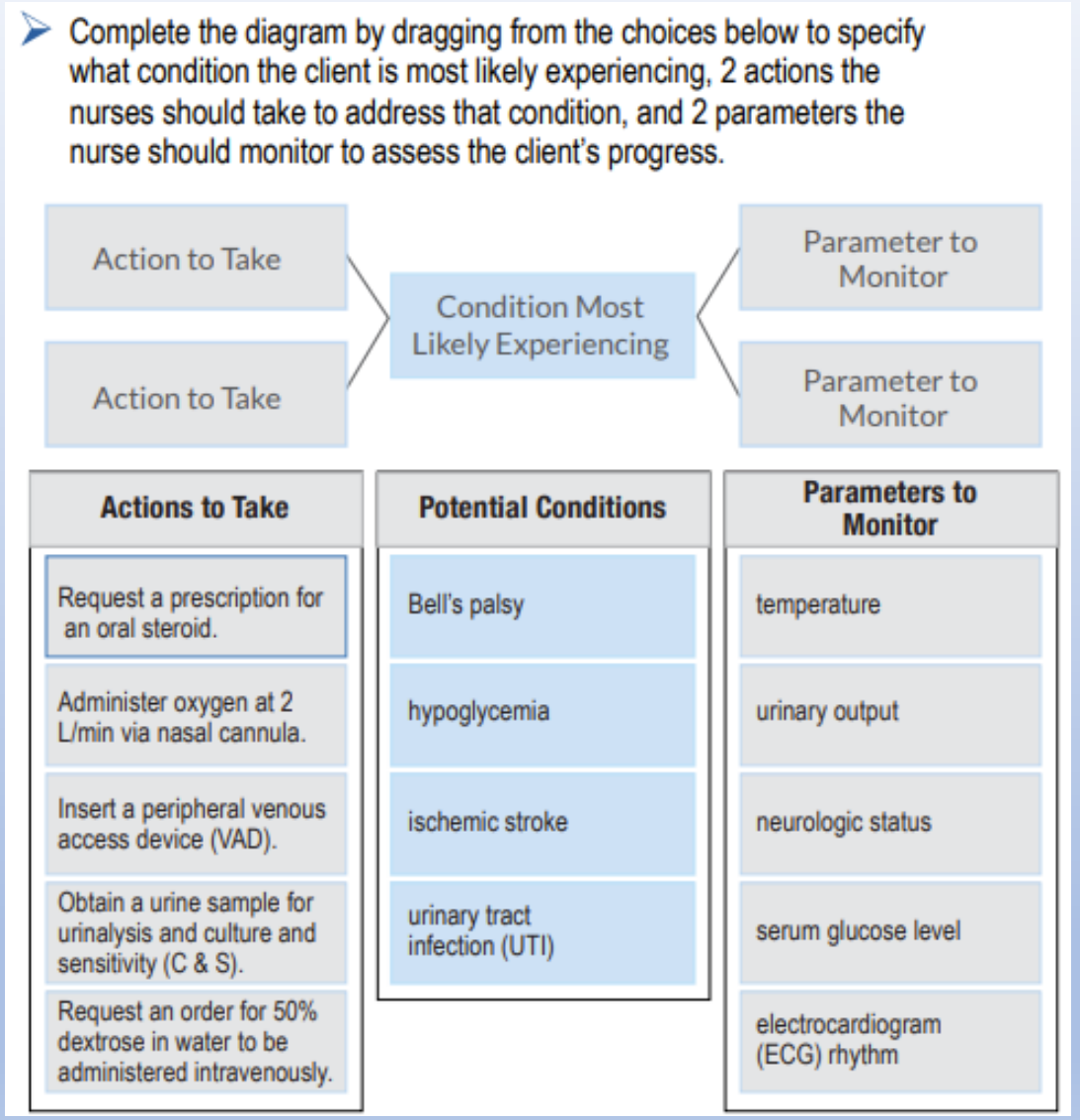
There are new results and nurses' notes.

At discharge, what statement(s) by the client indicates that he understands the discharge instructions? Select all that apply.

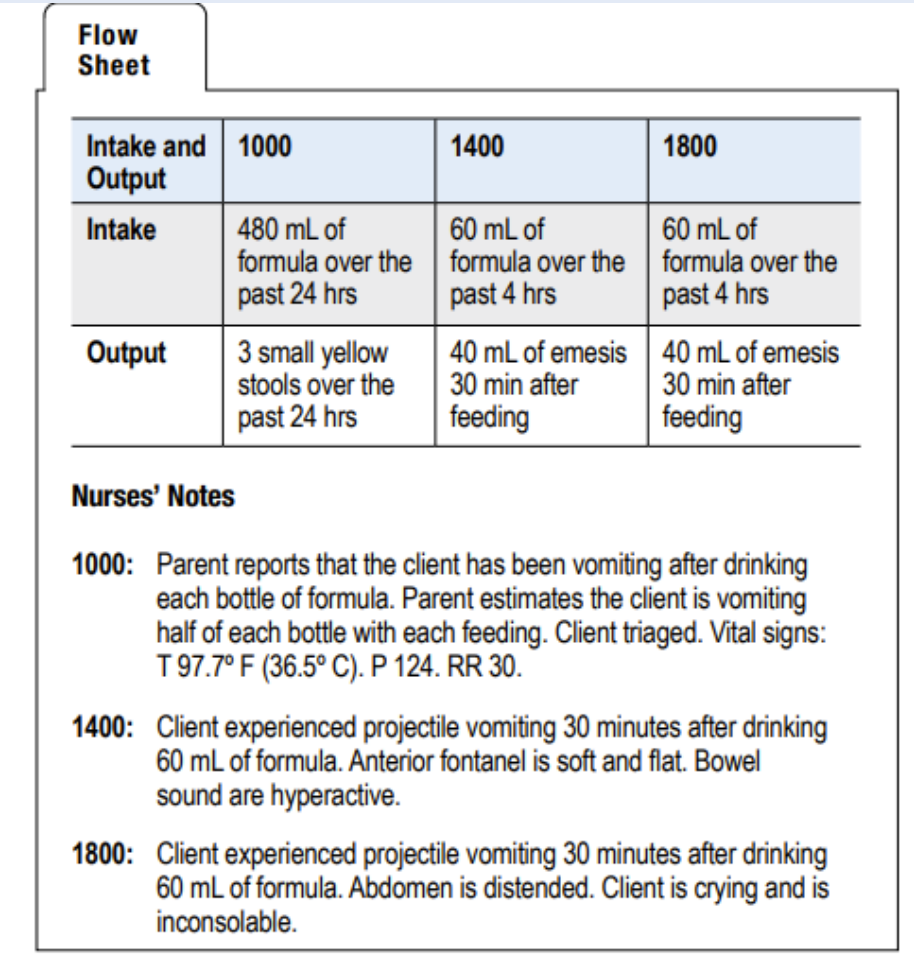
- ❑ "It is important that I not drink alcohol or take OTC cough medications."
- ❑ "I need to keep my monthly appts for phenytoin levels to be drawn."
- ❑ "I need to perform oral care twice per day."
- ❑ "I can drive after being seizure free for a week."
- ❑ "I should schedule my neurologist appointment regularly."
- ❑ "I will not discuss my seizures with people on campus so that there are no consequences with my living on campus."
- ❑ "It is important to participate in stress reduction exercises daily."
- ❑ "Only cocaine can cause my seizures to come back."

How: Bowtie

- Like Case Studies, address all 6 steps of CJM Info
- Start with middle
- Correct answers will be “drag and dropped” into Bowtie
- May include multiple tabs of info



How: Trend Item



Flow Sheet

Intake and Output	1000	1400	1800
Intake	480 mL of formula over the past 24 hrs	60 mL of formula over the past 4 hrs	60 mL of formula over the past 4 hrs
Output	3 small yellow stools over the past 24 hrs	40 mL of emesis 30 min after feeding	40 mL of emesis 30 min after feeding

Nurses' Notes

1000: Parent reports that the client has been vomiting after drinking each bottle of formula. Parent estimates the client is vomiting half of each bottle with each feeding. Client triaged. Vital signs: T 97.7° F (36.5° C). P 124. RR 30.

1400: Client experienced projectile vomiting 30 minutes after drinking 60 mL of formula. Anterior fontanel is soft and flat. Bowel sound are hyperactive.

1800: Client experienced projectile vomiting 30 minutes after drinking 60 mL of formula. Abdomen is distended. Client is crying and is inconsolable.

- Stand- alone CJ item
- Presents a case over time
- Item can be any part of clinical judgement model

Resources…

NCSBN

- Next Generation NCLEX® Newsletters
https://www.ncsbn.org/exams/next-generation-nclex/ngn-resources.page
- Next Generation NCLEX® Page
https://www.nclex.com/next-generation-nclex.page

References

NCSBN. Next Generation NCLEX News. (2021).https://www.ncsbn.org/ngn-resources.htm

NCSBN. Next Generation NCLEX News. (2022).https://www.ncsbn.org/ngn-resources.htm

NCSBN. 2019 NCLEX-RN® Test Plan (2019). https://www.ncsbn.org/public-files/2019_RN_TestPlan-English.pdf

NCSBN. 2023 NCLEX-RN® Test Plan (2023).

https://www.ncsbn.org/public-files/2023_RN_Test%20Plan_English_FINAL.pdf

Additional Unique Marshall © Strategies

Numbers Strategies©

- Number 2 (or variations of 2, i.e. 20/200)
- Range of 10-20 (most therapeutic drug levels)
- Range of 4-6 (related to time)
- Numbers which end in 0 and 5

Pharmacological Strategies©

- Generic versus Trade/Brand name
- Side Effects
- Adverse Effects
- Antidotes

Pharmacological Strategies (Con’t)

- Timing of medication administration

- What medications can/cannot be administered with

Multiple Response/Select All that Apply

- Usually 5-10 options to choose from
- Partial credit given…number right minus number wrong (incorrect or not chosen right ones)
- Think “out of the box” and broadly
  - Consider complications and broader system than simply health alteration/disease
  - Think beyond that 1 multiple choice options
  - Think beyond the obvious

MR/Select All that Apply

- Example
  - If SATA question was about assessment of patient with Lupus, then most of you would be looking for the obvious “butterfly rash” to select
  - In a SATA question, you need to think about assessments from a more broad perspective
    - What happens to the skin (think rash…dry, cracked)
    - Lupus is an autoimmune disorder so even an assessment that seems “too easy” like fever would be correct
- In reality it should be easier for you to answer SATA as you don’t have to choose the one best response but can choose several…
- Don’t let your anxiety of a different type of question get in your way of success

Dietary Strategies

Practice Questions

(Some original (Marshall) or modified, and/or adapted from work done initially for Silvetri (Saunders, 2011)

Question 1

A client with a history of hypertension has been prescribed triamterene (Dyrenium). The nurse provides information to the client about the medication and tells the client to minimize the eating of which of the following foods? Select all that apply.

a. Avocados

b. Dried prunes

c. Apples

d. Cranberries

e. Oranges

f. Boiled potatoes

Question 2

A client with a flail chest caused by four fractured rib segments is experiencing severe pain when trying to breathe. The nurse observes the client for which characteristics of a flail chest?

a. Pallor and paradoxical chest movement

b. Cyanosis and bradypnea

c. Severe dyspnea and paradoxical chest movement

d. Slight bradypnea and shallow breaths

Question 3

A client being seen in the emergency room with complaints of abdominal pain has a diagnosis of acute abdominal syndrome and the cause is undetermined at this time. The nurse would question an order for which of the following at this time?

a. Insertion of an intravenous line

b. Clear liquid diet only

c. Insertion of a nasogastric tube

d. Measurement of abdominal girth every 2 hours

Question 4

A client received a thermal burn caused by inhalation of steam. The client's mouth is edematous and their mouth is blistered. Based on these findings, the nurse should monitor the client most closely for

a. Dysphagia

b. Pain

c. Wheezing

d. Hypovolemic shock

Question 5

A nurse has given instructions to the client with chronic kidney injury about reducing pruritis from uremia. The nurse determines that the client needs further instructions if the client states to use which item for skin care?

a. Oil in the bath water

b. Lanolin-based lotion

c. Mild soap

d. Alcohol cleansing pads

Question 6

Vasopressin (Pitressin) is prescribed for a client with diabetes insipidus. The client asks the nurse about the purpose of the medication. The nurse responds, knowing that the action of the medication is to:

a. Decrease blood pressure

b. Decrease urinary output

c. Produce vasodilation

d. Inhibit smooth muscle contraction

Question 7

Neuroleptic malignant syndrome is suspected in a client who is taking an antipsychotic medication. Which medication would the nurse prepare in anticipation of being prescribed to treat this adverse reaction related tomthe use of the antipsychotic?

a. Naloxone (Narcan)

b. Bromocriptine (Parlodel)

c. Phytonadione (Vitamin K)

d. Enalapril maleate (Vasotec)

Question 8

A nurse assists with the transfer of a client from the operating room table to a stretcher. To maintain client safety, the nurse would: Select all that apply.

a. Asks the client to move self from table to stretcher if possible

b. Complete the transfer as quickly as possible

c. Checks the wheel locks of the operating room table

d. Assess the client's level of consciousness

e. Applies a safety belt to the client after the transfer

f. Wait for the client to be fully awake before transferring to stretcher

Question 9

A nurse caring for a postop client after bowel resection is restless. Vital signs indicate tachycardia and the blood pressure decreased significantly from previous readings. The nurse suspects shock and immediately:

a. Slows the IV rate infusing until talking to the dr

b. Rechecks vital signs to verify the findings

c. Checks the oxygen saturation level

d. Increases the rate of oxygen flow being delivered

Question 10

A client with an endotracheal tube gets easily frustrated when trying to communicate personal needs to the nurse. The nurse determines that which of the following methods for communication may be the easiest for the client?

a. Have the family interpret the client's needs

b. Use a pad of paper and pencil

c. Use a picture or word board

d. Devise a system of hand signals

Question 11

A nurse caring for a client receiving mechanical ventilation via an oral endotracheal tube understands the causes of the high-pressure alarm sounding include which of the following? Select all that apply.

a. A kink in the tubing

b. The ventilatory tubing disconnected from the endotracheal tube

c. The client biting the endotracheal tube

d. A mucous plug in the airway

e. A cuff leak in the endotracheal tube

f. The client gagging

Question 12

A nurse is caring for a client 1-day post-gastrectomy. The client has a NG tube, which is draining brown-tinged secretions. Which is the most appropriate nursing intervention?

a. Notify the physician STAT

b. Reposition the client

c. Irrigate the NGT

d. Document the findings

Question 13

The nurse notes an isolated PVC on the cardiac monitor. The appropriate nursing action is to:

a. Prepare to administer lidocaine hydrochloride (Xylocaine)

b. Prepare for defibrillation by cardiac team

c. Notify the physician immediately

d. Continue to monitor the rhythm

Question 14

A client has developed atrial fibrillation and has a ventricular rate of 150 beats/min. The nurse should assess the client for

a. Hypertension and headache

b. Flat neck veins

c. Hypotension and dizziness

d. Nausea and vomiting

Question 15

A nurse assesses the client with a diagnosis of thyroid storm. Which signs and symptoms associated with thyroid storm indicate a priority need for immediate nursing intervention?

a. Profuse diaphoresis, flushing, constipation

b. Fever, tachycardia, systolic hypertension

c. Hypotension, translucent skin, explosive diarrhea

d. Polyuria, severe headaches, nausea

Question 16

A neonate is diagnosed with imperforate anus. The parents ask the nurse to describe the abnormality. The nurse bases the response on which characteristic of disorder?

a. Presence of fecal incontinence

b. Infrequent and difficult passage of dry stools

c. Invagination of section of intestine into distal bowel

d. Absence of anus in normal position in perineum

Question 17

The nurse manager is planning assignments for day. Which staff members can be assigned to care for client with herpes zoster? Select all that apply.

a. Nurse who never had roseola

b. Nurse who never had mumps

c. Nurse who never had chickenpox

d. Nurse who never had German measles

e. Nurse who never received varicella-zoster vaccine

f. Nurse who has allergies to eggs

Question 18

A client who is HIV+ has had a Mantoux skin test. The nurse notes a 7 mm area of induration at site of test. The nurse interprets the results as:

a. Positive

b. Negative

c. Inconclusive

d. Need for repeat testing in 1 month

Question 19

A nurse reviews the arterial blood gas results of a client and notes the following results: pH 7.29; pCO_2 50; HCO_3 31. The nurse analyzes these results as indicating which of the following conditions?

a. Metabolic acidosis, compensated

b. Respiratory alkalosis, partially compensated

c. Metabolic alkalosis, uncompensated

d. Respiratory acidosis, partially compensated

Question 20

Prednisone is prescribed for a hospitalized client with severe asthma. Which laboratory result would the nurse monitor most closely for?

a. Serum glucose level

b. Serum cholesterol level

c. Complete blood count

d. Alpha-antitrypsin 1

Contact Information

Email: LSM4556@aol.com

Twitter/IG: @NCLEXprof

FB/LinkedIN: Lois Marshall

- (Additional Credit to Dr. Jessica Marcus)

BECOME A SIGMA NURSE.

Sigma makes nurse leaders the best they can be.

Sigma is the international honor society of nurses. Together, our dedicated members change lives and advance healthcare.

Sigma
GLOBAL NURSING EXCELLENCE

Learn how you can be a Sigma member at **Join.SigmaNursing.org**.

Sigma
REPOSITORY

A FREE, OPEN ACCESS RESOURCE FOR ALL NURSES

- ACCESS MORE THAN 13,000 MATERIALS
- SHARE YOUR KNOWLEDGE
- REACH A GLOBAL AUDIENCE

Submit your work today! Visit SigmaRepository.org to get started.

INTRODUCING

A Nurse First

Sigma's new podcast

Nursing is full of firsts. There is so much to learn from these initial experiences. A Nurse First is a podcast about firsts—stories from nurses who have been there, done that. Listen in to explore the world of nursing from all sorts of unexpected angles—leaving you to think, "What would I do if it were me?"

LISTEN ON: **Apple Podcasts | Spotify | Stitcher | Google Podcasts | YouTube**

Sigma

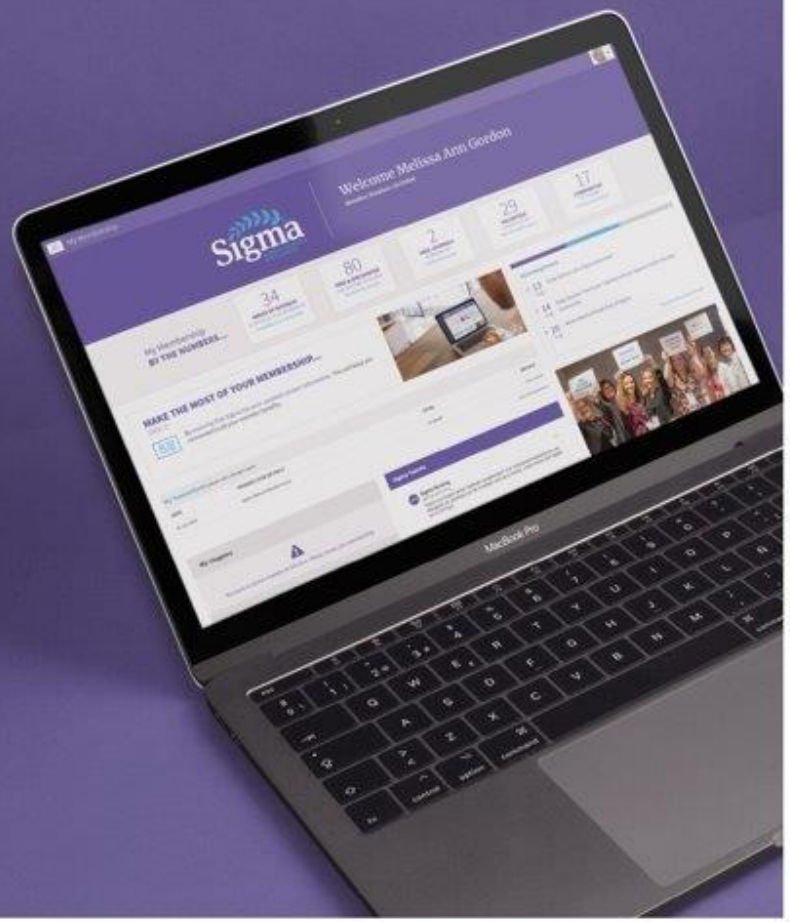
A NURSE FIRST

PODCAST

SigmaNursing.org/Podcast

Access your member benefits and more–

ALL FROM ONE PLACE!



+ **Enroll in Sigma's Automatic Membership Renewal Program** so that you retain your exclusive member benefits.

+ **View and print your invoices,** including membership receipts, at your convenience.

+ **Access more than 120 free and discounted nursing continuing professional development (NCPD) courses** valued at US $1,500!

+ **View your chapter news** and stay informed with the latest announcements.

+ **Register for upcoming training opportunities,** including the latest Sigma member webcasts.

Start accessing your member benefits today!

Membership.SigmaNursing.org

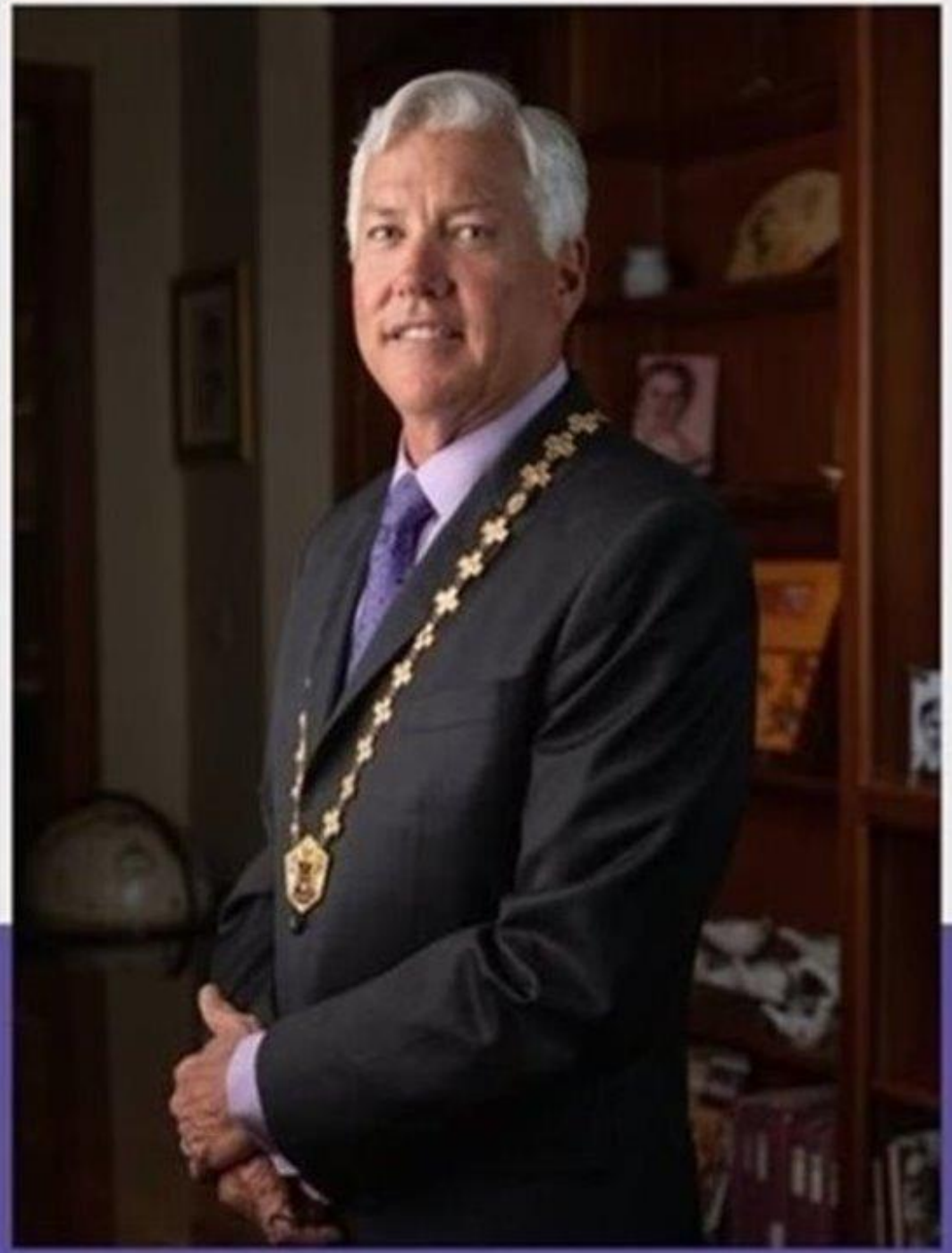
ABU DHABI, UNITED ARAB EMIRATES | 20-23 July 2023
VIRTUAL | 2-4 August 2023
a Sigma event
CONGRESS 2023
REGISTER TODAY! SigmaNursing.org/Congress/Registration
Early Registration Deadline: 24 May 2023

Volunteer with Sigma

Become an abstract or grant reviewer!

critique research grant proposals
and/or abstract submissions

Current reviewers will need to re-apply by completing the new application.



BE BOLD

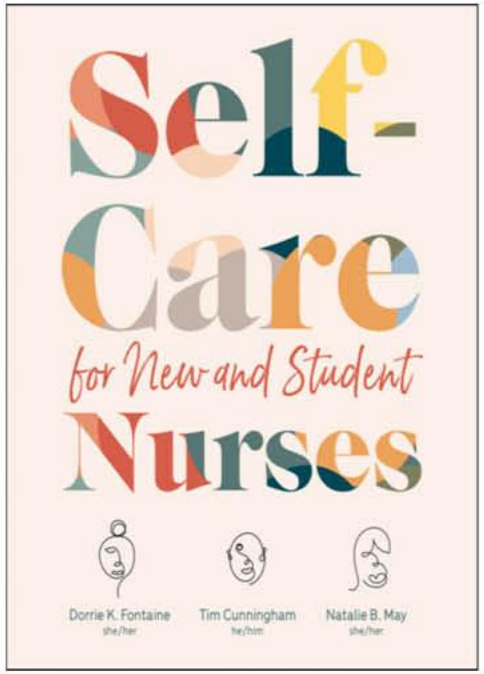
JOIN THE PRESIDENT'S CIRCLE

Make two donations in the 2021-2023 biennium to be recognized by Ken Dion in his President's Circle.

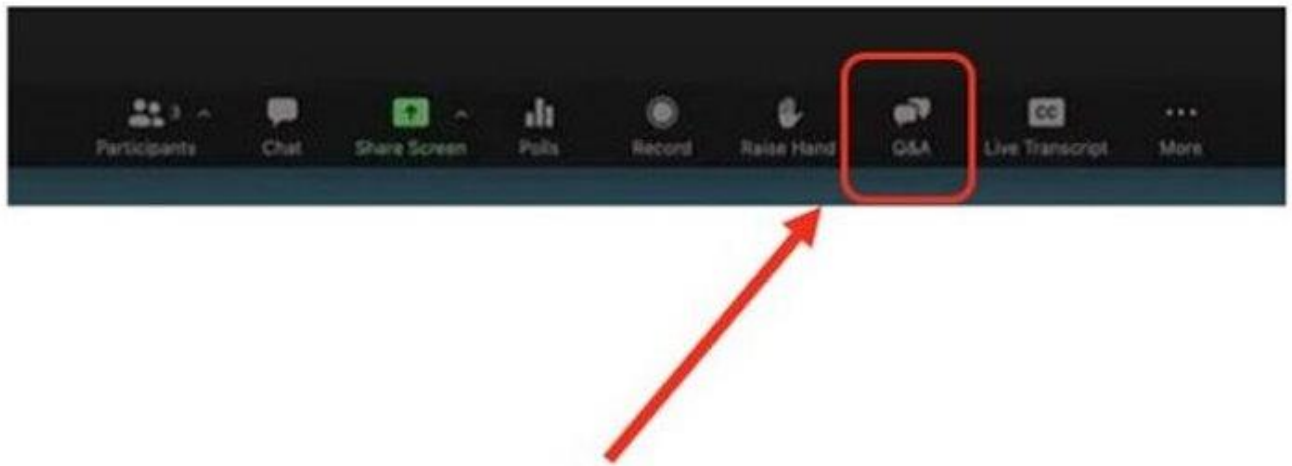
Sigma
FOUNDATION FOR NURSING

Sigma MARKETPLACE

Want to dive deeper into today's topic? Check out these resources and more at **SigmaMarketplace.org**!



QSEN 2020: Preparing Students for the Next Generation of NCLEX (NGN) with Clinical Judgement - Online Course

Sigma members: You automatically save 10% on all books and NCPD from Sigma Marketplace!

Submitting Questions