

NGN Question Format Guide

All 6 official Next Gen NCLEX formats — what they look like, how to approach each one

01 EXTENDED MULTIPLE RESPONSE (SATA)

Used for: Step 1 (Recognize Cues), Step 4 (Generate Solutions)

What it is:

Like traditional SATA but with 7-8 options instead of 5. Partial credit applies — you can get some answers right and some wrong.

Strategy:

- Read ALL options before selecting — more options means more distractors
- Evaluate each option independently: is THIS one correct on its own?
- Partial credit: select what you know, do not leave blank
- Watch for "plausible but not priority" distractors (e.g., mild headache in a sepsis scenario)

Example:

The nurse assesses a patient post-op day 1 after abdominal surgery. Which findings require immediate follow-up? (Select all that apply) A. HR 112 B. Temp 38.2°C C. BP 90/58 D. Urine output 20mL/hr E. SpO2 96% F. Patient rates pain 6/10 G. Abdomen distended, rigid H. WBC 14.2
Answer: A, C, D, G — all indicate potential hemorrhage / peritonitis

02 CLOZE (DROP-DOWN)

Used for: Step 2 (Analyze Cues)

What it is:

Complete clinical sentences by selecting the correct word/phrase from drop-down menus. Tests your ability to connect cues into a clinical picture.

Strategy:

- Read the full sentence before looking at options — predict the answer first
- Each blank is independent — a wrong answer in blank 1 does not affect blank 2
- Look for pathophysiology logic: cause → effect → clinical sign
- Eliminate physiologically impossible options first

Example:

The patient is most likely experiencing [1: septic shock / cardiogenic shock / DKA] as evidenced by [2: hypotension and tachycardia / bradycardia / hypertension] and [3: oliguria / polyuria / normal urine output]. The priority concern is [4: cardiovascular / respiratory / renal] failure. Answer: 1=septic shock, 2=hypotension and tachycardia, 3=oliguria, 4=cardiovascular

03

MATRIX / GRID

Used for: Step 4 (Generate Solutions), Step 6 (Evaluate Outcomes)

What it is:

A table where each row is an intervention or finding, and columns are categories (e.g. Indicated / Contraindicated / Non-Essential, or Effective / Ineffective).

Strategy:

- Treat each row as a separate question — do not let one answer bias another
- For interventions: Indicated = will help, Contraindicated = will harm, Non-Essential = irrelevant
- For outcomes: Effective = expected improvement sign, Ineffective = no change or worsening
- Think about the pathophysiology — what would this condition expect/require?

Example:

For a patient in septic shock, indicate: Indicated / Contraindicated / Non-Essential 1. Administer O2 via NRB mask → Indicated 2. Restrict IV fluids to 30mL/hr → Contraindicated 3. Obtain blood cultures x2 before antibiotics → Indicated 4. Trendelenburg position → Contraindicated (raises ICP, impairs breathing) 5. Continuous cardiac monitoring → Indicated

04

HIGHLIGHTING (HOT SPOT)

Used for: Step 1 (Recognize Cues)

What it is:

A mock medical document (nurse note, lab report, MAR, physician orders). You identify and list the clinically significant findings.

Strategy:

- Read the entire document first before identifying findings
- Flag: abnormal vitals, critical lab values, new or changed symptoms, allergy conflicts
- Consider the baseline: a "normal" value may be abnormal for this patient (e.g., low BP in a hypertensive patient)
- Think: what would I call the doctor about right now?

Example:

Nurse's Note 0600: Patient Maria S., 67F, pneumonia day 3. RR 26, SpO2 89% on 2L NC. BP 94/58 (baseline 138/82). HR 114. Temp 39.6°C. Urine 25mL x 4h. Labs: WBC 18.2, Lactate 3.8, Creatinine 2.1 (baseline 0.9). Confused since 0400. Critical findings: SpO2 89%, MAP low (BP 94/58 vs baseline), oliguria, Lactate 3.8 (>2 = sepsis), Creatinine 2.1 (AKI), new confusion

05 EXTENDED DRAG AND DROP

Used for: Step 3 (Prioritize Hypotheses), Step 5 (Take Actions)

What it is:

Arrange 5-6 items in the correct priority order. On the real exam, you drag items into ranked positions. In NurseIQ, you type the order.

Strategy:

- Apply ABCs: if airway/breathing/circulation is involved, it goes first
- Assessment comes before intervention — unless immediate life threat
- Least invasive → most invasive
- Independent nursing action → collaborative (call provider)
- Documentation always comes last

Example:

Priority-rank these actions for a deteriorating patient (1=first, 6=last): A. Notify physician (SBAR) B. Increase O₂, HOB 45° C. Obtain IV access D. Assess airway and LOC E. Administer IV fluid bolus F. Document Answer: D=1, B=2, C=3, E=4, A=5, F=6

06 BOW-TIE

Used for: Step 5 (Take Actions), Step 3 (Prioritize)

What it is:

Three-part clinical reasoning diagram: Actions to Take (left, choose 2) → Potential Condition (center, choose 1) → Parameters to Monitor (right, choose 2).

Strategy:

- Start with the CENTER: identify the condition from the cues first
- Left side (Actions): what would a nurse DO for this condition?
- Right side (Monitor): what objective data proves treatment is working?
- Think in chains: the condition explains the actions and the monitoring parameters
- Actions and monitoring should be directly linked to the condition — not generic nursing care

Example:

Actions (choose 2): A. IV fluid bolus 30mL/kg B. Restrict fluids C. Broad-spectrum antibiotics D. Ice packs Condition (choose 1): E. Septic shock F. Hypovolemic shock G. Cardiogenic shock Monitor (choose 2): H. MAP \geq 65 I. Daily weight J. Urine output \geq 0.5mL/kg/hr K. Skin turgor Answer: Actions=A,C | Condition=E | Monitor=H,J

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