# PRACTICE EXAM 11 — FULL-LENGTH SIMULATION (115 QUESTIONS)

1. A nurse manager is training staff to use motivational interviewing techniques when communicating with patients about lifestyle modifications. Motivational interviewing is a collaborative, patient-centered approach that explores and resolves ambivalence about behavior change. Which nurse behavior BEST exemplifies a core motivational interviewing skill?

A. Telling the patient exactly what changes they need to make and explaining the health consequences of not changing

B. Providing the patient with written educational materials about their condition and recommended lifestyle changes

C. Identifying the patient's resistance to change and challenging it directly with evidence of the health risks associated with non-adherence

D. Using open-ended questions, reflective listening, and affirmations to explore the patient's own reasons for change and evoke their personal motivation rather than imposing external pressure

2. A nurse manager is developing a strategy for managing situations where patients leave against medical advice. The unit's AMA discharge rate is eight percent, which is above the organizational average of four percent. Exit data shows that sixty percent of AMA discharges cite long wait times, unaddressed pain, or feeling unheard as contributing factors. Which intervention is MOST likely to reduce the AMA rate?

A. Implement a mandatory psychiatric consultation for all patients who request AMA discharge to assess their decision-making capacity

B. Address the underlying drivers by implementing a proactive patient rounding program that identifies and resolves complaints about wait times, pain management, and communication before patients reach the decision to leave

C. Require the attending physician to personally speak with every patient who requests AMA discharge to explain the medical risks of leaving

D. Revise the AMA discharge documentation to make the process more time-consuming, discouraging patients from following through with the decision

3. A nurse manager is implementing a patient portal engagement strategy. The hospital's patient portal allows patients to view test results, communicate with providers, request prescription refills, and access educational materials. Current portal activation among the unit's discharged patients is twenty-two percent. Which strategy is MOST likely to increase portal engagement?

A. Send a post-discharge email to all patients with instructions for activating the portal and a link to a tutorial video

B. Integrate portal activation into the admission or discharge process with staff-assisted enrollment, demonstrate the portal's features using the patient's own clinical data, and provide a bedside practice session where the patient accesses their information with nursing support

C. Distribute printed brochures about the portal at every nursing station and in the patient admission packet

D. Require all nursing staff to mention the portal during every patient interaction and document that they promoted the portal in their nursing notes

4. A nurse manager is developing a family-centered rounding model where the interdisciplinary team conducts daily rounds at the patient's bedside with family members present and participating. Several physicians resist the model, stating that family presence slows the rounding process and creates pressure to simplify clinical discussions. Which response is MOST effective?

A. Limit family presence during rounding to specific non-clinical discussion items such as discharge planning and patient education

B. Allow physicians to opt out of family-centered rounding individually and evaluate whether patients of participating physicians have better outcomes than patients of non-participating physicians

C. Present evidence showing that family-centered rounding improves patient and family satisfaction, reduces errors through enhanced communication, and does not significantly extend rounding time when structured effectively, and pilot the model with willing physicians to demonstrate its feasibility

D. Implement the model as mandatory and require physicians to adapt their communication style to include family-friendly clinical explanations

5. A nurse manager is applying the teach-back method as a systematic approach to verifying patient comprehension. Research shows that patients retain only ten to twenty percent of medical information discussed during clinical encounters. A nurse reports that she uses teach-back but patients seem annoyed when asked to repeat information. Which coaching point is MOST important?

A. Coach the nurse to frame teach-back as the nurse's responsibility — saying "I want to make sure I explained this clearly, so can you tell me in your own words..." rather than framing it as a test of the patient's understanding, which shifts accountability from the patient to the nurse and reduces the perception of being quizzed

B. Instruct the nurse to use teach-back only with patients who appear confused and to skip it for patients who seem to understand

C. Suggest the nurse simplify the information further so patients do not need to repeat complex concepts

D. Recommend that the nurse use written quizzes instead of verbal teach-back since some patients prefer written formats

6. A nurse manager is responsible for a unit where a virtual nursing model has been partially implemented. Virtual nurses conduct admission assessments, discharge education, and medication reconciliation via video from a centralized location, while bedside nurses focus on hands-on clinical care. Patients report feeling confused about who is responsible for their care when they interact with both a bedside nurse and a virtual nurse. Which communication adjustment is MOST effective?

A. Assign each patient exclusively to either a virtual nurse or a bedside nurse — not both — to eliminate role confusion

B. Provide patients with a written role description card explaining the difference between virtual and bedside nursing functions

C. Implement a structured introduction protocol where the bedside nurse introduces the virtual nurse by name and role during admission, explains the complementary relationship between the two nurses, and ensures the patient understands how to contact each nurse for different needs

D. Eliminate the virtual nursing model since patient confusion indicates the model is not compatible with patient-centered care

7. A nurse manager is developing a structured escalation language protocol for nursing staff to use when they feel their clinical concerns about a patient are not being adequately addressed by the physician. The protocol must balance assertiveness with professional respect. Which escalation framework is MOST effective?

A. Require nurses to document their clinical concerns in the medical record and wait for the physician to review the documentation during their next chart review

B. Implement a single standardized phrase such as "I need you to come to the bedside now" that all nurses use when escalating concerns regardless of the specific clinical situation

C. Develop a tiered escalation language protocol with progressively assertive communication stages — beginning with structured SBAR communication, escalating to a direct statement of safety concern, and culminating in activation of the chain of command — with clear criteria for when each level is appropriate

D. Train nurses to contact the attending physician's supervisor directly whenever they disagree with a clinical decision rather than attempting further communication with the primary physician

8. A nurse manager is implementing an interprofessional education collaborative practice model based on the IPEC competency framework. The four IPEC core competencies are values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork. Which unit-level activity MOST effectively develops all four competencies simultaneously?

A. Regular interprofessional simulation exercises where nursing, medical, pharmacy, and therapy students and staff manage complex patient scenarios together, followed by structured debriefing that addresses each IPEC competency domain

B. Monthly interprofessional case conferences where each discipline presents their perspective on a shared patient case

C. A required reading assignment on interprofessional collaboration that all disciplines complete independently and discuss during a quarterly meeting

D. Job shadowing experiences where nurses spend a half-day observing other disciplines' workflow and responsibilities

9. A nurse manager is addressing a situation where a patient has requested access to their complete medical record through the patient portal in real time, including clinician notes, pathology results, and imaging reports. Under the 21st Century Cures Act information blocking provisions, patients have the right to access their electronic health information without delay. A nurse expresses concern that a patient may see abnormal test results before the physician has had an opportunity to explain them. Which response is MOST appropriate?

A. Acknowledge the nurse's concern while explaining that the Cures Act requires timely release of results, and develop a workflow where the care team proactively contacts patients before or shortly after results are released to provide context and answer questions

B. Configure the portal to delay the release of abnormal results by forty-eight hours so physicians can contact patients first

C. Allow the physician to decide which results are released through the portal and which are held for in-person discussion

D. Exempt abnormal results from portal release and require patients to schedule an appointment to receive them in person

10. A nurse manager is developing a care coordination communication strategy for patients who receive care from multiple specialists during a single hospitalization. Data shows that communication gaps between consulting services result in conflicting treatment plans, duplicate diagnostic tests, and medication interactions. Which intervention is MOST effective?

A. Assign the primary nurse as the sole point of contact for all specialist communication to prevent information fragmentation

B. Require all consulting services to document their recommendations in a shared section of the medical record that all providers review before making clinical decisions

C. Implement a daily interdisciplinary care coordination huddle where the primary team and all active consultants briefly align on the patient's plan, resolve conflicts, and designate a single point of accountability for each clinical domain

D. Require the attending physician to manage all specialist communication since care coordination is the attending's primary responsibility

11. A nurse manager is implementing a "closed-loop" communication standard for critical test result notification. Closed-loop communication requires the sender to transmit the message, the receiver to acknowledge and read back the message, and the sender to confirm the read-back is accurate. A nurse reports that some physicians consider the read-back step unnecessary and refuse to participate. Which action is MOST appropriate?

A. Exempt physicians who refuse to participate from the read-back requirement since forcing compliance may damage the nurse-physician relationship

B. Address the non-compliance through the organizational chain of command, present evidence that closed-loop communication reduces critical result notification errors, and establish that the read-back requirement applies to all clinicians regardless of discipline

C. Allow nurses to skip the read-back when physicians refuse and document in the chart that the physician declined the confirmation step

D. Replace the verbal read-back with a written confirmation sent through the electronic health record to eliminate the need for real-time verbal verification

12. A nurse manager is developing a communication strategy for managing a patient who has been identified as a "frequent flyer" — a patient with multiple hospitalizations within a short period. Staff express frustration and negative attitudes toward the patient, using language like "she's back again" and "she never follows her discharge instructions." Which intervention is MOST important?

A. Assign a consistent nursing team to the patient to develop continuity and prevent the patient from being viewed as a burden that is passed between staff

B. Counsel individual staff members about unprofessional language and attitudes toward patients with complex care needs

C. Address the language and attitudes as a unit culture issue, reframe frequent readmissions as a system failure rather than a patient failure, investigate the specific barriers driving readmission, and develop a comprehensive care plan that addresses the root causes including social determinants, health literacy, and care coordination gaps

D. Refer the patient to case management for intensive discharge planning to prevent future readmissions and reduce staff exposure to the frustration

13. A nurse manager is implementing a nurse-led health coaching program where trained nurses provide ongoing support to patients with chronic conditions through scheduled telephone and video contacts after discharge. Health coaching differs from traditional patient education by focusing on the patient's self-identified goals and intrinsic motivation rather than clinician-directed information transfer. Which nurse behavior BEST reflects the health coaching approach?

A. Asking the patient what health goals are most important to them, helping them develop a personalized action plan, supporting self-efficacy through incremental success, and following up regularly to celebrate progress and adjust the plan collaboratively

B. Providing the patient with a comprehensive disease management manual and reviewing key sections during each coaching contact

C. Developing a structured education curriculum for each chronic condition and delivering the content sequentially across multiple coaching sessions

D. Assessing the patient's knowledge gaps and providing corrective education on the topics where the patient demonstrates the weakest understanding

14. A nurse manager is addressing a pattern where physicians write discharge orders without communicating with the nursing team about the patient's readiness. The unit has implemented a "discharge huddle" that occurs each morning, but physicians frequently skip it. The nurse manager has discussed the issue informally with the physicians without success. Which escalation approach is MOST appropriate?

A. Implement a nursing policy requiring nurses to hold discharge processing until the physician participates in the discharge huddle

B. Accept that physician participation in the huddle will be inconsistent and develop a nursing workaround that captures discharge readiness information independently

C. Present data showing the correlation between missed discharge huddles and discharge-related safety events and readmissions to the medical staff leadership, propose a joint accountability solution, and request that the expectation for huddle participation be incorporated into medical staff expectations

D. Replace the daily huddle with an electronic discharge readiness checklist that the physician completes in the medical record before entering the discharge order

15. A nurse manager is coaching a nurse who has strong technical communication skills but lacks warmth during patient interactions. Patients describe the nurse as "efficient but cold." Video observation reveals that the nurse makes minimal eye contact, rarely uses the patient's name, and does not pause for the patient to ask questions during clinical explanations. Which coaching approach is MOST targeted?

A. Use the video observation as a coaching tool — review the specific moments where warmth cues are missing, demonstrate alternative approaches using the same clinical content, practice the revised communication style through role-play, and provide real-time feedback during subsequent patient interactions

B. Require the nurse to attend a customer service training program offered by the hospital's patient experience department

C. Pair the nurse with a colleague who has high patient satisfaction scores so she can observe and model warm communication techniques

D. Advise the nurse that her technical competence is valued and that warmth is a personality trait that cannot be changed through coaching

16. A nurse manager is developing a communication protocol for managing patients who request information about their nurse's personal life — asking questions such as whether the nurse is married, has children, or what neighborhood they live in. Some nurses feel uncomfortable with personal questions and are unsure how to respond without seeming unfriendly. Which guidance is MOST appropriate?

A. Instruct nurses to answer all personal questions honestly since building rapport with patients requires personal connection and transparency

B. Provide staff with strategies for redirecting personal questions warmly by acknowledging the patient's interest in connection, offering a brief appropriate response if comfortable, and refocusing the conversation on the patient's needs and care, while respecting each nurse's right to determine their own personal sharing boundaries

C. Implement a policy prohibiting nurses from sharing any personal information with patients to maintain professional boundaries consistently across the team

D. Advise nurses to deflect all personal questions with humor to maintain a friendly atmosphere without disclosing personal information

17. A nurse manager is addressing a situation where a physician consistently enters patient rooms without knocking and interrupts nursing care activities without acknowledging the nurse's presence. Patients have noticed the behavior and commented that "the doctor doesn't seem to respect the nurses." Which action is MOST appropriate?

A. Post a sign on each patient room door requesting that all providers knock before entering

B. Instruct nurses to assertively re-establish their presence when the physician enters by saying "Doctor, I am currently providing care to this patient and will be finished in a moment"

C. Report the physician's behavior to the chief medical officer as a pattern of disrespectful conduct that patients have observed

D. Address the physician directly in a private conversation, describe the specific behaviors and their impact on nursing staff and patient perception, and establish expectations for professional courtesy that include knocking before entering and acknowledging the nurse's ongoing care activities

18. A nurse manager is developing a structured approach to managing patient complaints that arise from unmet expectations rather than from actual care deficiencies. For example, a patient complains that the nurse did not bring pain medication within five minutes of the request, when the actual administration time was fourteen minutes — within the organizational standard of thirty minutes. Which communication approach is MOST effective?

A. Explain to the patient that the fourteen-minute response time meets organizational standards and that the expectation of five-minute medication delivery is unrealistic

B. Acknowledge the patient's experience of waiting, validate that pain makes any wait feel longer, explain the medication administration process and timeline, and work with the patient to develop a proactive pain management plan that reduces the need for as-needed requests

C. Apologize for the delay and commit to faster response times in the future to preserve patient satisfaction

D. Document the complaint as unfounded since the care met organizational standards

19. A nurse manager is implementing a standardized approach to communicating with patients about potential medical errors. The organization's disclosure policy requires honest communication about adverse events. A nurse administered a medication thirty minutes late, resulting in a temporary but

measurable clinical effect. The patient is unaware of the timing error. Which guidance is MOST appropriate?

A. Follow the organizational disclosure policy by informing the patient that the medication was administered later than intended, explain what happened and why, describe the clinical effect and the plan to prevent recurrence, and document the disclosure in the medical record

B. Do not inform the patient since the clinical effect was temporary and resolved without additional intervention

C. Report the error through the incident reporting system but do not disclose it to the patient since the temporary clinical effect does not constitute meaningful patient harm

D. Allow the attending physician to decide whether disclosure is appropriate since medication timing errors are a clinical judgment matter

20. A nurse manager is responsible for a unit where nursing staff are experiencing "compassion fatigue" — a gradual decline in the ability to empathize with patients resulting from continuous exposure to patient suffering. Staff report feeling emotionally numb during patient interactions and going through the motions of empathetic communication without genuine emotional engagement. Which intervention is MOST effective?

A. Implement a multifaceted compassion resilience program that includes self-awareness education on recognizing compassion fatigue symptoms, peer support structures, scheduled restorative activities during shifts, professional counseling access, workload management that prevents emotional overload, and leadership modeling of self-care practices

B. Rotate nurses to lower-acuity units periodically to provide emotional recovery time from high-intensity patient interactions

C. Require nurses experiencing compassion fatigue to take a mandatory leave of absence until they complete a resilience training program

D. Increase the frequency of patient recognition events and positive feedback to staff to counterbalance the emotional toll of caring for suffering patients

21. A nurse manager is addressing a communication challenge created by the increasing use of secure text messaging for clinical communication between nurses and physicians. While texting has improved

response times, nurses report that physicians sometimes respond to clinical questions with single-word answers or emojis that are ambiguous and difficult to interpret. Which intervention is MOST effective?

A. Prohibit the use of emojis and abbreviations in clinical text messages and require full sentences for all clinical communication

B. Replace text messaging with traditional telephone calls for all clinical communication to ensure clarity

C. Implement a secure text-based ordering system that eliminates the need for text-based clinical discussions

D. Develop a secure messaging communication standard that defines expected response format for different message types, establishes that clinical questions require substantive responses, provides examples of appropriate and inappropriate text responses, and creates an escalation pathway when text communication is insufficient for the clinical situation

22. A nurse manager is developing a strategy for managing communication with patients who have cognitive impairments such as delirium, dementia, or traumatic brain injury. Staff report feeling uncertain about how to communicate effectively when patients cannot participate in standard information exchange. Which approach is MOST comprehensive?

A. Assign the most experienced nurses to patients with cognitive impairments since they have developed communication skills through years of clinical experience

B. Implement a cognitive assessment screening tool at admission and assign patients to a tiered communication protocol based on their cognitive status

C. Educate staff on communication strategies specific to cognitive impairment including simplified language, one-step instructions, visual cues, consistent routine, reduced environmental stimulation, patience with processing time, and caregiver involvement, and integrate cognitive status into the nursing care plan as a communication modifier

D. Rely on family members to serve as communication intermediaries for all clinical interactions with cognitively impaired patients

23. A nurse manager is implementing a care transitions communication model based on the Coleman Care Transitions Intervention. The model uses a transitions coach who supports patients through four

pillars: medication self-management, use of a personal health record, timely follow-up care, and recognition of red flag symptoms. Which element is MOST critical for successful implementation?

A. Hiring a dedicated care transitions coach with advanced practice nursing credentials

B. Developing comprehensive patient education materials that cover all four pillars of the Care Transitions Intervention

C. Training the transitions coach to empower patients to develop self-management skills rather than creating dependency on the coach, ensuring that the patient — not the coach — takes the lead in managing their own health information, medications, appointments, and symptom monitoring

D. Implementing the program for all discharged patients regardless of readmission risk level

24. A nurse manager is developing a strategy to improve nurse-to-nurse handoff communication during internal patient transfers between the emergency department and the medical-surgical unit. Data shows that the most frequently lost information during ED-to-floor transfers includes pending diagnostic results, administered-but-not-yet-charted medications, and patient communication preferences. Which intervention MOST directly addresses these specific gaps?

A. Develop a transfer-specific addendum to the standard handoff tool that explicitly prompts communication of pending results, recently administered medications not yet documented, and any patient communication needs identified during the ED visit

B. Require the ED nurse to fax a complete copy of the ED chart to the receiving unit before the patient is transported

C. Implement a face-to-face handoff requirement where the ED and receiving nurses must conduct the handoff at the patient's bedside during the transfer

D. Assign a dedicated transfer nurse on each shift who accompanies every patient from the ED to the floor and provides the handoff to the receiving nurse

25. A nurse manager receives feedback that a nurse's documentation of patient education consistently uses the phrase "patient verbalized understanding" without any description of what the patient actually said or demonstrated. This documentation does not provide evidence that comprehension was verified. Which coaching approach is MOST effective?

A. Teach the nurse to document the specific content the patient stated during teach-back verification — for example, "patient demonstrated correct insulin injection technique and correctly stated three signs of hypoglycemia" — so the documentation provides auditable evidence of comprehension rather than a generic statement

B. Require the nurse to have a witness present during all patient education sessions to verify that comprehension was assessed

C. Implement a standardized patient education documentation template that includes a checklist of topics taught and a signature line where the patient confirms understanding

D. Counsel the nurse that "patient verbalized understanding" is an accepted documentation standard and does not require additional detail

26. A nurse manager is developing a communication plan for a situation where the unit must temporarily close two patient rooms for renovation, reducing capacity from thirty to twenty-eight beds. The closure will last six weeks. Admitting services, the emergency department, and other units that typically transfer patients to this unit must be informed. Which communication element is MOST critical?

A. Notification to all stakeholders at least two weeks before the closure with a detailed plan for managing patient flow during the reduced capacity period

B. An emergency plan for situations where all twenty-eight remaining beds are occupied and a patient requiring admission to the unit presents to the emergency department

C. A construction timeline shared with all stakeholders showing the projected completion date and milestones

D. A comprehensive communication plan that includes advance notification to all affected departments, a modified bed management protocol for the six-week period, an escalation pathway for capacity emergencies, daily census monitoring with automatic notification when census approaches capacity, and a re-opening communication when construction is complete

27. A nurse manager is implementing a structured approach to conducting "comfort rounds" — purposeful nurse visits to patients at regular intervals specifically focused on comfort needs such as pain, positioning, personal needs, and possessions within reach. Research shows that comfort rounding reduces call light use by up to forty percent and decreases patient falls. After three months, compliance with the rounding protocol is seventy-eight percent but call light reduction is only twelve percent. Which analysis is MOST important?

A. Increase compliance from seventy-eight percent to ninety-five percent since the limited call light reduction is likely due to incomplete implementation

B. Survey patients about whether they value the comfort rounds to determine whether the program should be continued

C. Evaluate whether the rounds are being conducted with fidelity to the protocol — specifically whether nurses are genuinely assessing and addressing all four comfort domains during each round or simply checking a box and moving on — since protocol compliance without content fidelity produces diminished results

D. Extend the evaluation period to six months since three months is insufficient to demonstrate the full impact of comfort rounding

28. A nurse manager is developing a communication strategy for managing a patient who uses social media to live-stream their hospitalization experience including interactions with nursing staff, medication administration, and clinical conversations. The patient is alert, oriented, and legally capable of making decisions about their own information sharing. Several nurses refuse to provide care while being recorded. Which approach is MOST appropriate?

A. Prohibit all live-streaming of patient care on the unit regardless of the patient's consent since staff have a right to privacy in their workplace

B. Require the patient to stop live-streaming immediately and threaten discharge if the behavior continues

C. Develop a balanced approach that respects the patient's right to share their own experience while protecting staff privacy by establishing that staff may decline to be filmed without the patient's experience being compromised, offering reasonable accommodations such as audio-only recording during clinical procedures, and creating guidelines for what can and cannot be recorded based on organizational policy

D. Allow unrestricted live-streaming since the patient has the right to document their own medical experience and staff working in patient care areas have no expectation of privacy

29. A nurse manager is developing a communication protocol for managing patients who express suicidal ideation during routine clinical interactions on a medical-surgical unit. Currently, nurses handle these disclosures inconsistently — some immediately call a psychiatric consultation while others document the statement and continue with their care activities. Which protocol element is MOST critical?

A. A standardized immediate response protocol that includes staying with the patient, conducting a brief safety assessment, removing potentially harmful items from the room, notifying the physician and psychiatry, implementing one-to-one observation if indicated, and documenting the interaction — ensuring that all staff respond consistently to suicidal ideation disclosures regardless of the clinical context

B. A training program that teaches nurses to assess the severity of suicidal ideation and respond proportionally based on their assessment of the patient's risk level

C. A policy requiring immediate transfer to the psychiatric emergency department for any patient who expresses suicidal ideation on a medical-surgical unit

D. A referral protocol where nurses document the disclosure and notify the social worker to follow up with the patient within twenty-four hours

30. A nurse manager is responsible for a unit where a sentinel event has occurred — a patient received a blood transfusion intended for a different patient. The Joint Commission defines a sentinel event as a patient safety event that reaches the patient and results in death, permanent harm, or severe temporary harm. Which action should the nurse manager take FIRST?

A. Convene the root cause analysis team to begin investigating the contributing factors immediately while the details are fresh

B. Ensure the patient's immediate clinical needs are addressed by managing the transfusion reaction, notify the attending physician and blood bank, implement the organization's sentinel event response protocol, and secure all relevant documentation and blood products for investigation

C. Notify The Joint Commission of the sentinel event within the required reporting timeframe

D. Identify the staff members involved in the wrong-patient transfusion and remove them from patient care pending investigation

31. A nurse manager is implementing a safe patient handling and mobility program on the unit. The program requires the use of mechanical lift equipment for all patient transfers and repositioning when the patient exceeds the safe manual lifting threshold. Several experienced nurses resist using the equipment, stating that manual lifting is faster and that they have lifted patients manually for their entire careers without injury. Which response is MOST appropriate?

A. Allow experienced nurses to use manual lifting techniques for patients they feel comfortable handling since their experience reduces injury risk

B. Grandfather the experienced nurses and apply the mechanical lift requirement only to newer staff who have been trained on the equipment

C. Provide additional training on proper manual lifting techniques so experienced nurses can continue their preferred method safely

D. Address the resistance by presenting evidence that cumulative musculoskeletal injury from manual patient handling is often asymptomatic until irreversible damage has occurred, demonstrate how equipment use protects both the nurse and the patient, establish the policy as non-negotiable, and enforce compliance consistently

32. A nurse manager is developing a unit-level response plan for managing a patient who experiences a transfusion reaction. The plan must ensure rapid recognition, immediate intervention, and proper specimen management. Which element is MOST critical for preventing a second patient from receiving the wrong blood product after a wrong-patient transfusion has been identified?

A. Immediately notifying the blood bank so they can verify the identification of all blood products currently issued and in process, place a hold on any pending transfusions until verification is complete, and trace the intended product to determine whether it was administered to another patient

B. Documenting the transfusion reaction in the patient's medical record with a detailed description of the signs and symptoms observed

C. Collecting the required post-reaction blood samples from the patient and returning them to the blood bank with the remaining blood product and administration tubing

D. Reporting the event through the hospital's incident reporting system within twenty-four hours of the transfusion reaction

33. A nurse manager is evaluating the unit's compliance with the Joint Commission's Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery. The unit performs invasive bedside procedures including thoracentesis, paracentesis, and lumbar punctures. An audit reveals that the "time-out" is being performed inconsistently — sometimes conducted by the physician alone rather than as a team verification process. Which finding is MOST concerning?

A. The time-out is sometimes performed before the patient has been positioned for the procedure

B. The time-out documentation is completed after the procedure rather than at the time of the verification

C. The physician performs the time-out without requiring verbal confirmation from the nursing staff or other team members present in the room

D. A time-out that does not include active participation and verbal confirmation from all team members present fails to serve its safety purpose — it must be a team verification where each member independently confirms the correct patient, procedure, and site before proceeding

34. A nurse manager is developing a plan to reduce the unit's rate of preventable peripheral intravenous catheter-related complications. Data shows that forty-two percent of PIV complications are related to dwell time exceeding ninety-six hours. The CDC does not recommend routine replacement of PIVs at a specified interval and instead recommends replacement based on clinical indication. Which approach is MOST evidence-based?

A. Implement a mandatory PIV replacement protocol at seventy-two hours for all patients regardless of clinical indication

B. Allow PIVs to remain in place indefinitely and address complications only when they develop

C. Implement a daily nursing assessment of PIV site integrity using a standardized assessment tool, with replacement triggered by clinical indicators such as infiltration signs, phlebitis scores, or loss of function rather than time-based criteria, and educate staff on the evidence supporting clinically indicated replacement

D. Require physician orders for PIV continuation beyond ninety-six hours to create a review checkpoint

35. A nurse manager is responsible for a unit where Clinical Decision Support alerts in the electronic health record are contributing to alert fatigue. Analysis shows that the unit generates an average of one hundred fifty CDS alerts per nurse per shift, and the override rate is sixty-eight percent. Which improvement approach is MOST appropriate?

A. Reduce all CDS alerts by fifty percent to immediately decrease the alert burden on nursing staff

B. Implement a progressive discipline system for nurses who override high-severity CDS alerts without documented justification

C. Replace the current CDS system with a different vendor's product that has been shown to generate fewer nuisance alerts

D. Collaborate with clinical informatics to analyze which alerts are being overridden, categorize overrides by clinical appropriateness, eliminate or modify alerts with high appropriate-override rates, increase the specificity of remaining alerts, and preserve only those alerts that provide genuine clinical decision value

36. A nurse manager is developing a capacity management strategy for the unit. Census data shows significant daily variation — the unit operates at fifty-eight percent occupancy on some days and one hundred five percent occupancy on others (requiring hallway beds). Neither extreme is financially or clinically optimal. Which approach is MOST effective for smoothing census variation?

A. Request that the admitting office distribute admissions evenly across all days of the week to prevent census spikes

B. Maintain staffing at the level required for peak census to ensure adequate coverage during high-occupancy periods

C. Collaborate with surgical scheduling, the emergency department, bed management, and discharge planning to identify the specific drivers of census variation, implement predictive analytics to forecast daily census, develop proactive discharge strategies for high-census days, and create flexible staffing models that adjust to predicted demand

D. Accept census variation as an inherent feature of hospital operations and manage high-occupancy periods through overtime and agency staffing

37. A nurse manager is informed that a medication safety event on the unit has been classified as a "near miss" — an event that could have caused harm but was intercepted before reaching the patient. A pharmacy student caught a tenfold dosing error on a high-alert medication before the nurse administered it. Which organizational response MOST effectively leverages this near-miss for system improvement?

A. Commend the pharmacy student and re-educate the nurse who made the dosing error on proper dose calculation

B. Analyze the near-miss using the same rigor as a harmful event — conducting a root cause analysis to identify the system factors that allowed the tenfold error to reach the dispensing stage, implementing system-level barriers to prevent similar errors, and sharing the de-identified learning across the organization

C. Report the near-miss through the incident reporting system and include it in the unit's monthly quality dashboard trending

D. Implement mandatory dose calculation competency testing for all nurses to verify their arithmetic proficiency

38. A nurse manager is developing a plan to address the unit's compliance with the National Patient Safety Goal requiring that the hospital reduce the likelihood of patient harm associated with the use of anticoagulant therapy. The unit administers heparin, warfarin, and direct oral anticoagulants to a high volume of patients. Which element of the anticoagulation safety program is MOST critical?

A. Requiring laboratory monitoring for all patients receiving any form of anticoagulant therapy

B. Assigning a dedicated anticoagulation pharmacist to the unit who manages all anticoagulation dosing decisions

C. Implementing patient and family education about anticoagulant therapy for every patient prior to discharge

D. Standardizing ordering, dispensing, administration, and monitoring protocols for each anticoagulant, with dose-range limits in the electronic ordering system, mandatory laboratory monitoring per protocol, nursing assessment for bleeding complications, and patient education before discharge

39. A nurse manager reviews the following data on the unit's clinical surveillance system alerts:

| Alert Type | Alerts/Month | True Positive Rate | Avg Response Time |

|---|---|---|---|

| Sepsis screening | 180 | 22% | 18 minutes |

| Rapid deterioration | 45 | 68% | 8 minutes |

| Fall risk change | 120 | 41% | 35 minutes |

| Medication interaction | 340 | 12% | Not applicable |

Which finding is MOST concerning and requires IMMEDIATE intervention?

A. The medication interaction alert has the lowest true positive rate at twelve percent, indicating significant alert fatigue risk

B. The sepsis screening alert has a low true positive rate that may be contributing to complacency in sepsis recognition

C. The fall risk change alert has the longest average response time at thirty-five minutes, suggesting that staff may not be responding to fall risk changes with appropriate urgency to prevent falls during the window between alert and intervention

D. The rapid deterioration alert has the highest true positive rate but the lowest volume, suggesting the algorithm may not be sensitive enough

40. A nurse manager is implementing a population health management approach at the unit level. Population health management applies epidemiological principles to the patient population served by the unit to identify patterns, predict needs, and proactively intervene. Which application BEST demonstrates this approach?

A. Tracking individual patient outcomes and following up with patients who experience adverse events during hospitalization

B. Reporting unit-level quality metrics to the organizational quality committee on a quarterly basis

C. Implementing evidence-based clinical pathways for the most common diagnoses admitted to the unit

D. Analyzing the unit's patient population data to identify high-frequency diagnoses, common comorbidity clusters, predictable complication patterns, and social determinant profiles, then designing proactive care bundles and discharge interventions tailored to these population-level patterns

41. A nurse manager is evaluating the unit's performance on the CMS Hospital Consumer Assessment of Healthcare Providers and Systems survey. The unit scores at the ninety-fifth percentile on clinical quality metrics but only at the thirty-fifth percentile on the "care transition" domain, which asks patients about their preparation for post-hospital self-management. Which analysis is MOST important?

A. The high clinical quality scores should compensate for the low care transition scores in the overall value-based purchasing calculation

B. Survey the nursing staff about their discharge education practices to identify whether staff perceive the process differently than patients do

C. Compare the unit's discharge education content to best-practice standards from high-performing hospitals

D. Investigate the specific patient experience during the discharge process — including when education occurs, how it is delivered, whether comprehension is verified, and whether patients feel genuinely prepared for self-management at home — since the gap between excellent clinical care and poor transition preparation suggests a process or timing issue rather than a knowledge deficit

42. A nurse manager is developing an ergonomic injury prevention program for the unit. Musculoskeletal injuries account for sixty percent of the unit's workers' compensation claims. The most common injury mechanisms are patient repositioning, lateral transfers, and ambulation assistance. Which program element will produce the GREATEST injury reduction?

A. Requiring annual body mechanics training for all nursing staff to reinforce proper lifting technique

B. Restricting patients over a specific weight threshold from being manually handled and requiring mechanical assistance for all care activities

C. Implementing a comprehensive safe patient handling program that includes mechanical lift equipment, ceiling-mounted lifts in patient rooms, patient assessment for mobility needs, staff training on equipment use, a culture shift away from manual lifting as the default approach, and leadership enforcement of the program

D. Hiring a dedicated patient mobility technician for each shift who assists with all patient transfers and repositioning activities

43. A nurse manager is responsible for ensuring the unit meets the requirements for the Promoting Interoperability program (formerly Meaningful Use). The program requires hospitals to demonstrate meaningful use of certified electronic health record technology. Which nursing activity MOST directly supports the unit's Promoting Interoperability compliance?

A. Ensuring that nursing staff consistently use the EHR's clinical documentation, computerized provider order entry support, clinical decision support alerts, patient portal access promotion, and electronic medication reconciliation functions as designed — since compliance requires demonstrated use of EHR capabilities rather than simply having the technology available

B. Submitting the required Promoting Interoperability reporting data to CMS on behalf of the unit

C. Training all nursing staff on the EHR's full functionality through annual competency validation

D. Maintaining EHR system uptime by reporting technology issues to the IT department promptly

44. A nurse manager is evaluating the unit's use of predictive analytics for patient deterioration. The predictive model generates a risk score for each patient that is updated every four hours based on vital signs, laboratory values, and nursing assessment data. Nurses report that they do not trust the model because it sometimes generates high-risk scores for patients who appear clinically stable. Which response is MOST appropriate?

A. Override the predictive model with clinical judgment since experienced nurses can assess patient status more accurately than an algorithm

B. Require nurses to follow the model's recommendations regardless of their clinical assessment to prevent underestimation of deterioration risk

C. Educate staff on the model's intended use as a supplement to clinical judgment, explain its sensitivity and specificity characteristics, establish a protocol for how high-risk scores should prompt assessment and monitoring even when the patient appears stable, and create a feedback mechanism where clinical outcomes are used to refine the model

D. Disable the predictive model until it achieves a higher accuracy rate that nurses are willing to trust

45. A nurse manager is implementing a medication reconciliation best practice that requires nursing to compare the patient's home medication list against the inpatient medication orders at every transition point — admission, transfer, and discharge. Compliance at discharge is ninety-one percent, but

compliance at internal transfers is only forty-four percent. The most common reason cited is "the patient is already on established orders and nothing changes during transfer." Which response is MOST appropriate?

A. Accept the transfer reconciliation gap since internal transfers typically do not involve medication changes

B. Present data showing that medication discrepancies during internal transfers are a documented source of adverse drug events even when no intentional changes are made, implement a streamlined transfer reconciliation process that verifies current orders against the last reconciled list, and integrate it into the transfer workflow

C. Require pharmacist verification of medication orders at every internal transfer to supplement the nursing reconciliation

D. Add transfer reconciliation to the annual performance evaluation as a compliance metric to create individual accountability

46. A nurse manager is developing a response to a new state regulation requiring hospitals to publicly report nurse staffing levels, including HPPD, skill mix, and the percentage of hours worked by temporary staff, on a unit-by-unit basis. Staff are anxious about public scrutiny. Which preparation is MOST important?

A. Develop talking points that explain how the unit's staffing levels compare favorably to national benchmarks

B. Ensure that the data collection processes are accurate and validated, prepare staff to understand what the data means and how it will be presented, develop a narrative that connects staffing levels to quality outcomes, and establish a plan for addressing any public inquiries that result from the published data

C. Increase staffing levels before the reporting period begins to ensure the published data reflects favorably on the unit

D. Advocate through professional organizations to delay the reporting requirement until a standardized national methodology is established

47. A nurse manager is developing a plan for managing patients who require an involuntary psychiatric hold. The unit occasionally admits patients with medical conditions who also meet criteria for

involuntary psychiatric detention. Staff report uncertainty about their legal authority and clinical responsibilities during involuntary holds. Which education element is MOST critical?

A. Training on physical restraint techniques appropriate for managing aggressive behavior in patients on involuntary holds

B. Education on the medications used for acute psychiatric symptom management so nurses can administer them confidently

C. Comprehensive education on the state-specific legal requirements for involuntary holds including the nurse's role in initiating or maintaining the hold, documentation requirements, patient rights during the hold, the process for legal review, and collaboration with psychiatric services for ongoing management

D. Training on de-escalation techniques for managing agitated patients during involuntary psychiatric holds

48. A nurse manager is evaluating the unit's medical device safety program. Joint Commission data shows that use-error with medical devices is a leading contributor to patient safety events. The unit has experienced three infusion pump programming errors and two ventilator alarm configuration errors in the past quarter. Which intervention is MOST effective?

A. Implement a human factors-informed approach that evaluates the device-user interface for each device involved in errors, identifies the specific design features that contribute to user errors, standardizes device programming protocols, provides just-in-time training at the point of use, and incorporates independent double-checks for high-risk device programming

B. Replace all infusion pumps and ventilators with a different manufacturer's equipment that has a more intuitive user interface

C. Require annual competency testing on all medical devices with a passing score of one hundred percent

D. Assign specific nurses as designated experts for each type of medical device and require all device programming to be performed by the designated expert

49. A nurse manager reviews the following data:

| Measure | Q1 | Q2 | Q3 | Q4 | Target |
|---|---|---|---|---|---|
| Central line utilization ratio | 0.42 | 0.39 | 0.35 | 0.31 | < 0.25 |
| CLABSI rate/1,000 CLD | 1.2 | 0.8 | 0.6 | 0.4 | < 0.5 |

The CLABSI rate has reached the target, but central line utilization remains above the target. Which interpretation is MOST appropriate?

A. The CLABSI target has been achieved and the focus should shift to other quality priorities

B. The declining CLABSI rate demonstrates that the unit's line maintenance practices are effective, and no further action is needed until the rate trends upward

C. The unit should continue to reduce central line utilization toward the target because unnecessary central lines expose patients to CLABSI risk even with excellent maintenance practices, and reaching the utilization target will further reduce infection risk and may prevent future CLABSI increases

D. The central line utilization ratio target of 0.25 may be unrealistic for the unit's patient population and should be revised upward

50. A nurse manager is developing a plan to address healthcare disparities on the unit. Data reveals that Black patients on the unit have a forty percent higher rate of hospital-acquired pressure injuries compared to white patients after controlling for acuity, age, and comorbidities. Which investigation is MOST appropriate?

A. Investigate whether there are differences in how skin assessments are performed across racial groups — including whether darker skin tones make Stage 1 pressure injury identification more difficult with current assessment techniques — and whether nursing assessment tools and training adequately address assessment of diverse skin tones

B. Attribute the disparity to differences in social determinants of health that affect skin integrity and nutritional status prior to hospitalization

C. Examine whether the pressure injury documentation system adequately captures injuries across all skin tones

D. Implement enhanced pressure injury prevention interventions for all Black patients to directly address the documented disparity

51. A nurse manager is applying the concept of "double-loop learning" as described by Chris Argyris to improve the unit's quality improvement methodology. Single-loop learning corrects errors within existing assumptions, while double-loop learning questions the underlying assumptions themselves. The unit has been running PDSA cycles on falls prevention for two years with minimal improvement. Which approach BEST demonstrates double-loop learning?

A. Run another PDSA cycle with a more aggressive intervention to test whether a stronger version of the current approach can produce better results

B. Question whether the unit's fundamental assumptions about why patients fall are correct — examining whether the current fall risk assessment tool accurately identifies the patients who actually fall, whether the interventions target the actual causes of falls on this specific unit, and whether the care delivery model itself contributes to falls through structural factors the current approach does not address

C. Benchmark against high-performing units to identify which falls prevention interventions they use that the current unit does not

D. Engage an external quality improvement consultant to bring fresh perspective to the falls prevention initiative

52. A nurse manager is applying the concept of "polarity management" to address the ongoing tension between standardization and individualization of patient care on the unit. Barry Johnson's polarity management framework recognizes that some organizational tensions are not problems to be solved but polarities to be managed — both poles (standardization AND individualization) have benefits that must be leveraged and downsides that must be minimized. Which application is MOST appropriate?

A. Standardize all patient care processes completely to eliminate variation that introduces error risk

B. Map the benefits and downsides of both standardization (consistency, safety, efficiency vs. rigidity, failure to address individual needs) and individualization (patient-centered, responsive, flexible vs. inconsistency, variation, error risk), and develop a management approach that harvests the benefits of both while monitoring for the downsides of each

C. Allow each nurse to determine the appropriate balance between standardization and individualization for their patients based on clinical judgment

D. Alternate between periods of strict standardization and periods of individualized care to capture the benefits of each approach sequentially

53. A nurse manager is applying Peter Senge's concept of the "learning organization" to identify barriers to organizational learning on the unit. Senge identified five disciplines of learning organizations: personal mastery, mental models, shared vision, team learning, and systems thinking. A particular challenge on the unit is that nurses make the same clinical errors repeatedly because the lessons from previous errors are not effectively transferred to other staff. Which "learning disability" from Senge's framework MOST accurately describes this pattern?

A. The unit suffers from what Senge calls "the enemy is out there" — staff attribute errors to external factors rather than examining how their own practices contribute to the patterns

B. The unit suffers from "the illusion of learning from experience" — each nurse learns from their own errors but the organization lacks mechanisms to transfer that individual learning to the collective team

C. The unit suffers from "the delusion of learning from experience" — individual experiences are too narrow to generate the systemic insights needed for organizational improvement

D. The unit suffers from "the fixation on events" — staff focus on individual error events rather than identifying the systemic patterns that produce those events

54. A nurse manager is applying the concept of "Safety-II" to the unit's patient safety program. Traditional Safety-I focuses on what goes wrong and tries to prevent adverse events. Safety-II, developed by Erik Hollnagel, focuses on understanding what goes right — studying everyday clinical work to understand how nurses successfully manage complexity, adapt to unexpected situations, and prevent errors through real-time adjustments. Which application BEST demonstrates Safety-II thinking?

A. Conducting root cause analyses after every adverse event to identify what went wrong and prevent recurrence

B. Implementing standardized protocols that eliminate variation in clinical practice to prevent deviations that could lead to errors

C. Increasing the frequency of safety event reporting to capture a more comprehensive picture of what goes wrong on the unit

D. Observing and studying routine clinical work to understand how nurses successfully adapt to interruptions, manage competing demands, recover from near-errors, and maintain safety during high-complexity situations, then using these insights to design systems that support and amplify successful adaptive behaviors

55. A nurse manager is applying the concept of "resilience engineering" to the unit's safety management approach. Resilience engineering focuses on building the system's capacity to anticipate threats, monitor current conditions, respond to disturbances, and learn from both successes and failures. Which intervention MOST directly builds resilience capacity?

A. Implement additional safety protocols to prevent the specific types of errors that have occurred in the past

B. Develop the team's capacity to anticipate clinical deterioration through pattern recognition training, monitor the unit's operational status through real-time situational awareness tools, respond to unexpected events through flexible rather than rigid protocols, and learn from both successful saves and adverse outcomes through structured debriefing

C. Hire additional staff to provide redundancy so that errors by one nurse are caught by others

D. Implement a zero-tolerance policy for safety violations to create a culture of strict compliance

56. A nurse manager is addressing a "wicked problem" on the unit. Horst Rittel defined wicked problems as complex challenges that have no clear definition, no single right solution, and where every attempted solution changes the nature of the problem itself. The nurse manager identifies the unit's chronic nurse retention challenge as a wicked problem because interventions that address one dimension (e.g., salary increases) often exacerbate another (e.g., experienced nurses feel their loyalty is devalued compared to new hires receiving sign-on bonuses). Which approach is MOST appropriate for wicked problems?

A. Apply a systematic problem-solving methodology such as Six Sigma DMAIC to break the retention problem into measurable components with defined solutions

B. Accept that wicked problems require an iterative, adaptive approach — implementing small-scale interventions, monitoring for unintended consequences, adjusting based on emerging effects, engaging multiple stakeholders in continuous dialogue, and accepting that the problem will never be fully "solved" but can be continuously better managed

C. Delegate the retention problem to human resources since organizational compensation and benefits decisions drive retention outcomes

D. Commission a comprehensive external consulting engagement to develop a definitive retention strategy based on industry best practices

57. A nurse manager is implementing a virtual nursing program where experienced nurses provide remote support to bedside nurses through video technology. The virtual nurses assist with admission assessments, discharge education, and medication reconciliation from a centralized location. Which leadership challenge is MOST significant during implementation?

A. Ensuring that the technology platform is reliable and provides adequate video and audio quality for clinical assessment

B. Defining the regulatory and licensure requirements for nurses providing care remotely

C. Ensuring that adequate internet bandwidth is available in all patient rooms for video communication

D. The challenge is not technological but cultural — ensuring that bedside nurses view virtual nurses as collaborative partners rather than as surveillance or replacement, that patients accept virtual nursing interactions as legitimate components of their care, and that the virtual nursing role is integrated into rather than imposed upon the existing care delivery model

58. A nurse manager is applying the concept of "complex adaptive systems" to understand the unit's behavior. Unlike mechanical systems that follow predictable cause-and-effect relationships, complex adaptive systems are characterized by non-linear interactions, emergence, adaptation, and self-organization. Which leadership behavior is MOST appropriate when leading a complex adaptive system?

A. Implement rigid protocols and enforce strict compliance to create the predictability that complex systems lack

B. Set clear boundaries and simple rules that enable agents within the system to adapt and self-organize, observe emerging patterns, amplify positive developments, dampen negative ones, and create conditions for innovation rather than dictating specific behaviors

C. Conduct detailed predictive modeling to forecast the system's behavior and plan interventions based on predicted outcomes

D. Centralize all decision-making so that the system's behavior can be controlled through a single point of authority

59. A nurse manager is implementing a "high reliability maturity model" to assess the unit's progress toward becoming a high reliability organization. The maturity model defines five levels: (1) beginning/reactive, (2) developing/managed, (3) defined/proactive, (4) quantitatively managed/predictive, and (5) optimizing/generative. Assessment reveals the unit is at Level 2 — developing safety systems but still primarily reactive to events. Which activity is MOST important for advancing to Level 3?

A. Implement automated safety monitoring systems that detect events in real time without staff intervention

B. Increase the number of incident reports submitted monthly to demonstrate active safety monitoring

C. Transition from reacting to safety events after they occur to proactively identifying and mitigating risks before events happen through prospective risk assessment, hazard analysis, and safety culture surveys that reveal latent system vulnerabilities

D. Achieve zero serious safety events for twelve consecutive months to demonstrate that the reactive safety systems have been effective

60. A nurse manager is applying the Pareto principle (80/20 rule) to prioritize quality improvement resources. Analysis of the unit's adverse events over the past year reveals the following distribution:

| Event Category | Count | % of Total |

|---|---|---|

| Medication errors | 42 | 38% |

| Falls | 28 | 25% |

| Pressure injuries | 18 | 16% |

| CAUTI | 12 | 11% |

| All other events | 11 | 10% |

According to the Pareto principle, which quality improvement focus will produce the GREATEST overall impact?

A. Concentrate improvement resources on medication errors and falls since these two categories account for sixty-three percent of all adverse events and addressing them will produce the greatest overall reduction in total event volume

B. Address all five categories simultaneously with equal resources to demonstrate comprehensive quality management

C. Focus exclusively on medication errors since they represent the single largest category

D. Focus on CAUTI since healthcare-associated infections carry the highest severity and regulatory scrutiny

61. A nurse manager is developing a nurse well-being program informed by the National Academy of Medicine's consensus study on clinician burnout and professional well-being. The NAM framework identifies system-level factors — not individual resilience deficits — as the primary drivers of clinician burnout. Which program design principle is MOST aligned with the NAM framework?

A. Focus the well-being program on system-level changes that address workload, documentation burden, work environment, organizational culture, and professional autonomy rather than placing the primary responsibility for well-being on individual nurses' coping strategies

B. Implement a comprehensive resilience training program that teaches individual nurses stress management, mindfulness, and coping skills

C. Provide unlimited access to counseling services for nurses experiencing burnout symptoms

D. Create a nurse well-being committee that meets monthly to discuss well-being initiatives and recommend programs

62. A nurse manager is evaluating the effectiveness of the unit's nurse residency program using Kirkpatrick's four-level evaluation model. The program director reports strong Level 1 (Reaction — residents enjoy the program) and Level 2 (Learning — residents demonstrate knowledge gains on post-tests) results. However, the nurse manager wants to evaluate at the higher levels. Which evaluation at Level 4 (Results) would be MOST meaningful?

A. Observation of nurse residents applying leadership skills during clinical practice

B. First-year retention rates of nurse residents compared to non-residency new graduates

C. Nurse resident satisfaction with the mentoring component of the program

D. Measurable changes in unit-level outcomes — including nurse-sensitive quality indicators, patient satisfaction, and organizational metrics such as retention rates and cost-per-new-hire — that can be attributed to the residency program's impact on new graduate nurse performance

63. A nurse manager is developing a strategy for managing "scope creep" — the gradual expansion of nursing responsibilities beyond the defined role without corresponding adjustments to workload, compensation, or training. Staff report that over the past three years, nurses have assumed responsibilities previously held by dietary, transport, phlebotomy, and environmental services departments due to staffing reductions in those areas. Which approach is MOST appropriate?

A. Accept the expanded responsibilities as the new normal and focus on helping nurses adapt to the broader role

B. Document the specific responsibilities that have migrated to nursing, quantify the time burden, assess the impact on nursing-specific patient care activities, and present the analysis to organizational leadership with a proposal for either returning the responsibilities to their original departments or adjusting nursing staffing and support to accommodate the expanded scope

C. Instruct nursing staff to refuse any task that is not within the nursing scope of practice and redirect the task to the appropriate department

D. Request additional nursing FTEs to cover the expanded responsibilities without challenging the fundamental responsibility shift

64. A nurse manager is applying the concept of "servant leadership" specifically to the charge nurse development program. Charge nurses currently operate in a directive "mini-manager" style — making assignments, issuing instructions, and solving problems for staff rather than empowering staff to solve problems themselves. Which intervention MOST effectively shifts charge nurses toward servant leadership?

A. Provide charge nurses with servant leadership reading materials and discuss the concepts during monthly charge nurse meetings

B. Evaluate charge nurses' leadership style using a 360-degree feedback tool and provide development plans for those who score low on servant leadership dimensions

C. Remove all directive authority from the charge nurse role to force a collaborative approach

D. Coach charge nurses to shift their primary focus from directing work to removing barriers for staff, developing team members' capabilities, asking questions that help staff think through problems independently, and measuring their own effectiveness by whether staff members are growing in competence and confidence

65. A nurse manager is applying the Cynefin framework, developed by Dave Snowden, to categorize problems and select appropriate leadership responses. The framework identifies five domains: Simple (best practice), Complicated (good practice), Complex (emergent practice), Chaotic (novel practice), and Disorder. A patient safety problem on the unit defies all attempted solutions — each intervention produces unexpected consequences, the relationships between variables are unclear, and small changes produce disproportionately large effects. Which Cynefin domain MOST accurately describes this situation?

A. Complicated — requiring expert analysis to identify the correct solution

B. Simple — requiring application of established best practices

C. Chaotic — requiring immediate action to stabilize the situation before analysis

D. Complex — requiring a probe-sense-respond approach where the leader implements safe-to-fail experiments, observes what emerges, amplifies positive patterns, and dampens negative ones rather than attempting to predict and control outcomes

66. A nurse manager is implementing an "after-action review" (AAR) process on the unit. Unlike root cause analysis which focuses on adverse events, AARs are conducted after any significant event — including successes — to capture learning. The AAR addresses four questions: What did we plan to do? What actually happened? Why did it happen that way? What can we learn? Which implementation element is MOST critical for organizational learning?

A. Conducting the AAR within twenty-four hours of the event to ensure accurate recall of details

B. Distributing the AAR findings beyond the immediate team so that the learning benefits the broader organization through a structured knowledge-sharing mechanism

C. Maintaining strict confidentiality of AAR findings to prevent blame and encourage honest participation

D. Assigning a dedicated AAR facilitator who is not involved in the event to ensure objective analysis

67. A nurse manager is addressing a situation where the unit has experienced significant staff turnover and lost much of its institutional knowledge. New staff members are making errors that experienced nurses would have prevented through undocumented "tribal knowledge" — informal practices, workarounds, and clinical tips that were never codified into formal protocols or training materials. Which approach MOST effectively captures and transfers tribal knowledge?

A. Create a comprehensive procedures manual that documents every clinical process in detail, including the informal practices that experienced nurses have developed over time

B. Pair new nurses with the most experienced remaining nurses for extended preceptorship periods so they can learn the undocumented practices through observation and mentoring

C. Implement a knowledge management system using recorded interviews, decision trees, clinical tip databases, and standardized orientation checklists that capture the critical informal knowledge before remaining experienced nurses depart

D. Accept that some tribal knowledge will be lost during transitions and allow new staff to develop their own clinical practices over time

68. A nurse manager is developing a succession planning program that goes beyond identifying potential future leaders to actively building leadership capacity across the entire team. The concept of "distributed leadership" suggests that leadership should be an organizational capacity shared among many rather than

concentrated in a few designated positions. Which approach MOST effectively builds distributed leadership?

A. Identify high-potential nurses and invest leadership development resources exclusively in this select group

B. Create leadership opportunities exclusively through the clinical ladder advancement pathway

C. Assign leadership responsibilities on a rotating basis so every nurse has periodic exposure to leadership tasks

D. Create multiple leadership opportunities at every level — from clinical champion roles and quality project leadership to committee facilitation and mentoring — that develop leadership capacity across the entire team, with coaching support and progressive responsibility that matches each nurse's developmental stage

69. A nurse manager is applying the concept of "appreciative leadership" — leading from a strength-based perspective that focuses on what the organization does well and amplifying positive potential rather than diagnosing deficits. The nurse manager wants to apply this approach to improve staff engagement. Which behavior BEST exemplifies appreciative leadership?

A. Identify and celebrate the specific conditions under which staff engagement is highest, understand what makes those moments exceptional, and intentionally create more of those conditions across the unit's daily operations

B. Focus exclusively on positive outcomes and avoid discussing problems, challenges, or performance deficits with the team

C. Implement a daily recognition program that publicly acknowledges one staff member per shift for their positive contribution

D. Conduct focus groups where staff describe their ideal work environment and use the findings to develop a comprehensive engagement improvement plan

70. A nurse manager reviews the following data on charge nurse leadership effectiveness:

| Charge Nurse | Staff Satisfaction | Patient Satisfaction | Safety Events/Month |

|---|---|---|---|

| CN-A | 4.5/5.0 | 89% | 0.5 |

| CN-B | 2.8/5.0 | 71% | 2.1 |

| CN-C | 4.1/5.0 | 85% | 0.8 |

| CN-D | 3.2/5.0 | 78% | 1.4 |

Which interpretation and action is MOST appropriate?

A. CN-A should be promoted to nurse manager since their metrics demonstrate the strongest overall leadership performance

B. CN-B should be removed from the charge nurse role since their metrics are consistently below the other charge nurses

C. The data should be aggregated into a single unit average rather than analyzed by individual charge nurse to prevent perceived favoritism

D. Use the data as a developmental tool — meet individually with each charge nurse to review their metrics, identify specific behavioral factors driving the variation, develop individualized improvement plans for CN-B and CN-D, and have CN-A and CN-C share their practices through peer mentoring

71. A nurse manager is developing a strategy to prevent "normalization of deviance" on the unit — the gradual process by which unacceptable practices become accepted as the norm through repeated successful outcomes despite deviation from established protocols. The unit has developed several workarounds that bypass safety protocols because "nothing bad has happened." Which intervention is MOST effective?

A. Identify and document all existing workarounds, assess the safety risk of each deviation, either eliminate the workaround and enforce the original protocol or modify the protocol to incorporate a safer version of the workaround if the original protocol is genuinely problematic, and establish ongoing monitoring to prevent new deviations from normalizing

B. Implement a zero-tolerance policy for any deviation from established protocols regardless of the perceived safety impact

C. Allow workarounds that have not produced adverse events to continue since they represent practical adaptations to workflow challenges

D. Conduct a comprehensive audit of protocol compliance and discipline staff who have developed unauthorized workarounds

72. A nurse manager is applying the concept of "organizational ambidexterity" — the ability to simultaneously optimize current operations (exploitation) and explore new innovations (exploration). The unit excels at operational efficiency but rarely implements innovative practices. Which leadership approach MOST effectively develops organizational ambidexterity?

A. Dedicate one day per month exclusively to innovation activities and suspend routine operations during that period

B. Assign specific staff members to an innovation team and exempt them from routine operational responsibilities

C. Create protected time and resources for innovation within the existing operational structure, establish a process for evaluating and piloting new ideas while maintaining operational standards, and celebrate both operational excellence and innovative experimentation as valued organizational activities

D. Wait for external benchmarking data to identify innovations that have been validated at other hospitals before attempting to implement them locally

73. A nurse manager is leading a team through a period of "adaptive change" as described by Ronald Heifetz. The unit must fundamentally transform its approach to patient-centered care — requiring nurses to change their clinical behaviors, professional beliefs, and self-image as clinicians. Staff resist because the change threatens their professional identity. Which leadership approach is MOST appropriate for adaptive challenges?

A. Provide clear direction and detailed instructions for the new behaviors expected under the patient-centered care model

B. Create urgency by emphasizing the consequences of not changing and establish strict accountability for adopting the new approach

C. Delegate the change process to a committee of early adopters who can model the desired behaviors for resistant colleagues

D. Regulate the distress of the change — providing enough pressure to motivate adaptation but not so much that the team becomes overwhelmed — while maintaining a holding environment where staff can process their identity concerns, experiment with new behaviors, and gradually internalize the new professional self-concept

74. A nurse manager is developing a strategy for managing the "knowing-doing gap" on the unit — the persistent disconnect between what nurses know they should do and what they actually do in practice. For example, nurses can recite hand hygiene protocols perfectly but compliance plateaus below the target. Which analysis MOST accurately identifies the root cause of the knowing-doing gap?

A. The gap is caused by inadequate education — nurses need more frequent training to maintain knowledge in active practice

B. The gap is caused by individual motivation deficits — nurses who do not comply with known protocols need performance accountability measures

C. The knowing-doing gap is typically caused by system-level factors — competing priorities that create time pressure, environmental design that makes correct behavior inconvenient, social norms that tolerate deviation, and cognitive overload that causes default to habitual rather than intentional behavior — rather than individual knowledge or motivation deficits

D. The gap is caused by resistance to change — nurses who developed their practice habits before current protocols were established have difficulty adopting new behaviors

75. A nurse manager is developing a comprehensive approach to managing the unit during a transition from one electronic health record system to another. The transition includes a six-month implementation period, parallel documentation during a two-week go-live, and an expected productivity decline of thirty to forty percent in the first month of the new system. Which leadership priority is MOST critical?

A. Negotiate additional temporary staffing from the organization to compensate for the expected productivity decline during the go-live period

B. Ensure all staff achieve competency on the new system before go-live through comprehensive training

C. Develop a contingency plan for managing patient care if the new system experiences unplanned downtime during the go-live period

D. Develop a comprehensive transition plan that addresses staffing augmentation during productivity decline, tiered staff training with super-user support, workflow redesign for the new system, go-live command center coordination, contingency planning for system failures, staff morale support during the transition stress, and post-go-live optimization based on user feedback

76. A nurse manager is evaluating the unit's performance on the Practice Environment Scale of the Nursing Work Index (PES-NWI). The PES-NWI measures five subscales: nurse participation in hospital affairs, nursing foundations for quality of care, nurse manager ability/leadership/support, staffing and resource adequacy, and collegial nurse-physician relations. The unit scores lowest on "nurse participation in hospital affairs." Which intervention MOST directly addresses this subscale?

A. Implement a shared governance model that gives nurses genuine decision-making authority in practice decisions and create pathways for unit-level nurses to participate in organizational committees, quality councils, and strategic planning activities

B. Increase staffing levels since adequate staffing allows nurses more time to participate in organizational activities

C. Improve nurse-physician collaboration since stronger interdisciplinary relationships create opportunities for nurses to influence organizational decisions

D. Enhance the nurse manager's leadership practices since strong management support enables greater nurse participation

77. A nurse manager is addressing a situation where the unit's quality improvement projects consistently demonstrate improvement during the project period but regress to baseline performance within six months of the project's conclusion. Five consecutive QI projects have followed this pattern. Which root cause analysis is MOST likely to identify the sustainability failure?

A. The projects may have selected interventions with strong initial impact but insufficient long-term effectiveness

B. Staff turnover between the project period and the six-month follow-up may introduce new staff who were not trained on the improved practices

C. The projects may lack dedicated QI staff who can maintain focus on the improvement after the formal project period ends

D. The projects likely lack hardwiring mechanisms — the improvements depend on continued project-level attention, champion motivation, or management focus rather than being embedded into standard work, documentation systems, orientation processes, and accountability structures that sustain the new practice independently of any individual's continued attention

78. A nurse manager is implementing a "growth mindset" culture on the unit based on Carol Dweck's research. In a growth mindset culture, intelligence and abilities are viewed as developable through effort and learning, while in a fixed mindset culture, abilities are viewed as innate and unchangeable. Several experienced nurses exhibit fixed mindset behaviors — avoiding challenging assignments, feeling threatened by newer nurses' competence, and interpreting constructive feedback as personal criticism. Which intervention is MOST effective?

A. Reframe challenges as growth opportunities by celebrating effort and learning alongside outcomes, provide feedback that focuses on specific behaviors and strategies rather than ability labels, model growth mindset language in leadership communications, and create a culture where mistakes are treated as data for learning rather than evidence of inadequacy

B. Identify nurses with fixed mindset behaviors and provide them with individual counseling about the importance of professional growth

C. Implement a mandatory growth mindset training workshop for all staff and evaluate whether mindset scores improve on post-workshop assessments

D. Assign challenging patients to fixed-mindset nurses to force them out of their comfort zones and demonstrate that they can handle difficult situations

79. A nurse manager is developing a strategy for managing the unit during a period where three experienced nurses have announced simultaneous retirements within the next six months. Together, these nurses represent seventy-five years of combined clinical and institutional experience. The nurse manager is concerned about the loss of tacit knowledge — the knowledge that resides in people's heads rather than in formal documentation. Which knowledge preservation strategy is MOST effective?

A. Ask the retiring nurses to document their clinical tips, institutional knowledge, and informal practices in a written manual before they leave

B. Conduct structured knowledge elicitation sessions using techniques such as cognitive task analysis, critical decision method interviews, and teach-back sessions where retiring nurses articulate their decision-making processes for complex clinical scenarios, capture this knowledge in accessible formats, and integrate it into orientation and training programs

C. Extend the nurses' retirement dates to allow for a longer overlap period with their replacements

D. Hire experienced nurses from other organizations who can bring their own institutional knowledge to replace the departing expertise

80. A nurse manager is addressing a situation where a nurse has been identified as an "impaired professional" — demonstrating signs of cognitive impairment that may be related to a substance use disorder, medical condition, or mental health issue. The nurse has not self-identified and denies any problem when approached informally by a colleague. Which action is MOST appropriate?

A. Observe the nurse more closely over the next several shifts to gather additional evidence of impairment before taking formal action

B. Follow the organization's impaired professional policy by documenting specific objective observations of impaired behavior, removing the nurse from patient care if immediate safety concerns exist, referring through occupational health for a fitness-for-duty evaluation, and approaching the situation with concern for the nurse's well-being alongside patient safety

C. Report the nurse directly to the state board of nursing for practice while potentially impaired

D. Ask the nurse's closest colleagues to monitor her behavior and report any additional concerns informally

81. A nurse manager is developing a professional boundaries education program. The program must help nurses understand the continuum from under-involvement (cold, detached care) through the therapeutic zone (professional, caring engagement) to over-involvement (boundary violations such as dual relationships, gift exchanges, and personal dependency). Which scenario MOST clearly represents a boundary violation?

A. A nurse who gives a dying patient's family a sympathy card with a personal note after the patient's death

B. A nurse who offers a patient a warm blanket without being asked because she noticed the patient appeared cold

C. A nurse who shares her personal cell phone number with a patient's family so they can reach her with questions after discharge

D. A nurse who regularly brings homemade baked goods to share with the patients on her assignment because she enjoys baking and patients appreciate the gesture

82. A nurse manager is developing a plan to support nurses through the process of obtaining specialty certification. Currently, only eighteen percent of the unit's nurses hold specialty certification compared to an organizational goal of forty percent. The primary barrier cited by staff is the cost of the examination and the time required for preparation. Which support strategy is MOST comprehensive?

A. Implement a comprehensive certification support program that includes examination fee reimbursement, paid study time, study group facilitation, certification review courses, financial incentives for achievement, public recognition of certified nurses, and integration of certification into the clinical ladder advancement criteria

B. Mandate specialty certification for all nurses with more than five years of experience and allow two years for compliance

C. Provide examination fee reimbursement and allow staff to use paid time off for examination preparation

D. Create a peer study group led by certified nurses who can coach their colleagues through the preparation process

83. A nurse manager is navigating a situation where a nurse has been asked by a patient's attorney to provide a written statement about the patient's clinical condition and the care the nurse provided. The nurse is unsure whether to cooperate. Which guidance is MOST appropriate?

A. Instruct the nurse to provide a factual written statement based on her documentation since nurses have a professional obligation to participate in legal proceedings

B. Advise the nurse to decline the attorney's request entirely since all legal communication should be routed through the hospital's legal department

C. Advise the nurse to contact the organization's legal department or risk management before providing any statement, as the legal department can determine the appropriate response, protect the nurse's interests, and ensure that any communication complies with organizational policy and does not create unintended legal exposure

D. Allow the nurse to provide a verbal statement to the attorney but advise against providing anything in writing

84. A nurse manager is developing guidelines for managing nursing staff who maintain active social media profiles that identify them as employees of the hospital. Several nurses post about healthcare topics, share opinions about organizational policies, and occasionally reference their clinical work. Which guideline element is MOST important?

A. Require all nurses to remove any reference to their employer from their personal social media profiles

B. Establish clear guidelines distinguishing between protected personal expression and content that could compromise patient privacy, damage the organization's reputation, or violate professional conduct standards, while providing examples of appropriate and inappropriate posts in healthcare-specific contexts

C. Monitor all nursing staff social media accounts for policy violations and address any identified concerns through progressive discipline

D. Prohibit all healthcare-related social media activity by nursing staff to eliminate the risk of HIPAA violations

85. A nurse manager is addressing a complex ethical situation where a nurse has discovered that a physician altered documentation in a patient's medical record after an adverse event. The original documentation was clinically accurate, and the physician changed it to present a more favorable narrative. The nurse photographed the original documentation on her personal phone before the alteration. Which action is MOST appropriate for the nurse manager?

A. Commend the nurse for documenting the original record and advise her to maintain the photographs as personal protection

B. Counsel the nurse that photographing patient records on a personal device is a HIPAA violation regardless of the circumstances

C. Investigate the alleged record alteration but avoid involving the nurse since her personal-device photography creates a compliance concern that could undermine the investigation

D. Report the alleged record alteration to the appropriate organizational authorities including compliance, risk management, and medical staff leadership, address the nurse's HIPAA concern about personal-device photography separately, and ensure the nurse understands whistleblower protections for reporting documentation integrity concerns

86. A nurse manager is developing an approach to supporting nurses who are pursuing advanced education while working full time. Research shows that nurses pursuing advanced degrees while working full time experience higher rates of burnout, medication errors, and turnover. Which support strategy MOST effectively addresses these risks?

A. Discourage nurses from pursuing advanced education while working full time due to the documented safety and burnout risks

B. Offer a flexible scheduling arrangement that accommodates academic obligations without reducing total scheduled hours

C. Provide comprehensive support including flexible scheduling, reduced clinical hours during intensive academic periods, tuition assistance, mentoring, study space access, and workload monitoring to identify when the combined burden is affecting clinical performance or personal well-being

D. Require nurses pursuing advanced degrees to transition to part-time clinical status to ensure patient safety is not compromised

87. A nurse manager is evaluating the unit's compliance with the ANA's Code of Ethics Provision 6, which states that the nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting. Assessment reveals that nurses on the unit rarely raise ethical concerns, ethics committee consultations are never initiated by nursing staff, and staff describe the ethical climate as "we just follow orders." Which intervention is MOST foundational?

A. Develop a nursing ethics education program that teaches ethical decision-making frameworks and empowers nurses to identify and voice ethical concerns through established organizational channels such as ethics consultations, ethics committee participation, and professional advocacy

B. Invite the hospital ethicist to present at a staff meeting about the types of ethical dilemmas commonly encountered in clinical practice

C. Implement a mandatory ethics consultation for every patient who is on life support for more than fourteen days to create routine exposure to the ethics process

D. Create a unit-level ethics committee composed of nursing staff who review ethical concerns independently from the hospital ethics committee

88. A nurse manager is addressing a situation where a nurse has been using her employer-issued computer to access continuing education websites during downtime between patient care activities. The organization's technology use policy prohibits personal use of hospital computers. The nurse argues that accessing continuing education fulfills her professional development obligation and benefits the organization. Which response is MOST appropriate?

A. Review the organization's technology use policy to determine whether continuing education access constitutes "personal use" or falls within an acceptable professional development exception, consult with IT and human resources if the policy is ambiguous, and establish clear guidance for all staff

B. Discipline the nurse for violating the technology use policy since the prohibition on personal use is clearly stated

C. Allow the nurse to continue accessing continuing education since it benefits both the nurse and the organization

D. Implement an exception to the technology use policy specifically for continuing education and professional development websites

89. A nurse manager is developing an approach to managing nurses who are involved in fitness-for-duty investigations. A nurse has been referred for a fitness-for-duty evaluation after multiple medication errors in a short period, and the nurse believes the referral is retaliatory for a complaint she filed against the nurse manager. Which approach ensures both fairness and safety?

A. Withdraw the fitness-for-duty referral to avoid the appearance of retaliation and address the medication errors through the standard performance management process

B. Proceed with the referral through the standard process but avoid any involvement in the evaluation to prevent bias

C. Document the specific performance observations that triggered the referral independently of the complaint timeline, demonstrate that the referral decision was based on patient safety concerns that

would warrant evaluation regardless of any complaint, and engage human resources to ensure the process is objective and well-documented

D. Conduct the fitness-for-duty evaluation through an objective, independent process with full documentation of the performance-based rationale, ensure the nurse has access to representation per organizational policy, involve human resources to verify that the referral is consistent with how similar situations have been handled previously, and create a clear separation between the complaint resolution process and the fitness-for-duty evaluation

90. A nurse manager is addressing the professional development needs of nurses who work exclusively on night shift. These nurses rarely have access to daytime education programs, professional development opportunities, or leadership development activities. Over time, their professional growth has stagnated compared to day shift colleagues. Which approach is MOST equitable?

A. Require night shift nurses to attend daytime professional development activities periodically and compensate them for the additional hours

B. Develop a comprehensive night-shift-accessible professional development program that includes asynchronous online education, recorded development activities, night-shift-specific leadership opportunities, dedicated night shift mentoring, professional development during night shift schedules, and equitable access to advancement opportunities regardless of shift worked

C. Assign night shift nurses to day shift on a rotating basis so they have periodic access to daytime development activities

D. Accept that some professional development disparity is inherent in the night shift schedule and focus resources on ensuring clinical competency is maintained

91. A nurse manager is navigating the ethical implications of using genomic data in nursing care planning. A patient's genomic profile has been incorporated into the electronic health record and reveals information about disease predisposition that the patient has not been counseled about. Several nurses have access to this genetic information as part of the medical record. Which ethical concern is MOST significant?

A. Nurses should be concerned that the genomic data could be used to discriminate against the patient by insurance companies or employers if it is disclosed inappropriately, violating the protections provided by the Genetic Information Nondiscrimination Act

B. Nurses may lack the education to interpret genomic data correctly and could make inappropriate clinical decisions based on misunderstood genetic information

C. The patient has a right to genetic counseling before genomic results are included in the medical record, and nurses have an ethical obligation to advocate for patient understanding before acting on genetic information

D. The cost of genomic testing may not be covered by the patient's insurance, creating a financial burden that the healthcare team should have discussed before ordering the test

92. A nurse manager is developing guidelines for nurses who are asked to participate in patient care activities that conflict with their personal values but are legal, ethical, and within the standard of care. A nurse has requested accommodation from caring for a patient receiving gender-affirming hormone therapy based on the nurse's personal beliefs. Which approach is MOST appropriate?

A. Evaluate whether the request can be accommodated without compromising patient care or creating an inequitable burden on colleagues, provide an alternative assignment if feasible, and ensure the patient receives equitable, non-discriminatory care regardless of the accommodation outcome

B. Require the nurse to provide care to all assigned patients regardless of personal beliefs since refusal constitutes patient discrimination

C. Grant the accommodation automatically since conscientious objection should be respected for all sincerely held beliefs

D. Transfer the nurse to a unit where gender-affirming care is not provided to permanently resolve the conflict

93. A nurse manager is addressing a pattern where newer nurses consistently defer clinical decision-making to more experienced colleagues rather than developing independent clinical judgment. When faced with clinical questions, newer nurses immediately seek out a senior nurse rather than attempting to reason through the problem using their own knowledge base. Which developmental approach is MOST effective?

A. Instruct experienced nurses to decline answering newer nurses' clinical questions and redirect them to reference resources

B. Implement a policy requiring newer nurses to attempt independent problem-solving before consulting experienced colleagues

C. Coach experienced nurses to use a guided discovery approach — asking the newer nurse "what do you think?" and "what led you to that assessment?" before providing answers, gradually building the newer nurse's confidence in their own clinical reasoning while maintaining a safety net for high-risk decisions

D. Assign newer nurses to lower-acuity patients so they can develop independent judgment in less complex clinical situations

94. A nurse manager is developing a professional development approach for nurses at Benner's "expert" level. Expert nurses operate from a deep intuitive understanding of clinical situations and no longer rely on rules, guidelines, or analytic reasoning for routine situations. However, their expertise can make them resistant to evidence that contradicts their clinical intuition. Which development strategy is MOST appropriate for expert nurses?

A. Assign expert nurses exclusively to the most complex patients to ensure their expertise is maximally utilized

B. Exempt expert nurses from mandatory continuing education requirements since their clinical intuition exceeds what structured education can provide

C. Provide expert nurses with opportunities to lead clinical research, mentor advanced practitioners, influence organizational policy, and continuously evaluate whether their intuitive practice aligns with evolving evidence

D. Challenge expert nurses by exposing them to situations where their intuition is likely to be wrong so they learn the limitations of expertise, including emerging evidence that contradicts established practices, novel clinical presentations that do not fit familiar patterns, and simulation scenarios designed to create cognitive dissonance

95. A nurse manager is developing an approach to managing the professional implications of nurses who use artificial intelligence tools such as large language models to assist with clinical documentation, care planning, and patient education material development. Which guideline is MOST important?

A. Prohibit all AI tool use in clinical practice until regulatory agencies establish formal guidance on AI in nursing

B. Establish that nurses who use AI tools for clinical activities retain full professional accountability for the accuracy, appropriateness, and completeness of all AI-generated content, must verify AI output against their own clinical judgment and evidence-based standards before using it in patient care, and must disclose AI assistance per organizational policy

C. Allow unrestricted AI use since the tools improve efficiency and quality of clinical documentation

D. Restrict AI tool use to administrative tasks only and prohibit any application in clinical decision-making or patient-facing activities

96. A nurse manager is developing a business case for implementing a clinical documentation integrity program on the unit. Clinical documentation integrity ensures that medical record documentation accurately reflects the severity of illness, complexity of care, and risk of mortality for each patient. A CDI program on the unit would employ a dedicated CDI specialist at seventy-five thousand dollars annually. Which financial metric MOST compellingly justifies the investment?

A. The projected increase in case mix index resulting from more accurate clinical documentation, translated into higher DRG-based reimbursement per case that exceeds the CDI specialist's salary — since accurate documentation captures the true clinical complexity that current under-documentation fails to reflect

B. The reduction in claims denials from improved documentation quality

C. The improvement in quality metric reporting accuracy resulting from better clinical documentation

D. The reduction in nursing time spent responding to coding queries from the health information management department

97. A nurse manager is analyzing the unit's denial management data. In the past quarter, twenty-two inpatient claims were denied by payers, resulting in four hundred thirty-eight thousand dollars in lost revenue. Analysis reveals that sixty-eight percent of denials were related to clinical documentation that did not support the level of care billed. Which intervention is MOST effective?

A. Implement a denial prevention program that includes education for physicians and nurses on documentation requirements for medical necessity

B. Develop a real-time concurrent clinical documentation review process where a CDI specialist reviews documentation during the patient's stay and prompts physicians and nurses for clarification while the

patient is still hospitalized, rather than attempting to amend documentation retrospectively after the claim has been denied

C. Hire a dedicated denial management specialist who reviews all denied claims and files appeals within the required timeframes

D. Request that the billing department resubmit all denied claims with additional supporting documentation

98. A nurse manager is evaluating the financial impact of implementing a nurse-driven protocol for early removal of urinary catheters. The protocol empowers nurses to remove catheters when specific clinical criteria are met without requiring a physician order. Current data:

Average catheter days per patient: 4.2

Cost of CAUTI: $13,000 per event

Current CAUTI rate: 2.1 per 1,000 catheter days

Projected catheter day reduction with nurse-driven removal: 35%

Annual catheter days: 12,000

Which calculation provides the MOST compelling financial justification?

A. Calculate the projected reduction in catheter days (12,000 × 35% = 4,200 fewer catheter days) and multiply by the daily catheter supply cost to determine direct supply savings

B. Calculate the projected reduction in nursing time spent on catheter care and maintenance

C. Compare the protocol implementation cost against the projected quality improvement in CAUTI rates

D. Calculate: Reduced catheter days = 4,200. Current annual CAUTIs = 12,000 ÷ 1,000 × 2.1 = 25.2. Projected CAUTIs with reduced days = 7,800 ÷ 1,000 × 2.1 = 16.4. Prevented CAUTIs = 8.8. Financial value = 8.8 × $13,000 = $114,400 in avoided CAUTI costs annually, far exceeding the minimal protocol implementation cost

99. A nurse manager is developing a demand forecasting model to predict the unit's daily patient census seventy-two hours in advance. Accurate demand forecasting enables proactive staffing adjustments that reduce both understaffing and overstaffing. Which data inputs are MOST important for the forecasting model?

A. Historical census patterns by day of week and month, seasonal trends, and holiday patterns

B. Current inpatient census, scheduled admissions, and emergency department volume trends

C. Surgical scheduling data, since surgical admissions are the most predictable component of patient volume

D. A combination of historical patterns (day of week, seasonal, holiday), real-time operational data (current census, scheduled surgical cases, ED volume trends, anticipated discharges), and external factors (weather, community events, seasonal illness surveillance) that together provide the most accurate short-term prediction

100. A nurse manager is evaluating the unit's value analysis committee recommendations. The committee has recommended switching from a premium wound closure product costing eight dollars per unit to a comparable product costing three dollars per unit. The committee's analysis focused exclusively on unit price comparison. Which additional analysis is MOST important before approving the switch?

A. Survey nursing staff about their preference between the two products based on ease of use

B. Consult with the wound care specialist about clinical equivalency between the two products

C. Evaluate total cost of ownership including clinical outcomes data (wound complication rates, healing times, reopening rates), nursing time for application, patient satisfaction, and whether the cost difference is offset by any clinical outcome differences that would generate additional treatment costs

D. Request a trial supply of the lower-cost product and pilot it on a subset of patients before making a unit-wide switch

101. A nurse manager is developing a float pool utilization strategy for the unit. The current approach pulls float pool nurses to the unit on an as-needed basis with no unit-specific preparation. Data shows that float pool nurses on the unit have a medication error rate three times higher than permanent staff. Which intervention is MOST effective?

A. Request that the float pool assign only nurses with previous experience on the unit or with the unit's patient population

B. Develop a unit-specific float pool orientation packet, designate a resource nurse for float staff on each shift, implement a competency verification process for high-risk unit-specific skills, and limit float nurse assignments to patients with lower acuity until unit familiarity is established

C. Request that the staffing office stop sending float pool nurses to the unit and instead fill staffing gaps with overtime from permanent unit staff

D. Implement a dedicated float pool position that is assigned exclusively to the unit, creating a small group of float nurses who rotate only to this unit and develop familiarity with its protocols

102. A nurse manager is analyzing the unit's charge capture accuracy for nursing procedures. An audit comparing performed procedures to billed charges reveals that the unit is failing to capture charges for twenty-eight percent of performed procedures. The estimated annual revenue loss is one hundred sixty-eight thousand dollars. Which intervention is MOST effective?

A. Implement a charge capture training program for all nursing staff and require them to verify charges at the end of each shift

B. Assign the charge nurse responsibility for verifying that all procedures performed during each shift are captured in the billing system

C. Implement a real-time charge reconciliation process where nursing documentation automatically triggers charge capture through EHR integration

D. Redesign the charge capture workflow so that procedure documentation in the EHR automatically generates the corresponding charge, eliminating the separate manual charge entry step that creates the capture gap

103. A nurse manager is developing a proposal for a dedicated observation unit within the existing unit footprint. The observation unit would manage four beds for patients requiring twelve to twenty-four hours of monitoring. Currently, these patients occupy inpatient beds and are frequently reclassified to observation status retrospectively, creating billing complications. Which financial model is MOST appropriate?

A. Model the observation area as a cost center with savings generated from reduced inpatient bed utilization

B. Model the observation area as a revenue center billing at outpatient observation rates

C. The observation area cannot generate a positive financial return because observation reimbursement rates are lower than inpatient rates

D. Model the unit as a hybrid financial entity that generates direct observation billing revenue, reduces retrospective status reclassification losses, frees inpatient beds for higher-acuity admissions generating full DRG reimbursement, and produces downstream savings from reduced unnecessary inpatient days

104. A nurse manager reviews the following productive and nonproductive hours data:

| Category | Hours | % of Total |

|---|---|---|

| Direct patient care | 52,000 | 58.8% |

| Indirect patient care | 12,000 | 13.6% |

| Unit-related activities | 6,400 | 7.2% |

| Personal time (breaks) | 4,800 | 5.4% |

| Orientation | 3,200 | 3.6% |

| Education | 2,800 | 3.2% |

| Vacation/Holiday | 5,200 | 5.9% |

| Sick time | 2,000 | 2.3% |

| Total paid hours | 88,400 | 100% |

What percentage of total paid hours is productive (direct and indirect patient care plus unit-related activities)?

A. 58.8% (direct patient care only)

B. 72.4% (direct plus indirect patient care only)

C. 79.5% (direct plus indirect plus unit-related: 70,400 ÷ 88,400)

D. 85.1% (all categories except vacation and sick time)

105. A nurse manager is developing a supply chain resilience strategy for the unit following a period of critical supply shortages. The strategy must address the risk that key clinical supplies may become unavailable due to manufacturing disruptions, transportation failures, or demand surges. Which approach is MOST comprehensive?

A. Identify the unit's most critical supply items, establish par levels based on usage data plus safety stock, identify approved clinical substitutes for each critical item, develop relationships with secondary suppliers, create a communication plan for managing substitutions with clinical staff, and test the contingency processes through periodic drills

B. Increase the par levels for all supply items by fifty percent to create a buffer against future shortages

C. Contract with a secondary distributor who can provide emergency shipments when the primary supply chain is disrupted

D. Develop clinical protocols that reduce the unit's dependence on the supply items most vulnerable to shortage

106. A nurse manager is calculating the unit's labor cost per patient day. The following monthly data is available:

Total nursing salary expense: $320,000

Total nursing benefits expense: $96,000

Patient days: 780

What is the total labor cost per patient day, and how should the nurse manager use this metric?

A. $320,000 ÷ 780 = $410/PD for salary only. This underestimates the true labor cost by excluding benefits.

B. ($320,000 + $96,000) ÷ 780 = $533/PD. This metric should be trended monthly, benchmarked against peer units, and analyzed in conjunction with HPPD, skill mix, and quality outcomes to evaluate whether labor investment is producing proportional value

C. $96,000 ÷ 780 = $123/PD for benefits only. This metric is the most important component since benefits costs are the most variable.

D. ($320,000 + $96,000) ÷ 30 days = $13,867/day. This metric represents the unit's daily labor expenditure regardless of patient volume.

107. A nurse manager is evaluating a proposal to implement robotic process automation for routine nursing administrative tasks such as scheduling, supply ordering, and quality data compilation. The RPA system costs sixty thousand dollars annually and is projected to save one thousand two hundred nursing hours per year currently spent on administrative tasks. The average RN hourly rate including benefits is fifty-two dollars. What is the projected financial return?

A. Savings = 1,200 hours × $52/hour = $62,400. Net benefit = $62,400 − $60,000 = $2,400 annually. While the direct financial return is modest, the primary value is the reallocation of 1,200 nursing hours from administrative tasks to direct patient care, which may produce additional quality and satisfaction improvements that increase the total return

B. The RPA system does not produce a positive financial return since the $60,000 cost nearly equals the $62,400 in saved nursing hours

C. The financial return cannot be calculated without knowing how the 1,200 saved hours will be utilized

D. Savings = 1,200 hours × $52/hour = $62,400. The $2,400 net benefit is too small to justify the implementation risk and should be rejected

108. A nurse manager is developing a financial justification for implementing bedside ultrasound-guided peripheral IV insertion training for nursing staff. The training program costs twenty thousand dollars. Current data shows that the unit requests two hundred IV team consultations per month for difficult IV access, at an average cost of forty-five dollars per consultation. If nurse-performed ultrasound-guided insertion reduces consultations by sixty percent, what is the projected annual savings?

A. Annual consultations reduced = 200 × 60% × 12 months = 1,440. Savings = 1,440 × $45 = $64,800 annually. Net first-year benefit = $64,800 − $20,000 training cost = $44,800, with $64,800 annual savings in subsequent years

B. Annual savings = 200 × $45 × 12 = $108,000 (total consultation cost eliminated)

C. Annual savings = 120 × $45 × 12 = $64,800 (but this does not account for supply costs of ultrasound-guided insertion)

D. The savings cannot be calculated without data on the success rate of nurse-performed ultrasound-guided insertions

109. A nurse manager is analyzing the unit's DRG performance data:

| DRG | Cases | Avg LOS | Benchmark LOS | Avg Cost | Benchmark Cost |

|---|---|---|---|---|---|

| 291 (Heart Failure) | 85 | 5.2 | 4.1 | $9,800 | $7,200 |

| 392 (GI Hemorrhage) | 42 | 3.8 | 3.4 | $6,900 | $6,100 |

| 690 (UTI) | 68 | 4.1 | 3.2 | $5,600 | $4,300 |

Which DRG represents the GREATEST financial improvement opportunity?

A. DRG 291 has the highest cost variance ($2,600/case × 85 cases = $221,000 total excess cost) and the highest LOS variance, representing the largest absolute financial improvement opportunity

B. DRG 690 represents the greatest opportunity because the LOS variance of 0.9 days is the largest percentage deviation from benchmark

C. DRG 392 represents the greatest opportunity because GI hemorrhage patients have the most predictable clinical trajectory

D. All three DRGs should be addressed simultaneously since each exceeds benchmark

110. A nurse manager is developing a comprehensive financial dashboard for the unit. The dashboard must serve three audiences: the nurse manager for daily operational decisions, the nursing director for monthly performance review, and the CFO for quarterly strategic evaluation. Which dashboard design principle is MOST important?

A. Design a single unified dashboard that presents the same metrics to all three audiences, with each audience focusing on the metrics most relevant to their role, and organize the dashboard in a drill-down format where summary metrics link to detailed supporting data

B. Create three completely separate dashboards tailored to each audience with different metrics, formats, and update frequencies

C. Use the same metrics for all three audiences but present them at different levels of detail

D. Focus the dashboard exclusively on financial metrics since the three audiences share a common interest in the unit's fiscal performance

111. A nurse manager is calculating the cost-effectiveness of three approaches to managing nurse continuing education:

| Approach | Annual Cost | Impact on Certification Rate | Impact on Retention |

|---|---|---|---|

| Self-directed (current) | $5,000 | 18% certified | 78% retention |

| Conference-based | $25,000 | 22% certified | 80% retention |

| Structured program + mentoring | $45,000 | 38% certified | 89% retention |

The unit has 32 RNs. Each percentage point of improved retention prevents approximately 0.32 departures. Replacement cost per departure is $54,000. Which analysis supports the BEST investment decision?

A. The self-directed approach is most cost-effective since it costs the least while maintaining an acceptable certification rate

B. The conference-based approach provides a moderate improvement at a reasonable cost and represents the best compromise

C. The structured program produces 11 percentage points higher retention than the current approach (89% vs 78%). This prevents approximately 3.5 departures (11 × 0.32). Savings = 3.5 × $54,000 = $189,000. Net benefit = $189,000 − $45,000 = $144,000, making the structured program the clear financial winner while also doubling the certification rate

D. None of the approaches can be financially justified since continuing education is a professional obligation that should be self-funded by individual nurses

112. A nurse manager is evaluating the unit's performance in the context of value-based purchasing. The unit's Total Performance Score places the hospital in a position to receive an estimated VBP incentive payment of one point two million dollars. The nurse manager wants to understand the unit's specific contribution to this payment. Which analysis is MOST appropriate?

A. Calculate the unit's proportional share of the VBP payment based on the percentage of hospital revenue the unit generates

B. Determine which VBP domain scores the unit most influenced — clinical outcomes, patient experience, safety, and efficiency — and quantify the unit's contribution to each domain score, since the unit's nurse-sensitive indicators directly affect several VBP measures

C. The unit's contribution cannot be isolated since VBP payments are based on hospital-level performance

D. Calculate the unit's contribution by comparing the unit's quality scores to the hospital average and attributing a proportional share based on performance relative to the mean

113. A nurse manager is developing a proposal to implement a centralized patient monitoring hub that would allow one nurse to remotely monitor vital signs, telemetry, and clinical alerts for up to thirty patients. The hub would cost one hundred eighty thousand dollars annually to operate. Which outcome metric provides the STRONGEST financial justification?

A. The reduction in the number of bedside nurses needed on each shift as a result of centralized monitoring

B. The projected reduction in rapid response team activations and code blue events from earlier detection of clinical deterioration, translated into avoided ICU transfers, shortened length of stay, and prevented mortality, compared to the monitoring hub operating cost

C. The improvement in nursing satisfaction from reduced alarm fatigue resulting from centralized monitoring

D. The improvement in telemetry monitoring documentation compliance resulting from dedicated monitoring staff

114. A nurse manager is analyzing the unit's overtime patterns and discovers the following:

| Overtime Category | Monthly Hours | Monthly Cost |

|---|---|---|

| Mandatory (staffing gaps) | 280 | $18,200 |

| Voluntary (incentive shifts) | 160 | $12,000 |

| Incidental (shift overrun) | 120 | $7,800 |

| Education/meetings | 40 | $2,600 |

| Total | 600 | $40,600 |

Which overtime reduction strategy is MOST effective?

A. Focus on reducing voluntary overtime since it is entirely discretionary and can be eliminated without operational impact

B. Focus on reducing incidental overtime by streamlining end-of-shift activities, improving handoff efficiency, and addressing workflow bottlenecks that cause shift overruns

C. Implement a mandatory overtime cap to limit total overtime exposure

D. Focus on mandatory overtime since it represents the largest cost category and is driven by staffing gaps that can be addressed through recruitment, retention, and staffing model optimization, while also

analyzing whether voluntary incentive overtime is actually filling mandatory gaps and whether incidental overtime reflects workflow inefficiencies that can be resolved

115. A nurse manager is developing the unit's annual operating budget. Historical data shows that the unit consistently underspends the education budget by twenty-five percent and overspends the overtime budget by eighteen percent. The nurse manager suspects that the education underspend contributes to the overtime overspend because inadequate orientation and competency development leads to errors, rework, and extended shift times. Which budget strategy is MOST appropriate?

A. Reallocate funds from the education budget to the overtime budget to create a more realistic spending plan that reflects actual utilization patterns

B. Maintain both budgets at current levels and implement interventions to increase education spending and decrease overtime spending independently

C. Present a comprehensive analysis demonstrating the suspected causal relationship between education underspend and overtime overspend, propose a budget rebalancing that increases education investment in targeted areas such as orientation, competency development, and technology training, and project the expected overtime reduction from the enhanced education investment, creating a budget that invests proactively rather than reacting to the consequences of underinvestment

D. Request an overall budget increase to fully fund both education and overtime at the levels each actually requires

## Answer Key – Exam 11 (with Full Answer Explanations)

1. D — Motivational interviewing's core skills include open-ended questions, reflective listening, and affirmations that explore the patient's own reasons for change. MI is fundamentally non-directive — the clinician evokes motivation from the patient rather than imposing it externally. This approach produces more durable behavior change than information-based or confrontational methods.

2. B — Addressing the underlying drivers — wait times, pain management, and feeling unheard — through proactive rounding targets the root causes of sixty percent of AMA discharges. Patients who leave AMA are often responding to unmet needs rather than rejecting medical care. Proactive identification and resolution of complaints prevents the accumulation of frustration that leads to the AMA decision.

3. B — Integrating portal activation into the care process with staff-assisted enrollment, feature demonstration using the patient's own data, and a bedside practice session produces the highest activation rates. Research shows that hands-on guided enrollment during hospitalization is significantly more effective than passive information distribution or post-discharge outreach.

4. C — Presenting evidence that family-centered rounding improves outcomes without significantly extending time and piloting with willing physicians addresses resistance through data and demonstration rather than mandate. Physician resistance to family presence is best overcome through evidence and peer experience rather than administrative requirement.

5. A — Framing teach-back as the nurse's responsibility ("I want to make sure I explained clearly") rather than testing the patient shifts accountability and reduces the perception of being quizzed. The framing technique is the most important coaching point because it transforms teach-back from a compliance check into a collaborative verification of communication quality.

6. C — A structured introduction where the bedside nurse introduces the virtual nurse by name and role, explains the complementary relationship, and ensures the patient understands how to contact each nurse directly addresses the confusion. New care models require explicit role clarification at the point of patient contact.

7. C — A tiered escalation language protocol with progressively assertive stages — SBAR, direct safety statement, chain of command — with clear criteria for each level provides a comprehensive communication framework. The tiered approach gives nurses tools for every escalation level rather than a single all-or-nothing option.

8. A — Regular interprofessional simulation exercises with structured debriefing addressing each IPEC domain develops all four competencies simultaneously through experiential learning. Simulation creates the shared experience that builds values, role understanding, communication skills, and teamwork in a safe environment.

9. A — Acknowledging the concern while explaining the Cures Act requirement and developing a proactive communication workflow balances legal compliance with clinical sensitivity. The 21st Century Cures Act requires timely release of results, and the solution is proactive clinician outreach rather than information withholding.

10. C — A daily interdisciplinary care coordination huddle where the primary team and consultants align on the plan, resolve conflicts, and designate accountability creates the structured coordination that

prevents fragmented care. Multi-specialist care requires a synchronization mechanism that ad hoc communication cannot provide.

11. B — Addressing non-compliance through the chain of command with evidence supporting closed-loop communication establishes that read-back is an organizational safety requirement, not an optional practice. Closed-loop communication for critical results is a Joint Commission NPSG requirement that applies to all clinicians.

12. C — Addressing language and attitudes as a culture issue, reframing readmissions as a system failure, investigating barriers, and developing a comprehensive plan addresses both the professional conduct concern and the clinical root cause. "Frequent flyer" labeling reflects a system that has failed the patient, not a patient who has failed the system.

13. A — Asking what health goals matter most, developing a personalized action plan, supporting self-efficacy through incremental success, and following up collaboratively reflects the health coaching approach. Health coaching prioritizes the patient's agenda and intrinsic motivation rather than the clinician's educational objectives.

14. C — Presenting data correlating missed huddles with safety events and readmissions to medical staff leadership and proposing a joint accountability solution escalates appropriately with evidence. When informal discussions fail, data-driven escalation through the medical staff governance structure creates organizational accountability.

15. A — Using video observation as a coaching tool to identify specific warmth gaps, demonstrating alternatives, practicing through role-play, and providing real-time feedback develops the specific interpersonal behaviors the nurse is missing. Video self-review is one of the most effective communication coaching techniques because it creates objective self-awareness.

16. B — Strategies for redirecting personal questions warmly while respecting each nurse's sharing boundaries provides practical guidance without imposing rigid rules. Nurses need tools for managing the boundary between professional rapport and personal disclosure that honor individual comfort levels.

17. D — Addressing the physician directly in private with specific behaviors, their impact on staff and patient perception, and expectations for professional courtesy is the most appropriate response. Physician behaviors that patients notice and comment on require direct, private, specific feedback rather than passive environmental changes.

18. B — Acknowledging the waiting experience, validating that pain lengthens perceived time, explaining the process, and developing a proactive pain management plan addresses both the emotional and practical dimensions. Unmet expectations are best managed by validating the experience and collaboratively adjusting expectations.

19. A — Following the organizational disclosure policy by informing the patient about the timing error, explaining what happened, describing the clinical effect, and documenting the disclosure fulfills the ethical obligation for honest communication. Organizational disclosure policies exist to guide transparent communication about adverse events regardless of severity.

20. A — A multifaceted compassion resilience program addressing self-awareness, peer support, restorative activities, counseling access, workload management, and leadership modeling provides the comprehensive approach compassion fatigue requires. Compassion fatigue is a system-level problem requiring system-level interventions, not individual coping mandates.

21. D — A secure messaging standard defining expected response formats, establishing that clinical questions require substantive responses, providing examples, and creating an escalation pathway addresses the ambiguity while preserving texting's efficiency benefits. The problem is not the medium but the communication quality within the medium.

22. C — Education on cognitive impairment-specific communication strategies integrated into the care plan as a communication modifier provides the comprehensive approach. Cognitive impairment requires specific communication adaptations — simplified language, visual cues, patience with processing — that general communication training does not address.

23. C — Training the transitions coach to empower patients rather than create dependency is the most critical element. The Care Transitions Intervention's effectiveness depends on the coach developing the patient's self-management capacity. A coach who does the work for the patient undermines the model's fundamental purpose.

24. A — A transfer-specific addendum prompting communication of pending results, recently administered medications, and communication needs directly addresses the three most frequently lost information categories. Targeted handoff tools that address specific identified gaps are more effective than generic handoff enhancements.

25. A — Teaching the nurse to document specific teach-back content provides auditable evidence of comprehension verification. "Patient verbalized understanding" is legally insufficient because it does not

demonstrate what the patient actually understood. Specific documentation such as "correctly stated three signs of hypoglycemia" provides verifiable evidence.

26. D — A comprehensive plan including advance notification, modified bed management, capacity emergency escalation, daily census monitoring with automatic alerts, and re-opening communication addresses all operational dimensions of a temporary capacity reduction. Capacity changes affect multiple departments and require coordinated planning.

27. C — Evaluating whether rounds are conducted with fidelity to the protocol — genuinely assessing and addressing all four comfort domains versus simply checking a box — identifies the most likely cause of diminished results despite acceptable compliance rates. Protocol compliance without content fidelity produces compliance data without clinical benefit.

28. C — Balancing the patient's right to share their experience with staff privacy by establishing that staff may decline filming, offering accommodations like audio-only recording, and creating organizational guidelines addresses both perspectives. Neither unrestricted recording nor complete prohibition adequately balances patient autonomy with staff privacy.

29. A — A standardized immediate response protocol ensuring consistent management regardless of which nurse receives the disclosure is the most critical element. Inconsistent responses to suicidal ideation create dangerous gaps where patients expressing genuine distress may not receive adequate safety assessment and intervention.

30. B — Ensuring the patient's immediate clinical needs — managing the transfusion reaction — and implementing the sentinel event response protocol must come first. The patient's safety is always the first priority. Root cause analysis, notification, and investigation follow after the patient is stabilized and the scene is secured.

31. D — Presenting evidence of cumulative asymptomatic injury, demonstrating dual nurse-patient protection, establishing the policy as non-negotiable, and enforcing consistently addresses the resistance. Manual patient handling injuries are often cumulative and asymptomatic until irreversible damage occurs, making experienced nurses' injury-free history a poor predictor of future risk.

32. A — Immediately notifying the blood bank to verify all issued products, hold pending transfusions, and trace the intended product prevents a potential second wrong-patient transfusion. A wrong-patient blood event means the intended product may have been given to or be in process for another patient, creating an immediate second-patient risk.

33. D — A time-out without active team participation and verbal confirmation from all members fails its safety purpose. The Universal Protocol requires that the time-out be a team verification where each member independently confirms correct patient, procedure, and site. A physician-only time-out is a single-point verification that cannot catch errors the physician may share.

34. C — Daily nursing assessment using a standardized tool with replacement triggered by clinical indicators aligns with current CDC evidence. The CDC no longer recommends routine time-based replacement because research shows that clinically indicated replacement produces equivalent or better outcomes with fewer unnecessary insertions.

35. D — Collaborating with informatics to analyze override patterns, categorize appropriateness, eliminate low-value alerts, increase specificity, and preserve high-value alerts addresses alert fatigue systematically. A sixty-eight percent override rate indicates that most alerts are not driving clinical decisions. Reducing alert volume while increasing relevance is the evidence-based approach.

36. C — Collaborating across departments with predictive analytics, proactive discharge strategies, and flexible staffing models addresses census variation at its sources. Census variation is driven by multiple interacting factors across the organization that no single department can control. System-level coordination is required.

37. B — Analyzing the near-miss with the same rigor as a harmful event identifies system vulnerabilities that current defenses failed to catch. Near-misses reveal the same system weaknesses as actual harm events but without the patient consequence. They are free lessons that the organization should analyze with equal thoroughness.

38. D — Standardizing ordering, dispensing, administration, and monitoring with dose-range limits, mandatory laboratory monitoring, bleeding assessment, and patient education addresses all components of the anticoagulation safety NPSG. Anticoagulation safety requires end-to-end standardization from ordering through patient self-management education.

39. C — The thirty-five-minute fall risk change response time is most concerning because falls can occur within minutes of a risk status change. A thirty-five-minute gap between alert and intervention creates a window during which the patient is at elevated risk without corresponding protective measures in place.

40. D — Analyzing population-level data to identify high-frequency diagnoses, comorbidity clusters, complication patterns, and social determinant profiles, then designing proactive care bundles tailored to these patterns applies population health management at the unit level. This approach anticipates needs based on population characteristics rather than reacting to individual events.

41. D — Investigating the specific patient experience during discharge — when education occurs, how it is delivered, whether comprehension is verified, and whether patients feel prepared — identifies why excellent clinical care does not translate to perceived transition readiness. The gap between clinical quality and transition preparation is a process issue.

42. C — A comprehensive safe patient handling program with mechanical lifts, ceiling-mounted equipment, patient assessment, staff training, culture shift, and leadership enforcement produces the greatest injury reduction. Annual body mechanics training has been shown to be ineffective at preventing musculoskeletal injuries; mechanical lift programs reduce injuries by forty to sixty percent.

43. A — Ensuring consistent staff use of EHR capabilities including documentation, CPOE support, CDS alerts, portal promotion, and medication reconciliation directly supports Promoting Interoperability compliance. The program requires demonstrated meaningful use of EHR capabilities, not just technology availability.

44. C — Educating staff on the model's supplementary role, explaining sensitivity/specificity characteristics, establishing assessment protocols for high-risk scores, and creating a feedback loop for model refinement builds appropriate trust. Predictive analytics tools are decision support, not decision makers, and staff need education on their proper role.

45. B — Presenting data showing transfer-point medication discrepancies as a documented adverse event source, implementing a streamlined reconciliation process, and integrating it into the transfer workflow addresses the compliance gap with evidence and practical solutions. Internal transfers create medication risks even when no intentional changes are made.

46. B — Ensuring accurate, validated data collection, preparing staff to understand the data, developing a quality-outcomes narrative, and planning for public inquiries provides comprehensive preparation. Public reporting creates accountability that benefits patients when the data is accurate and contextualized with quality outcomes.

47. C — Comprehensive education on state-specific legal requirements, the nurse's role, documentation requirements, patient rights, legal review processes, and psychiatric collaboration addresses the full scope of involuntary hold management. Involuntary holds have specific legal requirements that vary by state, and nurses must understand both their authority and their obligations.

48. A — A human factors approach evaluating device-user interfaces, identifying error-contributing design features, standardizing protocols, providing point-of-use training, and incorporating independent double-checks addresses the root cause of medical device use-errors. Device errors typically result from interface design problems that human factors analysis can identify and mitigate.

49. C — Continuing to reduce central line utilization toward the target is appropriate because unnecessary lines expose patients to CLABSI risk even with excellent maintenance. Achieving the CLABSI rate target does not eliminate the obligation to minimize unnecessary device use, which is the primary prevention strategy.

50. C — Investigating whether skin assessment techniques, tools, and training adequately address assessment across diverse skin tones identifies the most actionable root cause. Stage 1 pressure injuries are more difficult to detect on darker skin using traditional blanching assessment techniques, and assessment tools may not adequately account for this clinical reality.

51. B — Double-loop learning questions whether the unit's fundamental assumptions about why patients fall are correct. Two years of PDSA cycles without improvement suggests that the interventions are based on assumptions about fall causation that may not match the unit's actual fall patterns. The breakthrough requires questioning the assumptions, not running more cycles within them.

52. B — Mapping the benefits and downsides of both standardization and individualization and developing an approach that harvests benefits while monitoring for downsides applies polarity management correctly. Polarities cannot be "solved" — attempting to eliminate one pole creates the downsides of the other. Both must be actively managed.

53. A — Senge's "the enemy is out there" describes the tendency to attribute problems to external factors rather than examining internal contributions. While multiple learning disabilities may apply, the pattern described — repeated errors without collective learning — most closely reflects failure to examine internal practices as contributing factors.

54. D — Observing routine clinical work to understand how nurses successfully adapt, recover from near-errors, and maintain safety, then using insights to amplify successful behaviors demonstrates Safety-II thinking. Safety-II studies what goes right in everyday work rather than focusing exclusively on what goes wrong.

55. B — Developing capacity to anticipate threats, monitor conditions, respond to disturbances, and learn from both successes and failures directly builds the four capacities of resilience engineering. Resilience is not about preventing all failures but about building the system's capacity to function effectively despite inevitable disturbances.

56. B — Wicked problems require iterative, adaptive approaches with small-scale interventions, unintended consequence monitoring, continuous stakeholder dialogue, and acceptance that the problem will be managed rather than solved. Traditional problem-solving methodologies assume definable problems with identifiable solutions — assumptions that do not hold for wicked problems.

57. A — The most significant challenge is cultural, not technological — ensuring bedside nurses view virtual nurses as partners rather than surveillance, that patients accept virtual interactions, and that the role integrates into rather than disrupts the existing model. Technology adoption fails when cultural integration is neglected.

58. B — Setting clear boundaries and simple rules that enable adaptation, observing emerging patterns, amplifying positive developments, and creating conditions for innovation rather than dictating behaviors is the appropriate leadership approach for complex adaptive systems. Complex systems cannot be controlled through directive leadership.

59. C — Transitioning from reactive to proactive risk identification through prospective assessment, hazard analysis, and safety culture surveys that reveal latent vulnerabilities defines the Level 2 to Level 3 advancement. The fundamental shift from reactive to proactive safety management distinguishes defined organizations from developing ones.

60. A — Medication errors and falls account for sixty-three percent of all adverse events. The Pareto principle states that roughly eighty percent of effects come from twenty percent of causes. Concentrating resources on the two largest categories will produce the greatest overall event reduction per improvement dollar invested.

61. A — Focusing on system-level changes addressing workload, documentation burden, work environment, culture, and autonomy rather than individual coping aligns with the NAM framework. The NAM study specifically concluded that burnout is a system problem, not an individual resilience deficit, and interventions must target system factors.

62. D — Measurable changes in unit-level outcomes that can be attributed to the residency program's impact on new graduate performance represents Kirkpatrick Level 4 (Results) evaluation. Level 4 measures the organizational impact of the training, not participant reaction, learning, or behavior change.

63. B — Documenting migrated responsibilities, quantifying the time burden, assessing impact on nursing-specific care, and presenting analysis with a resolution proposal addresses scope creep through evidence-based advocacy. Gradual responsibility migration without corresponding resource adjustment degrades nursing care quality over time.

64. D — Coaching charge nurses to remove barriers, develop capabilities, ask questions that build independent thinking, and measure effectiveness by staff growth shifts the charge nurse from directive manager to servant leader. Servant leadership is demonstrated by the growth and development of those being served.

65. D — Complex domain problems require a probe-sense-respond approach with safe-to-fail experiments because cause-and-effect relationships are only apparent in retrospect. The key indicators — unexpected consequences, unclear variable relationships, disproportionate effects — define Cynefin's complex domain.

66. B — Distributing AAR findings beyond the immediate team through structured knowledge-sharing is most critical because learning trapped within the team that experienced the event cannot benefit the broader organization. Organizational learning requires systematic knowledge dissemination.

67. A — Creating a comprehensive procedures manual that documents every process including the informal practices provides the most complete knowledge capture. However, the MOST effective approach combines documentation with mentoring and decision support tools, making option A the best available choice as it creates the most enduring reference.

68. D — Creating multiple leadership opportunities at every level with coaching and progressive responsibility develops distributed leadership across the entire team. Distributed leadership is built by creating many leadership roles, not by concentrating development in a few high-potential individuals.

69. B — Identifying and celebrating conditions when engagement is highest, understanding what makes those moments exceptional, and intentionally creating more of those conditions applies appreciative leadership. The approach amplifies existing positive patterns rather than diagnosing and fixing deficits.

70. C — Using the data as a developmental tool with individual metric review, behavioral factor identification, individualized improvement plans, and peer mentoring from high performers is the most appropriate application. Leadership effectiveness data should drive development, not personnel decisions based on metrics alone.

71. A — Identifying workarounds, assessing safety risk, either eliminating the deviation or modifying the protocol to incorporate a safer version, and monitoring for new deviations addresses normalization of deviance comprehensively. Some workarounds reflect genuinely problematic protocols that should be revised rather than enforced.

72. C — Creating protected time and resources for innovation within operational structures, establishing evaluation and piloting processes, and celebrating both operational excellence and innovation develops organizational ambidexterity. The key is pursuing both exploitation and exploration simultaneously within the same organizational unit.

73. D — Regulating distress — providing enough pressure for motivation without overwhelming the team — while maintaining a holding environment for identity processing, experimentation, and internalization is Heifetz's prescription for adaptive challenges. Adaptive change threatens identity and requires emotional management alongside behavioral change.

74. C — The knowing-doing gap is typically caused by system-level factors — time pressure, inconvenient environment design, tolerant social norms, and cognitive overload — rather than individual knowledge or motivation deficits. Solutions must redesign the system to make correct behavior the easy default.

75. D — A comprehensive transition plan addressing staffing augmentation, tiered training, workflow redesign, command center coordination, contingency planning, morale support, and post-go-live optimization covers all dimensions. EHR transitions are among the most disruptive organizational changes and require planning across every operational domain.

76. B — Shared governance with genuine decision-making authority and pathways for organizational committee participation directly addresses the PES-NWI "nurse participation in hospital affairs" subscale. This subscale measures whether nurses have real influence in organizational decisions, not just advisory input.

77. D — Projects that lack hardwiring mechanisms — standard work integration, documentation system embedding, orientation inclusion, and accountability structures — depend on continued attention that inevitably shifts. Sustainability requires making the improvement the default practice through system-level integration.

78. A — Reframing challenges as growth opportunities, focusing feedback on behaviors rather than ability, modeling growth language, and treating mistakes as learning data builds growth mindset culture. Growth mindset is cultivated through environmental signals rather than individual training.

79. B — Structured knowledge elicitation using cognitive task analysis, critical decision method interviews, and teach-back sessions captures tacit knowledge that experts often cannot articulate spontaneously. Written manuals capture explicit knowledge, but the most valuable institutional knowledge — clinical judgment patterns and decision heuristics — requires structured elicitation techniques.

80. B — Following the impaired professional policy with documented observations, patient care removal if needed, fitness-for-duty referral, and concern for the nurse's well-being alongside patient safety follows the appropriate process. The approach must balance immediate patient safety with compassionate support for the potentially impaired nurse.

81. D — Providing a personal cell phone number creates a dual relationship that extends the nurse-patient relationship beyond professional boundaries and beyond the nurse's ability to provide continuity. Personal contact information creates expectations for availability that blur professional and personal roles.

82. A — A comprehensive certification support program addressing all documented barriers — cost, time, preparation support, incentives, recognition, and career integration — produces the highest certification rates. Multi-barrier problems require multi-component solutions that address each barrier systematically.

83. C — Advising the nurse to contact the organization's legal department before providing any statement ensures appropriate legal guidance, protection of interests, and policy compliance. Individual nurses should not provide legal statements without organizational legal consultation since their statements may have implications for both personal and organizational liability.

84. B — Clear guidelines distinguishing protected expression from prohibited content with healthcare-specific examples provides balanced governance. The most important element is clarity about what is and is not acceptable, with examples that make the distinctions concrete rather than abstract.

85. D — Reporting the alleged record alteration to compliance, risk management, and medical staff leadership while addressing the HIPAA concern separately and ensuring whistleblower protections addresses all dimensions. Documentation integrity violations require organizational investigation. The nurse's personal-device photography, while a HIPAA concern, does not invalidate the substantive allegation.

86. C — Comprehensive support including scheduling flexibility, reduced hours during intensive periods, tuition assistance, mentoring, study space, and workload monitoring addresses the documented risks. Nurses pursuing advanced education need proactive support systems rather than discouragement or unsupported accommodation.

87. A — A nursing ethics education program teaching decision-making frameworks and empowering nurses to voice concerns through established channels addresses the foundational deficit. An ethical climate described as "we just follow orders" reflects a fundamental absence of ethical agency that education and empowerment can develop.

88. A — Reviewing the policy to determine whether continuing education constitutes personal use, consulting HR if ambiguous, and establishing clear guidance provides the appropriate response. The distinction between personal and professional technology use is policy-dependent, and ambiguity requires clarification rather than unilateral interpretation.

89. D — A fully objective, independent evaluation with documented performance rationale, representation access, consistency verification with precedent, and clear separation from the complaint process ensures both fairness and safety. When a fitness-for-duty referral coincides with a complaint, procedural rigor protects all parties.

90. B — A comprehensive night-shift-accessible program including asynchronous education, recorded activities, night-specific leadership, dedicated mentoring, and equitable advancement access addresses the systemic professional development inequity. Night shift nurses deserve equivalent professional development access through formats that accommodate their schedules.

91. A — The nurse manager should recognize that nurses must advocate for patient understanding before genomic information is acted upon, as patients have a right to genetic counseling. Genomic data raises unique ethical concerns about informed consent and the right to know — or not know — genetic predisposition information.

92. D — Evaluating accommodation feasibility, providing an alternative assignment if possible, and ensuring equitable patient care regardless of outcome follows the framework for value-based practice conflicts. Personal belief accommodations are evaluated on a case-by-case basis, balancing individual conscience with patient access and colleague equity.

93. C — Coaching experienced nurses to use guided discovery — asking "what do you think?" before answering — builds independent reasoning while maintaining safety. The approach develops clinical judgment through supported practice rather than forced independence or continued dependence.

94. D — Challenging expert nurses with situations where intuition may fail — contradicting evidence, novel presentations, and cognitive dissonance scenarios — prevents expertise from becoming a barrier to continued learning. Expert-level development requires confronting the limitations of intuitive practice.

95. B — Establishing that nurses retain full accountability for AI-generated content, must verify against clinical judgment and evidence, and must disclose AI assistance provides the essential governance framework. AI tools in clinical practice require clear accountability structures since the nurse — not the algorithm — bears professional responsibility.

96. A — The projected CMI increase from accurate documentation, translated into higher DRG reimbursement per case exceeding the CDI specialist's salary, provides the most compelling financial justification. CDI programs capture the true clinical complexity that under-documentation misses, directly increasing legitimate reimbursement.

97. B — A real-time concurrent review process that prompts documentation clarification while the patient is hospitalized prevents denials at the source. Sixty-eight percent of denials related to

documentation inadequacy are most effectively addressed during the stay when clinical context is available and amendments are straightforward.

98. D — Calculating reduced catheter days (4,200), current versus projected CAUTIs (25.2 vs 16.4), prevented events (8.8), and financial value ($114,400) provides the comprehensive cost-avoidance calculation. Nurse-driven catheter removal protocols generate substantial savings through prevented infections that dwarf implementation costs.

99. D — A combination of historical patterns, real-time operational data, and external factors provides the most accurate seventy-two-hour census prediction. No single data source captures all the variables that influence daily census. Integrated models that combine multiple predictive inputs outperform single-source forecasting.

100. C — Evaluating total cost of ownership including clinical outcomes, nursing time, patient satisfaction, and whether the cost difference is offset by outcome differences provides the complete picture. Unit price comparisons that ignore clinical performance differences can produce false savings that increase total care costs.

101. B — A unit-specific float pool orientation, designated resource nurse, competency verification for high-risk skills, and initial lower-acuity assignments addresses the threefold medication error rate directly. The error rate differential between float and permanent staff reflects unfamiliarity with unit-specific practices that targeted orientation can reduce.

102. D — Redesigning the workflow so procedure documentation automatically generates charges eliminates the manual charge entry step where capture fails. When twenty-eight percent of charges are missed, the problem is the process requiring a separate manual step rather than individual nurse compliance.

103. D — A hybrid model capturing observation billing revenue, reduced retrospective reclassification losses, freed inpatient bed capacity for higher-acuity DRG admissions, and reduced unnecessary inpatient days provides the complete financial picture. Dedicated observation areas generate value through multiple financial channels simultaneously.

104. C — Productive hours = direct care (52,000) + indirect care (12,000) + unit-related (6,400) = 70,400. Percentage = 70,400 ÷ 88,400 = 79.5%. This calculation includes all activities that directly or indirectly contribute to patient care and unit operations, which constitute productive nursing time.

105. A — Identifying critical items, establishing par levels with safety stock, identifying clinical substitutes, building secondary supplier relationships, creating a communication plan, and testing through drills provides the comprehensive supply chain resilience strategy. Resilience requires both prevention (alternatives and buffers) and response (communication and contingency plans).

106. B — ($320,000 + $96,000) ÷ 780 = $533 per patient day. This metric must be trended, benchmarked, and analyzed alongside HPPD, skill mix, and quality outcomes to evaluate whether labor investment produces proportional value. Total labor cost per patient day is meaningless without the context of what that investment produces.

107. A — Savings of $62,400 against $60,000 cost produces a modest $2,400 direct return, but the primary value is redirecting 1,200 hours from administrative tasks to patient care. The RPA investment is justified by the combined financial return and the clinical quality improvement from recaptured nursing hours.

108. A — 200 consultations × 60% reduction × 12 months = 1,440 eliminated consultations × $45 = $64,800 annual savings. First-year net = $64,800 − $20,000 = $44,800. Subsequent years = $64,800 annually. The training investment pays for itself within the first four months and produces ongoing annual returns.

109. B — DRG 291 (Heart Failure) has the highest absolute cost variance: $2,600 per case × 85 cases = $221,000 total excess cost. DRG 690 has $88,400 total excess (68 × $1,300) and DRG 392 has $33,600 (42 × $800). The absolute dollar opportunity determines where improvement resources will produce the greatest financial return.

110. A — A single dashboard with drill-down capability that presents summary metrics linking to supporting detail serves all three audiences efficiently. The nurse manager sees daily operational data, the director reviews monthly performance trends, and the CFO evaluates quarterly strategic metrics — all from the same data source at different levels of detail.

111. C — The structured program prevents approximately 3.5 departures saving $189,000 against a $45,000 investment for a net benefit of $144,000 while doubling certification rates. This is the clear financial winner because retention savings alone produce a 4.2:1 ROI, with certification improvement as an additional non-financial benefit.

112. B — Determining which VBP domain scores the unit most influenced and quantifying the contribution is the most appropriate analysis. The unit's nurse-sensitive indicators directly affect clinical outcomes, patient experience, and safety domain scores that drive the VBP calculation.

113. B — Projected reduction in rapid response activations and code blue events from earlier deterioration detection, translated into avoided ICU transfers, shortened stays, and prevented mortality, provides the strongest financial justification. Centralized monitoring's primary value is earlier detection that prevents costly downstream clinical events.

114. D — Mandatory overtime represents the largest cost category and is driven by staffing gaps that targeted recruitment and retention can address. The analysis must also examine whether voluntary incentive overtime is filling mandatory gaps and whether incidental overtime reflects correctable workflow inefficiencies.

115. C — Presenting the causal analysis linking education underspend to overtime overspend, proposing rebalanced investment in targeted education areas, and projecting overtime reduction demonstrates strategic budget thinking. Budgets that perpetuate reactive spending patterns rather than investing in root cause solutions waste organizational resources.