

PRACTICE EXAM 12 — FULL-LENGTH SIMULATION (115 QUESTIONS)

1. A nurse manager is implementing a patient navigation program where trained staff guide patients through the complexities of the healthcare system from pre-admission through post-discharge. The navigator role requires extensive communication with multiple departments, physicians, insurance companies, and community resources. The nurse manager must decide whether to hire a registered nurse or a non-clinical community health worker as the navigator. Which factor should receive the **GREATEST** weight in the hiring decision?

A. The specific communication demands of the role — if the position requires clinical assessment, care coordination decisions, and medication management communication, an RN is required, while if the role focuses primarily on logistics, system navigation, scheduling, and social service coordination, a community health worker may be equally or more effective at lower cost

B. The organizational preference for hiring registered nurses for all patient-facing positions to ensure clinical credibility

C. The salary differential between an RN navigator and a community health worker navigator since the lower-cost option preserves budget for other patient experience initiatives

D. The availability of candidates in each category since the regional nursing shortage may make it easier to recruit a community health worker

2. A nurse manager is coaching a nurse who has difficulty adapting communication style to different audiences. The nurse communicates clinical information identically whether speaking to a physician, a nursing assistant, a patient with a doctoral degree, or a patient with limited health literacy. Which coaching approach is **MOST** effective?

A. Provide the nurse with a communication style guide that describes the appropriate register for each audience type

B. Assign the nurse to observe a colleague who naturally adapts communication style and discuss the observed differences

C. Use specific recorded examples of the nurse's communication with different audiences, identify where adaptation was needed but absent, demonstrate how the same clinical content can be framed

differently for different audiences, and practice audience-adaptive communication through role-play with feedback

D. Accept that some nurses communicate in a single style and focus coaching on other interpersonal skills

3. A nurse manager is developing a strategy for communicating with patients who are experiencing homelessness and have been admitted for medical care. These patients often distrust healthcare institutions, have unmet social needs that affect their health, and may leave before treatment is complete. Staff report feeling frustrated when discharge planning is impossible because the patient has no home to be discharged to. Which communication approach is MOST effective for this population?

A. Focus communication exclusively on the immediate medical condition and defer social service discussions to the case management department

B. Provide the patient with a comprehensive list of community resources for housing, food, and social services at the time of admission

C. Assign the most empathetic nurse to homeless patients since they require more emotional support than the average patient population

D. Build trust through consistent, non-judgmental communication, address the patient's self-identified priorities alongside medical needs, involve social work from admission, develop a realistic discharge plan that accounts for the patient's actual living situation, and create a follow-up communication pathway that does not depend on a home address or telephone

4. A nurse manager is implementing a "communication time-out" protocol for high-risk clinical handoffs. Similar to the surgical time-out, this protocol requires a structured pause before critical care transitions where both the sending and receiving teams verbally confirm patient identity, clinical status, active treatments, safety risks, and the plan of care. Staff express concern that the protocol adds time to an already rushed process. Which implementation approach is MOST effective?

A. Implement the protocol for all patient transitions regardless of risk level to create a universal habit

B. Mandate the protocol with strict enforcement and progressive discipline for non-compliance

C. Pilot the protocol during high-risk transitions only — such as ICU-to-floor transfers and post-operative handoffs — demonstrate that the time investment prevents errors and callbacks that consume more time than the protocol itself, and use outcome data to build support for broader adoption

D. Allow each sending and receiving team to negotiate whether the communication time-out is necessary for each individual transfer

5. A nurse manager discovers that patient satisfaction scores for "courtesy and respect" have declined sharply among patients ages eighteen to thirty-four while remaining stable among older patients. Focus group data reveals that younger patients experience nurse interactions as "condescending" and feel their health concerns are minimized with phrases like "you're young and healthy" or "you'll bounce back quickly." Which intervention is MOST targeted?

A. Educate staff on age-related communication biases, provide examples of how language that minimizes symptoms based on age affects younger patients' trust and engagement, develop communication approaches that validate concerns regardless of the patient's age, and monitor satisfaction scores by age group after intervention

B. Implement a standardized patient communication script that uses the same language with all patients regardless of age

C. Assign younger nursing staff to patients ages eighteen to thirty-four since generational similarity may improve communication quality

D. Survey younger patients specifically about what communication behaviors they find condescending and share the feedback with nursing staff

6. A nurse manager is responsible for a unit where a patient with a documented severe latex allergy has been placed in a room that was recently cleaned using latex-containing gloves and had latex supplies stored in the room. The patient has not yet been exposed but the risk is present. The error occurred because the allergy alert was documented in the medical record but not communicated to environmental services or the bed management office. Which system improvement is MOST effective?

A. Implement an allergy alert system that automatically flags patients with severe allergies across all relevant departments — including bed management, environmental services, dietary, and supply chain — when the allergy is documented in the medical record, triggering environmental preparation protocols before the patient arrives in the room

B. Require the admitting nurse to personally notify all relevant departments of any patient allergies upon admission

C. Post allergy signs on the patient's door so anyone entering the room can verify that their supplies are allergy-safe

D. Assign an allergy verification step to the charge nurse during the bed assignment process

7. A nurse manager is developing a communication protocol for managing patients who bring their own medical devices to the hospital — including continuous glucose monitors, insulin pumps, and wearable cardiac monitors. Current practice is inconsistent: some nurses allow patients to continue using personal devices while others require all personal medical devices to be removed and replaced with hospital-issued equipment. Which approach is MOST appropriate?

A. Implement a policy requiring all patients to use hospital-issued equipment exclusively since personal device accuracy cannot be verified by hospital biomedical engineering

B. Develop a standardized assessment protocol that evaluates each patient's personal device for functionality and compatibility with hospital systems, establishes communication expectations for how personal device data will be integrated into the clinical record, and defines criteria for when personal devices should be supplemented with hospital monitoring

C. Allow patients to use their personal devices without restriction since patients are most familiar with their own equipment and self-management practices

D. Defer all personal medical device decisions to the attending physician since device management is a medical decision

8. A nurse manager is addressing a pattern where attending physicians communicate significant care plan changes to patients during rounds when the assigned nurse is not present in the room. Patients then relay the physician's plan to the nurse, often inaccurately. The nurse is left uninformed about treatment changes until she reviews the chart later. Which intervention is MOST effective?

A. Require nurses to accompany the physician during all patient rounds regardless of other care activities

B. Implement a physician notification system that requires physicians to update the nurse directly after making significant care plan changes during rounds

C. Establish a structured rounding communication process where the nurse is notified before rounding begins, joins rounds for her assigned patients when possible, receives a post-rounding verbal or electronic summary of changes from the physician or rounding team, and updates the patient communication board to reflect the current plan

D. Instruct patients to ask the physician to communicate all plan changes to their nurse directly rather than relying on the patient to relay information

9. A nurse manager is developing a strategy for managing communication in a shared-room environment where patient privacy during clinical conversations is compromised by the presence of a roommate. HCAHPS data shows that the unit's "respect for privacy" scores are below the organizational average. Which intervention is MOST practical?

A. Request capital funding to convert all double-occupancy rooms to private rooms to eliminate the shared-room privacy challenge

B. Install privacy curtain systems that provide visual separation and use white noise machines to mask clinical conversations

C. Implement a communication protocol that includes drawing the privacy curtain during all clinical discussions, lowering voice volume, using portable communication shields for sensitive conversations, and offering patients the option to discuss sensitive topics in a private consultation room when available

D. Accept that some privacy compromise is inherent in shared-room environments and focus improvement efforts on other HCAHPS dimensions

10. A nurse manager is implementing a "situation monitoring" communication practice from TeamSTEPPS where all team members actively scan the clinical environment for potential safety threats and communicate observations to the team. The concept requires every team member to feel responsible for identifying risks — not just the risks within their assigned patients. Several nurses argue that monitoring situations beyond their assignment creates liability exposure. Which response is MOST accurate?

A. The nurses' concern is valid, and situation monitoring should be limited to each nurse's assigned patients to prevent scope-of-practice and liability issues

B. Situation monitoring is a professional obligation that enhances team safety — nurses who identify potential safety concerns outside their assignment are fulfilling their professional duty to patient safety,

not expanding their liability, and the organization's safety culture depends on every team member serving as a safety surveillance sensor

C. Implement situation monitoring only for high-risk patients and exempt nurses from monitoring patients outside their assignment

D. Require each nurse to sign a liability waiver before participating in situation monitoring to protect against legal exposure

11. A nurse manager is responsible for a unit that has been selected to pilot a patient co-design initiative where patients and families participate in the actual design of clinical workflows, documentation tools, and care delivery processes — not just as advisory council members but as active co-designers with equal decision-making authority alongside clinical staff. Physicians and experienced nurses resist giving patients equal authority over clinical workflow design. Which approach is MOST effective for managing this resistance?

A. Limit patient co-design authority to non-clinical elements such as room design, food service, and visiting policies

B. Implement the co-design model exactly as designed since the initiative has executive sponsorship and resistance must be overcome

C. Scale back the model to advisory rather than co-design authority to accommodate clinical staff concerns about patient competency

D. Clarify that patient co-design authority applies to the patient experience dimensions of clinical workflows rather than clinical decision-making itself, demonstrate through examples how patient insight improves workflow design without compromising clinical standards, and pilot with a single workflow to demonstrate the model's value before expanding

12. A nurse manager is developing a communication strategy for a patient who has been placed on isolation precautions for a multidrug-resistant organism. Research shows that isolated patients receive fewer nursing visits, less clinical monitoring, and report higher rates of loneliness and depression compared to non-isolated patients. Staff report that donning and doffing PPE discourages frequent room entry. Which intervention MOST directly addresses the communication and care disparity?

A. Implement a structured visit frequency standard for isolated patients that ensures they receive the same number of nurse visits as non-isolated patients, with documentation of visit frequency, inclusion of

isolated patients in the hourly rounding protocol, and use of technology such as video monitoring or communication tablets to supplement in-person visits

B. Assign a dedicated isolation nurse for each shift who manages all isolated patients and eliminates the PPE barrier for other nursing staff

C. Provide isolated patients with a call bell extension cord so they can easily request nurse visits when they need attention

D. Stock sufficient PPE at each isolation room entrance to minimize the time barrier associated with donning and doffing

13. A nurse manager is implementing a "warm handoff" model for transitions between the hospital and post-acute care facilities. A warm handoff involves a live three-way conversation between the hospital nurse, the receiving facility nurse, and the patient or family member, conducted before the patient leaves the hospital. Currently, transitions rely on written discharge summaries that frequently arrive after the patient. Which element of the warm handoff is MOST critical for preventing post-discharge adverse events?

A. Documentation of the handoff conversation in both the hospital and receiving facility medical records

B. Scheduling the warm handoff at a time when all three parties are available simultaneously

C. A structured discussion of the patient's active clinical issues, current medications, pending follow-up needs, red flag symptoms requiring immediate attention, and the patient's own questions and concerns, conducted with all parties listening and confirming understanding in real time

D. Verification that the receiving facility has the clinical capability to manage the patient's specific medical conditions

14. A nurse manager is working to improve the unit's "quiet at night" HCAHPS scores. The unit scores at the twenty-second percentile nationally on nighttime noise. Direct observation reveals that the primary noise sources are staff conversations at the nursing station, clinical alarm sounds, equipment wheels on hard floors, and door closings. Which intervention provides the MOST comprehensive noise reduction?

A. Implement a multi-pronged approach including staff education on noise awareness, designated quiet zones for conversations, alarm volume adjustment and management, equipment noise reduction through

wheel maintenance and door dampeners, ambient sound monitoring with real-time feedback displays, and nighttime workflow redesign that minimizes corridor activity during sleep hours

B. Install sound-absorbing panels at the nursing station and in patient hallways to reduce ambient noise levels

C. Implement a strict noise curfew after ten o'clock in the evening and enforce it through charge nurse monitoring

D. Provide patients with earplugs and white noise machines and educate them that hospitals are inherently noisy environments

15. A nurse manager is developing a communication approach for managing families who use the nurse call system excessively — activating the call light fifteen to twenty times per shift for non-urgent requests. Staff report that the excessive call light use diverts nursing attention from higher-acuity patients and creates frustration. Which approach is MOST appropriate?

A. Implement a call light response protocol that triages calls by urgency and assigns lower-priority calls to non-nursing staff

B. Speak with the family about the impact of excessive call light use on other patients' care and request that they limit calls to urgent needs

C. Investigate the underlying cause of the excessive calling — which may include anxiety, unmet information needs, fear, pain, or environmental discomfort — address the root cause through proactive rounding, a personalized communication plan, and a family conference that establishes a care partnership with agreed-upon communication expectations

D. Assign a patient care assistant to the patient's room full-time to address requests immediately and reduce call light activation

16. A nurse manager is implementing a structured approach to managing "difficult conversations" that nurses must have with patients and families — including delivering bad news, discussing code status, addressing non-adherence, and managing unrealistic expectations. A skills assessment reveals that nurses avoid these conversations or handle them poorly because they lack a framework for conducting them. Which training model is MOST effective?

- A. Provide nurses with scripted language for each type of difficult conversation so they have ready-made phrases for challenging situations
- B. Require nurses to defer all difficult conversations to the physician, social worker, or chaplain who has specialized training in these areas
- C. Implement a communication skills training program that includes didactic content on frameworks such as SPIKES for delivering bad news, role-play practice with simulated patients, observation-based coaching during actual clinical conversations, and structured debriefing after challenging interactions
- D. Assign experienced nurses as mentors for newer nurses and allow communication skills to develop naturally through observation and practice

17. A nurse manager is implementing a language access improvement initiative after data reveals that patients with limited English proficiency have a forty-seven percent higher rate of adverse events compared to English-speaking patients on the unit. The analysis attributes the disparity primarily to communication gaps during medication education, discharge instructions, and symptom assessment. Which intervention is MOST targeted?

- A. Implement a mandatory professional interpreter requirement for all high-risk clinical communications including medication education, procedure consent, discharge instructions, and symptom assessment for patients with limited English proficiency, combined with documentation of interpreter use for these specific interactions
- B. Hire bilingual nursing staff who can provide direct care in the languages most commonly spoken by the unit's patient population
- C. Provide all patient education materials in the ten most common languages spoken by the unit's patient population
- D. Require the use of professional interpreters for all patient interactions regardless of the type of communication or the nurse's language ability

18. A nurse manager is addressing a situation where a patient's family has been recording nursing interactions on a hidden device — discovered when a family member accidentally played the recording in the nurse's presence. The recording captured a conversation between two nurses about the patient's prognosis that was not intended for the family. Which response addresses ALL dimensions of the situation?

- A. Report the family to hospital security for recording without consent and request the recording be deleted
- B. Counsel the two nurses about discussing patient information where it could be overheard and remind them of HIPAA requirements
- C. Address the situation with the family by establishing organizational recording expectations and the legal framework for consent
- D. Address the family by explaining the organization's recording policy and expectations for consent, address the nursing staff about communicating patient information only in appropriate private settings, review the clinical content of the overheard conversation with the family if disclosure is warranted, and advocate for the organization to develop or reinforce a formal recording policy

19. A nurse manager is developing a communication plan for a patient who speaks a language for which the hospital has no interpreter available — in person, by video, or by telephone. The language is spoken by a very small population and no certified interpreters exist in the region. A family member offers to interpret but has limited medical vocabulary. Which approach is MOST appropriate?

- A. Use the family member as the interpreter while supplementing with translation technology applications designed for medical communication, document the accommodation and its limitations, communicate the situation to the care team, and advocate for the organization to develop a language access solution for rare languages
- B. Communicate through visual aids and gestures until a certified interpreter can be located through a national interpreter service
- C. Transfer the patient to a larger hospital that may have interpreter resources for the patient's language
- D. Use a general-purpose translation application on a hospital tablet for all clinical communication since technology-based translation is more accurate than untrained family interpretation

20. A nurse manager receives a complaint from a deaf patient who communicates exclusively through American Sign Language. The patient reports that nursing staff have been using written notes for all communication, including clinical assessments and medication education. The patient states that written English is his second language and he misses nuances in complex written clinical information. Staff report that scheduling ASL interpreters is difficult because the hospital's interpreter service has limited availability. Which intervention is MOST appropriate?

A. Provide the nursing staff with basic ASL training so they can communicate essential clinical information directly with the patient

B. Request that the patient bring a family member or friend who can interpret during clinical interactions to supplement hospital interpreter services

C. Implement a video remote interpreting service that provides on-demand ASL interpretation through a tablet at the bedside, eliminating the scheduling barrier while ensuring that all clinical communication is conducted through a qualified interpreter rather than written notes

D. Ensure on-demand access to qualified ASL interpretation for all significant clinical communications through either in-person, video remote, or a combination of both, supplement with written communication only for simple non-clinical interactions, document interpreter use, and advocate for expanded ASL interpreter availability within the organization

21. A nurse manager is implementing a peer-to-peer recognition program where nurses can formally recognize colleagues for exemplary clinical care, teamwork, or patient advocacy. After six months, data reveals that eighty-five percent of recognitions are exchanged within existing friend groups and only five percent cross shift boundaries. The program has become an in-group social tool rather than a genuine recognition system. Which adjustment is MOST effective?

A. Eliminate the peer recognition program and replace it with a manager-driven recognition system that applies consistent criteria

B. Redesign the program to require cross-shift nominations, establish recognition criteria based on specific behavioral examples, create a review process that validates recognition submissions, publicly celebrate cross-team recognitions, and track recognition patterns to ensure equitable distribution

C. Maintain the current program since any peer recognition is better than none and the social bonding within groups has value

D. Require each nurse to submit at least one recognition per month to ensure universal participation

22. A nurse manager is developing a strategy for communicating with a patient who has been newly diagnosed with a terminal illness. The patient is in denial and responds with anger when clinical staff attempt to discuss prognosis. The family wants the care team to "make her understand" that the illness is terminal. Which communication approach is MOST therapeutically appropriate?

A. Continue attempting to communicate the terminal diagnosis until the patient acknowledges the prognosis since informed consent requires patient understanding

B. Respect the patient's current emotional processing stage, provide truthful but compassionate information when the patient asks questions, avoid forcing prognostic conversations the patient is not ready for, support the family in understanding that denial is a protective mechanism, and involve palliative care for ongoing communication support

C. Comply with the family's request and schedule a formal family meeting where the physician directly communicates the terminal prognosis to ensure the patient receives accurate information

D. Document the patient's refusal to engage in prognostic discussions and focus nursing care exclusively on symptom management

23. A nurse manager is coaching a charge nurse who has excellent clinical and leadership skills but communicates through email for nearly all interactions — including performance feedback, schedule changes, and clinical updates — rather than having face-to-face conversations. Staff report feeling disconnected from the charge nurse and describe the communication as "impersonal and bureaucratic." Which coaching approach is MOST effective?

A. Help the charge nurse identify which communication types benefit from face-to-face delivery versus email, practice in-person conversations for high-impact communications such as performance feedback and recognition, and develop the charge nurse's comfort with direct interpersonal interaction while preserving email's efficiency for routine informational updates

B. Require the charge nurse to conduct all communication in person and eliminate email as a communication channel for leadership interactions

C. Accept the charge nurse's communication preference since email provides a documented record that is more reliable than verbal communication

D. Assign the charge nurse to a communication skills workshop that covers multiple communication channels and when each is most appropriate

24. A nurse manager is responsible for a unit that serves a growing refugee population from a region experiencing conflict. These patients present with complex medical conditions, untreated chronic diseases, psychological trauma, and unfamiliarity with the Western healthcare system. Staff report feeling overwhelmed by the clinical and communication complexity. Which support structure is MOST comprehensive?

A. Hire a translator who speaks the predominant refugee language and assign them to the unit during peak admission hours

B. Develop a culturally responsive care framework that includes interpreter access, trauma-informed communication training, cultural orientation for staff about the refugee population's health beliefs and experiences, collaboration with refugee resettlement agencies, and a clinical resource guide addressing common medical conditions seen in this population

C. Request that the hospital's social work department assign a dedicated social worker to the unit to manage the psychosocial complexity of refugee patients

D. Refer the most complex refugee patients to an academic medical center with a specialized refugee health program

25. A nurse manager is developing a communication strategy for the unit's transition to a completely paperless workflow. All forms that previously existed on paper — including consent documents, patient education handouts, equipment checklists, and communication logs — will be migrated to electronic formats. Several veteran nurses express anxiety about losing the tactile familiarity of paper documentation and fear that technology failures will leave them without access to critical patient information. Which communication approach is MOST effective?

A. Implement the paperless transition immediately and allow staff to adapt through experience since prolonged transition periods create more anxiety than rapid implementation

B. Provide paper alternatives alongside electronic versions permanently so staff can use whichever format they prefer

C. Delay the transition until all staff have demonstrated proficiency with the electronic formats through competency testing

D. Acknowledge the anxiety, provide comprehensive training with hands-on practice, establish a clearly defined downtime procedure for technology failures that maintains paper backup for critical functions, identify super-users on each shift for real-time support, and implement a phased rollout that migrates the simplest forms first before progressing to more complex workflows

26. A nurse manager is developing a plan for managing the communication challenges created by increasing use of telehealth for inpatient consultations. Specialists who previously visited the bedside now conduct consultations via video screen, and patients report feeling that the video consultations are impersonal and inadequate. Nurses report that they are uncertain about their role during a telehealth

consultation — whether to remain at the bedside, facilitate the interaction, or leave the room for patient privacy. Which protocol is MOST appropriate?

A. Define the nurse's role during telehealth consultations as a bedside facilitator who prepares the patient for the consultation, ensures the technology is functional, assists with the physical examination when needed, advocates for the patient during the interaction, documents the consultation findings, and follows up on any orders generated

B. Require all specialist consultations to be conducted in person rather than via telehealth for inpatients since the bedside evaluation is clinically superior

C. Allow each nurse to determine their role during telehealth consultations based on the specific clinical situation and patient needs

D. Assign the telehealth facilitation role to a dedicated tech support position rather than the bedside nurse

27. A nurse manager is implementing a proactive family communication program where the unit contacts patient families with a daily update at a scheduled time. The goal is to reduce incoming family phone calls that interrupt nursing workflow and to improve family satisfaction with communication. After one month, the program has reduced incoming calls by forty percent. However, nurses report that the outgoing calls are time-consuming and take them away from patient care. Which adjustment is MOST appropriate?

A. Discontinue the proactive call program since the time burden on nursing offsets the benefit of reduced incoming calls

B. Transition the daily family update to a structured brief format with a defined time limit, assign the calls to non-direct-care staff such as a unit secretary or care coordinator, and supplement with a patient portal messaging option for families who prefer written updates

C. Reduce the call frequency from daily to every other day to decrease the nursing time burden while maintaining some proactive communication

D. Automate the daily updates using a pre-recorded voice message system that delivers standardized patient status updates to families

28. A nurse manager is addressing a situation where a patient's legal guardian and the patient's adult children disagree about the plan of care. The guardian wants to continue aggressive treatment while the adult children want comfort-focused care. The patient is unable to participate in the decision. The legal guardian has documented authority. Which communication facilitation is MOST appropriate?

A. Follow the legal guardian's decision without further discussion since the guardian has documented legal authority and the adult children's preferences are not legally binding

B. Facilitate a family meeting that includes the legal guardian, the adult children, the physician, a social worker, and potentially the ethics committee, where the patient's previously expressed wishes are explored, the guardian's authority is acknowledged, the children's concerns are heard, and all parties are supported in working toward a decision that honors the patient's values

C. Instruct the physician to follow the legal guardian's wishes and document that the adult children disagree with the treatment decision

D. Delay clinical decision-making until the family resolves their disagreement independently and presents a unified treatment preference to the care team

29. A nurse manager is developing a communication standard for nursing documentation of patient responses to interventions. Audit reveals that seventy-eight percent of nursing notes document what intervention was performed but fail to document the patient's response to the intervention. For example, notes state "medication administered" without documenting whether the patient's pain improved. Which improvement is MOST effective?

A. Implement a documentation reminder poster at each workstation listing the documentation elements that must be included for every intervention

B. Redesign the electronic documentation system to require a response-to-intervention field that must be completed before the nurse can finalize documentation for each intervention, with structured response options and a free-text narrative field for detailed clinical descriptions

C. Educate nursing staff on the importance of documenting patient responses to interventions and its impact on care continuity and legal defensibility

D. Assign the charge nurse to audit documentation in real time during each shift and provide immediate feedback to nurses whose notes are missing response information

30. A nurse manager is developing a comprehensive fall prevention strategy. Data analysis reveals a paradox: the unit's fall risk assessment compliance is ninety-eight percent, but the actual fall rate has not decreased. Further analysis shows that seventy percent of patients who fell were assessed as "low risk" by the fall risk assessment tool. Which conclusion is MOST appropriate?

A. The high assessment compliance rate demonstrates that nursing staff are performing adequately and the continued falls are attributable to patient factors beyond the unit's control

B. The fall risk assessment tool has poor sensitivity for the unit's specific patient population and may need to be replaced or supplemented with additional risk criteria that capture the factors leading to falls among patients currently classified as low risk

C. The nursing staff may be completing the fall risk assessment inaccurately, checking boxes without performing a genuine clinical evaluation of fall risk

D. The fall rate will eventually decrease as the assessment compliance rate is sustained at ninety-eight percent over a longer period

31. A nurse manager is evaluating the unit's medication safety system after a near-miss event where a nurse almost administered insulin to a non-diabetic patient. The barcode scanning system flagged the error before administration. Analysis reveals that the near-miss occurred because of a look-alike patient name, a workaround where a nurse borrowed medication from an adjacent patient's drawer in the automated dispensing cabinet, and time pressure during a shift with three simultaneous admissions. Which analysis framework is MOST appropriate?

A. Conduct a single root cause analysis focused on the nurse's workaround behavior since borrowing from another patient's drawer was the proximate cause of the near-miss

B. Focus the investigation on the automated dispensing cabinet's design since the system allowed access to a medication not profiled for the patient

C. Apply James Reason's organizational accident model analyzing how latent conditions (look-alike names, staffing pressure, system design allowing workarounds) combined with active failures (borrowing from the wrong drawer) to create the near-miss, then address both latent conditions and active failure opportunities

D. Implement a policy prohibiting nurses from accessing any medication drawer other than their assigned patient's drawer and monitor compliance

32. A nurse manager is developing an evidence-based pressure injury prevention program. The Braden Scale risk assessment is currently used, and compliance is high. However, recent literature suggests that the Braden Scale's predictive validity varies significantly across patient populations and may overpredict risk in some populations while underpredicting in others. Which approach is MOST evidence-based?

A. Replace the Braden Scale with a newer risk assessment tool that has been validated in a broader patient population

B. Maintain the Braden Scale as the primary assessment tool since it is the most widely used and familiar tool for nursing staff

C. Supplement the Braden Scale with unit-specific clinical judgment criteria based on the patient population's actual risk factors, analyze which Braden subscales are most predictive for the unit's patients, and adjust the prevention protocol to target the specific risk factors most commonly associated with pressure injuries on this unit

D. Eliminate formal risk assessment tools and rely entirely on clinical nursing judgment for pressure injury risk identification

33. A nurse manager reviews the following data on the unit's compliance with evidence-based sepsis care:

| Bundle Element | Compliance | Barrier |

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

| Blood cultures before antibiotics | 94% | Lab draw delays |

| Lactate within 3 hours | 87% | Order entry delays |

| Antibiotics within 3 hours | 72% | Pharmacy dispensing |

| Fluid resuscitation per protocol | 68% | Nurse knowledge gaps |

| Repeat lactate within 6 hours | 61% | Forgotten/not ordered |

Which improvement strategy is MOST likely to produce the greatest overall bundle compliance increase?

A. Focus on fluid resuscitation since it has the second-lowest compliance and the barrier (nurse knowledge) can be addressed through education

B. Focus on antibiotic timing since it falls below the Joint Commission's minimum compliance threshold and directly affects patient survival

C. Focus on the repeat lactate since it has the lowest compliance rate and would produce the largest absolute percentage improvement

D. Address all five elements simultaneously through a comprehensive sepsis improvement initiative since bundle compliance requires adherence to ALL elements and the lowest-performing element determines overall bundle success

34. A nurse manager is responsible for a unit that admits patients with severe behavioral health crises who require medical admission. These patients may exhibit agitation, aggression, self-harm behaviors, or psychosis alongside their medical conditions. The unit is not a designated psychiatric unit and does not have psychiatric-trained nursing staff. Which preparation element is MOST critical for patient and staff safety?

A. Comprehensive training for all nursing staff in de-escalation techniques, behavioral emergency management, safe restraint use, environmental safety assessment, and collaboration protocols with psychiatric consultation services, supplemented by environmental modifications that reduce safety risks

B. Establishing a policy requiring all patients with behavioral health crises to be transferred to a designated psychiatric unit within twenty-four hours of admission regardless of their medical status

C. Hiring a full-time psychiatric nurse consultant for the unit who manages all patients with behavioral health conditions

D. Installing cameras in all patient rooms to monitor patients with behavioral health conditions for safety purposes

35. A nurse manager is evaluating the unit's performance on a new CMS quality measure tracking the percentage of patients who receive follow-up contact within forty-eight hours of discharge. The measure applies to all discharged patients regardless of diagnosis. Current compliance is thirty-four percent. The primary barrier is that the unit has no dedicated staff for post-discharge follow-up. Which implementation approach is MOST realistic?

- A. Hire a dedicated post-discharge follow-up nurse to contact all patients within forty-eight hours
- B. Assign the discharge phone call responsibility to the bedside nurse who cared for the patient on the day of discharge
- C. Implement an automated post-discharge text messaging system that contacts all patients within forty-eight hours and routes patients with concerns to a nurse for live follow-up
- D. Develop a risk-stratified approach where high-risk patients receive nurse-led telephone follow-up within forty-eight hours, moderate-risk patients receive an automated text or IVR system with nurse callback for identified concerns, and low-risk patients receive an automated check-in with self-escalation capability — maximizing coverage within existing resources

36. A nurse manager is implementing an evidence-based venous thromboembolism prevention protocol. The protocol requires pharmacological prophylaxis for all eligible patients unless a documented contraindication exists. Audit data reveals that forty-two percent of patients who are eligible for prophylaxis are not receiving it. The most common reason documented is "patient refused." However, a chart review suggests that patient education about VTE prophylaxis is inconsistent and inadequate. Which intervention is MOST appropriate?

- A. Implement a policy requiring patients to sign a written refusal form with documented informed consent if they decline VTE prophylaxis
- B. Accept patient refusals since patients have the right to decline any treatment and the documentation of refusal constitutes adequate compliance
- C. Develop a standardized VTE prophylaxis patient education process that explains the purpose, risks, and benefits in plain language before asking the patient for a decision, implement a nurse-driven protocol that triggers automatic education and prophylaxis initiation unless a contraindication is documented, and re-audit the "patient refused" rate after the education improvement
- D. Request that the physician discuss VTE prophylaxis with each patient since patients are more likely to accept physician recommendations than nursing recommendations

37. A nurse manager reviews the following root cause analysis data for serious safety events over two years:

| Contributing Factor | % of Events |

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

| Communication failure | 68% |

| Inadequate supervision | 42% |

| Equipment/technology | 31% |

| Training/competency | 28% |

| Staffing | 24% |

| Physical environment | 18% |

Which interpretation is MOST actionable?

A. Communication failure should receive exclusive focus since it contributes to sixty-eight percent of all events

B. Staffing and physical environment should receive the lowest priority since they contribute to fewer events

C. Each contributing factor should receive improvement resources proportional to its contribution percentage

D. Communication failure is the most prevalent contributing factor but the percentages total more than one hundred percent because most events involve multiple contributing factors, requiring interventions that address the interactions between factors rather than targeting each in isolation

38. A nurse manager is implementing an early warning system for clinical deterioration. The system generates scores based on vital signs and nursing assessment data. Research shows that clinical deterioration often begins with subtle changes in mental status, respiratory rate, and urine output that precede vital sign abnormalities by twelve to twenty-four hours. Which system design element is MOST critical?

A. Configuring the early warning system to generate alerts at lower vital sign thresholds than standard parameters to detect changes earlier

B. Training nursing staff to recognize and report subtle clinical changes that are not captured by automated vital sign monitoring

C. Implementing continuous monitoring technology that eliminates the gaps between intermittent vital sign assessments

D. Incorporating nursing assessment data — including mental status changes, subtle respiratory pattern alterations, declining urine output, and clinical intuition that "something is different" — into the early warning algorithm alongside vital signs, since these nursing observations provide earlier detection than vital sign changes alone

39. A nurse manager is evaluating the unit's readiness for a potential infectious disease surge similar to a pandemic wave. The evaluation must assess whether the unit can rapidly scale capacity, manage increased patient acuity, maintain staff safety, and sustain operations during a prolonged crisis. Which assessment finding represents the GREATEST vulnerability?

A. The unit's personal protective equipment supply is sufficient for only fourteen days of surge-level consumption

B. The unit lacks a documented and rehearsed surge staffing plan that defines how nursing resources will be reallocated, cross-trained staff will be deployed, crisis staffing ratios will be implemented, and clinical roles will be modified during sustained high-volume operations

C. The unit's ventilator supply is limited to the number of ICU-level beds currently in operation

D. The unit does not have a designated isolation area that can be rapidly activated for cohorting patients during an infectious disease surge

40. A nurse manager is implementing a "safety stop" protocol that empowers any team member — regardless of role or seniority — to stop a clinical activity when they believe a patient safety risk exists. The stop requires the team to pause, verify safety, and proceed only when the concern is resolved. Several physicians express frustration that the protocol allows nursing assistants and students to halt physician procedures. Which response is MOST appropriate?

A. Restrict safety stop authority to licensed clinicians only since they have the clinical knowledge to accurately assess safety risks

B. Implement the safety stop for nursing activities only and develop a separate escalation pathway for physician-related concerns

C. Implement the protocol as designed since the primary value of a safety stop system is its universality — safety concerns identified by any team member are equally valid regardless of the observer's role, and restricting the authority to certain roles defeats the purpose of the safety net

D. Allow physicians to override safety stops at their discretion since they bear ultimate clinical responsibility for patient outcomes

41. A nurse manager is developing a strategy for managing the clinical and ethical challenges of caring for patients receiving medical assistance in dying in a jurisdiction where it is legal. Some nursing staff support the practice while others have deep moral objections. The unit will care for these patients alongside patients receiving curative treatment. Which approach is MOST appropriate?

A. Develop a comprehensive protocol that includes staff education on the legal and ethical framework, a process for conscience-based objection with alternative assignment that does not compromise patient care, training for willing staff on the specific clinical management requirements, emotional support resources for all staff, and clear documentation and communication standards

B. Exclude patients receiving medical assistance in dying from the unit and transfer them to a dedicated facility

C. Require all nurses to participate in the care since it is a legally sanctioned medical procedure and personal objections do not apply

D. Allow individual nurses to decide whether to participate without a formal process and manage staffing on a case-by-case basis

42. A nurse manager reviews the following unit quality dashboard:

Metric	Jan	Feb	Mar	Apr	Trend
CLABSI/1,000 CLD	0.0	0.0	0.0	2.4	↑
CAUTI/1,000 CD	1.8	1.6	1.4	1.2	↓

| Falls/1,000 PD | 2.6 | 2.5 | 2.7 | 2.4 | → |

| HAPI Stage 2+/1,000 PD | 0.4 | 0.6 | 0.8 | 1.0 | ↑ |

Which interpretation requires the MOST urgent attention?

- A. The CLABSI increase from 0.0 to 2.4 since any increase from zero represents a significant safety event
- B. The CAUTI improvement should be celebrated but not assumed to be sustainable without continued monitoring
- C. The stable falls rate suggests the current prevention program has plateaued and needs redesign
- D. The HAPI progression from 0.4 to 1.0 over four months represents a consistent worsening trend that, unlike the CLABSI spike which could represent a single event, indicates a systemic process failure that is progressively deteriorating and will continue to worsen without intervention

43. A nurse manager is developing a patient safety event classification system for the unit. The system must distinguish between near-miss events, no-harm events, adverse events, and sentinel events to enable appropriate investigation and response for each category. Which classification principle is MOST important?

- A. Near-miss events should receive less investigation than actual adverse events since no patient was harmed
- B. Events should be classified based on the severity of the actual outcome rather than the potential outcome that could have occurred
- C. All event categories should receive the same level of investigation since the contributing factors are similar regardless of whether harm reached the patient
- D. Events should be classified based on BOTH actual outcome and potential severity, with near-miss events that had potential for serious harm receiving investigation equivalent to actual adverse events, since the same system failures that allowed a near-miss can produce harm when circumstances align differently

44. A nurse manager is evaluating the unit's approach to managing indwelling urinary catheters. Data shows that the unit's catheter utilization ratio is 0.38, compared to a benchmark of 0.22. The nurse-driven catheter removal protocol has been in place for six months but utilization has not decreased. Investigation reveals that nurses are conducting the assessment but physicians are overriding the removal recommendation in sixty-two percent of cases. Which action is MOST appropriate?

A. Present the utilization data and override rate to the medical staff leadership, collaborate on revising the removal criteria to address physicians' clinical concerns, establish an expectation that overrides require documented clinical justification, and implement a peer review process for high-override physicians

B. Remove physician override authority from the nurse-driven protocol so nurses can remove catheters without physician approval

C. Accept the physician overrides as clinically appropriate since physicians may have information about catheter necessity that is not captured in the nursing assessment criteria

D. Implement a mandatory catheter utilization review by the infection prevention department for any catheter that remains in place after a nurse-driven assessment recommends removal

45. A nurse manager is developing a response plan for a cyberattack that disables the hospital's electronic health record, laboratory information system, and pharmacy dispensing technology. Unlike a planned downtime, a cyberattack creates an unplanned, prolonged system outage with unknown recovery timeline. Which element is MOST critical for maintaining patient safety?

A. A cache of critical patient information printed from the EHR before the system went down, stored securely on the unit

B. A comprehensive cyber-downtime protocol that includes paper-based clinical documentation, manual medication dispensing procedures, verbal order protocols, patient identification verification without electronic barcode systems, communication pathways that do not depend on the hospital's network, and a process for reconciling paper documentation into the electronic record after system restoration

C. An emergency generator system that maintains power to the electronic health record servers during the cyberattack

D. A backup EHR system hosted on a separate network that can be activated during the primary system outage

46. A nurse manager is evaluating the unit's implementation of a mobility culture where ambulation is the default expectation for all patients unless a specific contraindication is documented. Six months after implementation, the percentage of patients who ambulate at least twice daily has increased from thirty-two percent to sixty-eight percent. Length of stay has decreased by 0.4 days. However, nursing staff report that the mobility program has increased their workload by approximately forty-five minutes per shift. Which evaluation is MOST appropriate?

A. Calculate the financial value of the 0.4-day length of stay reduction across the unit's patient volume, compare it to the cost of the additional forty-five minutes of nursing time per shift, and evaluate whether the mobility culture produces a net positive return that justifies the workload increase while also considering the quality benefits of improved patient outcomes

B. Accept the increased workload as an acceptable trade-off for improved patient outcomes and provide positive feedback to staff

C. Reduce the ambulation target from twice daily to once daily to decrease the nursing workload while maintaining some mobility benefit

D. Hire a dedicated mobility aide for each shift to perform the ambulation activities and relieve nursing staff of the additional workload

47. A nurse manager is developing an approach to managing patients who present with symptoms of an acute stroke during a weekend when the hospital's neurologist is not available. The hospital is a primary stroke center with teleneurology capabilities. The time-sensitive nature of stroke treatment requires rapid assessment and intervention. Which protocol element is MOST critical?

A. A standardized stroke alert activation protocol that any nurse can initiate based on recognized stroke symptoms

B. Immediate CT imaging availability within twenty-five minutes of patient arrival regardless of time of day

C. A comprehensive stroke response protocol that integrates rapid nursing assessment and stroke scale scoring, immediate CT imaging, teleneurology activation for real-time remote neurological evaluation, standing orders for thrombolytic administration when criteria are met, and defined timeframes for each step of the response — ensuring that off-hours care meets the same time-critical standards as weekday care

D. Transfer agreements with comprehensive stroke centers for patients who require endovascular intervention beyond the primary stroke center's capability

48. A nurse manager is implementing an opioid stewardship program on the unit. The program aims to reduce unnecessary opioid prescribing and promote multimodal pain management. Nursing staff report that physicians resist multimodal approaches and default to opioid prescribing for convenience. Which intervention is MOST effective?

- A. Educate nursing staff on multimodal pain management so they can implement non-pharmacological interventions independently
- B. Present prescribing data to the medical staff showing the unit's opioid utilization compared to evidence-based benchmarks
- C. Require pharmacy approval for all opioid orders that exceed a defined threshold to create a prescribing checkpoint
- D. Implement a pharmacist-physician-nurse collaborative protocol where multimodal pain management is the default order set for common conditions, opioids require documented justification above the multimodal baseline, and nursing assesses pain response to guide de-escalation

49. A nurse manager reviews the following data:

Metric	Unit	Benchmark	Percentile
RN satisfaction	3.8/5.0	3.6/5.0	62nd
MD satisfaction with nursing	4.2/5.0	3.9/5.0	78th
Patient satisfaction	88%	82%	85th
RN turnover	24%	18%	28th

Which finding represents the MOST significant paradox requiring investigation?

- A. The high MD satisfaction suggests that the unit prioritizes physician preferences over nursing well-being

B. The combination of above-average nurse satisfaction, strong physician satisfaction, and high patient satisfaction coexisting with a turnover rate significantly above benchmark suggests that the satisfaction measures are not capturing the factors actually driving nurse departure, and exit interview analysis is needed to identify the hidden retention barriers

C. The patient satisfaction percentile is the strongest metric and should be leveraged in recruitment messaging to address the turnover rate

D. The turnover rate is the least reliable metric since it is influenced by regional market factors outside the unit's control

50. A nurse manager is developing an approach to managing patients with substance use disorders who are admitted for medical conditions. Evidence shows that these patients often receive inadequate pain management because clinicians fear enabling addiction, have shorter lengths of stay because of behavioral discharges, and have higher readmission rates. Which systemic intervention is MOST comprehensive?

A. Implement a specialized pain management protocol for patients with substance use disorders that addresses the unique pharmacological considerations

B. Require addiction medicine consultation for all admitted patients with known substance use disorders

C. Train nursing staff on motivational interviewing techniques for communicating with patients who have substance use disorders

D. Implement an integrated approach that includes evidence-based pain management protocols for patients with substance use disorders, addiction medicine consultation pathways, nursing education on therapeutic communication and stigma reduction, behavioral agreement frameworks that preserve patient dignity, and discharge planning that connects patients with ongoing addiction treatment resources

51. A nurse manager is evaluating two fundamentally different approaches to quality improvement. Approach A uses incremental continuous improvement through small PDSA cycles. Approach B uses breakthrough redesign that fundamentally reimagines the care process from scratch. The unit has been running incremental PDSA cycles on medication administration errors for eighteen months with only marginal improvement. Which strategic decision is MOST appropriate?

- A. The eighteen months of marginal improvement through incremental cycles suggest the problem requires innovation rather than optimization — breakthrough redesign should be considered as the current approach has likely reached its improvement ceiling within the existing process architecture
- B. Continue the incremental approach for another eighteen months since quality improvement research shows that sustained PDSA cycling eventually produces breakthrough results
- C. Implement both approaches simultaneously to maximize improvement potential
- D. Abandon the medication error reduction initiative and redirect improvement resources to a different quality metric with greater improvement potential

52. A nurse manager is applying the concept of "strategic workforce planning" to develop a five-year nursing workforce plan for the unit. The plan must account for projected retirements, anticipated volume changes, evolving care models, and regional workforce availability trends. Which planning approach is MOST comprehensive?

- A. Project future staffing needs based on historical turnover rates and replace departing nurses with equivalent positions
- B. Analyze demographic trends of current staff to predict retirement timing and begin recruiting replacements twelve months before anticipated departures
- C. Develop scenario-based workforce models that project staffing needs under multiple future conditions including volume growth, volume decline, care model transformation, and technology-driven role evolution, then create flexible staffing strategies that can adapt to whichever scenario materializes
- D. Hire above current staffing levels to create a buffer against future vacancies and turnover

53. A nurse manager is applying the concept of "systems archetype" analysis from Peter Senge's systems thinking framework. The unit experiences a recurring pattern where quality improvement gains are followed by budget reductions that eliminate the resources supporting the improvement, which causes quality to regress, which triggers a new quality improvement initiative. Senge would identify this as which systems archetype?

- A. The "fixes that fail" archetype where short-term solutions produce unintended long-term consequences that recreate the original problem in a different form

B. The "tragedy of the commons" archetype where individual departments optimize their own resources at the expense of the organizational whole

C. The "shifting the burden" archetype where the organization addresses symptoms rather than root causes

D. The "success to the successful" archetype where initial success attracts resources away from other initiatives, creating a self-reinforcing cycle

54. A nurse manager is implementing a "Lean daily management" system on the unit. The system includes a visual management board, a fifteen-minute daily tier huddle, leader standard work, and a structured escalation process. After three months, the daily huddle has become a one-directional information broadcast where the charge nurse reads announcements rather than a bidirectional safety and improvement conversation. Which correction is MOST important?

A. Replace the charge nurse as huddle facilitator with the nurse manager to model effective facilitation

B. Restructure the huddle to begin with frontline staff reporting safety concerns, barriers, and improvement ideas, followed by leadership response and resource commitment, transforming the huddle from a top-down information push to a bottom-up intelligence pull with visible leadership follow-through

C. Reduce the huddle frequency from daily to three times weekly to create more substantive content for each session

D. Add a formal agenda template that prescribes the exact topics and time allocation for each huddle segment

55. A nurse manager is developing a strategy for managing innovation on the unit. Currently, innovative ideas are occasionally discussed but rarely progress beyond the idea stage because no structured pathway exists for evaluation, testing, and implementation. Which innovation management framework is MOST effective?

A. Implement a formal innovation committee that evaluates all proposed ideas and selects the most promising for implementation

B. Encourage all staff to submit ideas through a suggestion box and implement the most popular ideas based on staff voting

C. Create a structured innovation pipeline that includes idea submission, rapid feasibility screening, small-scale testing through safe-to-fail experiments, outcome evaluation, and a defined pathway from successful pilot to standard practice, with visible leadership support and protected resources for innovation activities

D. Dedicate one staff meeting per quarter to brainstorming innovative ideas and assign volunteers to develop the most promising concepts

56. A nurse manager is evaluating whether the unit's leadership development program is producing leaders who can navigate the complexity of contemporary healthcare. The program currently focuses on operational competencies — scheduling, budgeting, staffing, and policy compliance. Assessment reveals that graduates struggle with ambiguity, cannot manage competing stakeholder demands, and default to rule-following when adaptive responses are needed. Which program enhancement is MOST important?

A. Add complexity leadership competencies including comfort with ambiguity, adaptive problem-solving, stakeholder navigation, and the ability to lead through uncertainty alongside the existing operational curriculum

B. Replace the operational curriculum entirely with a complexity-focused leadership development approach since operational skills can be learned on the job

C. Extend the program duration to allow more time for both operational and complexity competency development

D. Require program graduates to complete a graduate-level leadership course at a local university to supplement the operational training

57. A nurse manager is implementing a "leader standard work" practice. Leader standard work in Lean methodology defines the specific activities a leader should perform at specific times during the day to ensure that processes are functioning correctly and problems are identified early. Which element of leader standard work MOST directly supports quality and safety?

- A. Scheduled daily observation of high-risk clinical processes at the point of care — such as medication administration, handoff communication, and patient identification verification — with real-time coaching when deviations are observed, demonstrating that leadership is present, attentive, and committed to the standards
- B. Daily review of the unit's quality dashboard metrics and discussion of trends during the tier huddle
- C. Weekly one-on-one meetings with each charge nurse to review operational issues and provide coaching
- D. Monthly review of incident reports and completion of root cause analyses for all serious events

58. A nurse manager is evaluating the unit's approach to managing "bright spots" — areas or individuals on the unit where performance is consistently exceptional. The unit has two nurses whose patients consistently have shorter lengths of stay, fewer complications, and higher satisfaction scores than their colleagues' patients. These nurses' practices have never been studied or disseminated. Which approach is MOST effective?

- A. Study the two nurses' specific practices through shadowing, interview, and outcome comparison to identify the behavioral and process differences that produce their exceptional results, then disseminate these practices through structured peer-to-peer teaching while preserving the flexibility that enables individual clinical excellence
- B. Recognize the two nurses publicly for their exceptional performance and encourage other nurses to observe and emulate their practices
- C. Assign the two nurses as preceptors for all new staff so their practices are transferred through the orientation process
- D. Include the two nurses' outcome data in the quality dashboard to motivate other nurses to achieve similar results

59. A nurse manager is navigating a leadership challenge where organizational strategy and unit-level clinical reality are in conflict. The organization has mandated a reduction in average length of stay across all units, but the nurse manager's data shows that premature discharge is driving readmissions that cost more than the LOS savings. Which leadership approach is MOST appropriate?

A. Comply with the organizational mandate while documenting the readmission consequences for future reference

B. Present a data-driven analysis to organizational leadership showing the total cost of the LOS reduction including readmission costs, propose an alternative approach that optimizes discharge timing based on readmission risk prediction, and advocate for a unit-specific LOS target that balances efficiency with readmission prevention

C. Refuse to implement the LOS reduction mandate until organizational leadership addresses the readmission consequence

D. Implement the LOS reduction for low-readmission-risk patients while maintaining longer stays for high-risk patients without informing leadership of the selective implementation

60. A nurse manager is developing a team effectiveness assessment using the Lencioni model of team dysfunction. Lencioni identified five dysfunctions: absence of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results. Assessment reveals that the unit team's primary dysfunction is absence of trust — team members do not feel safe being vulnerable with each other, hide mistakes, and avoid asking for help. Which intervention is MOST foundational?

A. Implement a team accountability system that tracks individual performance and creates transparency about each team member's contribution

B. Conduct a team-building retreat focused on developing interpersonal relationships and personal vulnerability

C. Begin with leadership modeling of vulnerability — the nurse manager openly acknowledges personal mistakes, asks for help, and admits uncertainty — then create structured opportunities for team members to practice vulnerability in progressively challenging situations, establishing that vulnerability is valued and rewarded rather than exploited

D. Address all five dysfunctions simultaneously since they are interconnected and improving trust alone will not improve overall team effectiveness

61. A nurse manager is applying the concept of "situational leadership" as described by Hersey and Blanchard. The model matches leadership style (telling, selling, participating, delegating) to the follower's development level. A newly promoted charge nurse is enthusiastic and motivated but lacks experience and confidence in the role. According to the model, which leadership style is MOST appropriate?

- A. Delegating — assigning responsibility and stepping back to allow the charge nurse to develop independently
- B. Participating — sharing decision-making and providing support while reducing directive behavior
- C. Selling (coaching) — providing clear direction and guidance while also offering explanation, encouragement, and support, since the charge nurse needs both task direction for the unfamiliar role and relationship support for her developing confidence
- D. Telling — providing specific task instructions and closely monitoring performance until the charge nurse demonstrates competence

62. A nurse manager is evaluating the effectiveness of a shared governance model that has been in place for three years. The model includes a unit practice council, a quality council, and an education council. Participation data shows that the same twelve nurses (out of forty) rotate through all three councils. The remaining twenty-eight nurses have never participated in any governance activity. Which evaluation finding is MOST concerning?

- A. The governance model may have created an informal "governance elite" that makes decisions for the unit while the majority of nurses are not represented, potentially undermining the democratic principle that shared governance intends to embody
- B. The low participation rate is normal since governance requires a specific skill set and interest level that not all nurses possess
- C. The twelve participating nurses have developed strong leadership skills through their governance experience
- D. The model should be considered successful since all three councils are actively meeting and producing practice changes

63. A nurse manager is developing a comprehensive approach to managing "moral injury" on the unit. Moral injury, distinct from moral distress, occurs when a nurse is forced to act in ways that violate deeply held moral beliefs — such as participating in care the nurse believes is harmful — and the resulting psychological damage is similar to that experienced by military personnel exposed to morally injurious events. Which organizational response is MOST appropriate?

- A. Provide individual counseling for nurses experiencing moral injury symptoms through the employee assistance program
- B. Implement conscience-based accommodation policies that allow nurses to decline participation in morally objectionable care
- C. Train charge nurses to identify signs of moral injury among their team members and refer them for professional support
- D. Address moral injury at the organizational level by creating forums for ethical dialogue about systemic practices that cause moral injury, advocating for policy changes that reduce morally injurious situations, providing specialized psychological support that addresses the moral dimension of the injury, and building organizational awareness that moral injury is a system-level problem requiring system-level solutions

64. A nurse manager is implementing a "real-time demand signal" staffing approach where staffing levels are adjusted multiple times per day based on actual patient acuity, census changes, admissions, discharges, and transfers rather than using a fixed schedule. The approach requires a flexible staffing resource — either an internal float pool or on-call staff — that can respond to demand signals within thirty to sixty minutes. Which implementation challenge is MOST significant?

- A. The technology required to generate real-time demand signals and communicate them to available staff is expensive and complex
- B. Nurses in the flexible resource pool may experience scheduling unpredictability that reduces job satisfaction and increases turnover, creating a paradox where the solution to staffing variability creates its own retention problem that must be addressed through equitable incentives and scheduling practices
- C. Charge nurses may lack the analytical skills to interpret real-time demand signals and translate them into appropriate staffing adjustments
- D. The approach requires organizational investment in float pool positions that add cost even when demand is low

65. A nurse manager is applying the AONL competency framework for nurse managers. The framework identifies competencies across three domains: the science of managing the business, the art of leading people, and the leader within. A self-assessment reveals that the nurse manager is strongest in business management but weakest in "the leader within" — which includes self-knowledge, personal resilience, and values-based decision-making. Which development approach is MOST effective?

- A. Invest in self-reflection practices such as journaling, executive coaching focused on self-awareness, 360-degree feedback with honest interpretation, mentoring relationships that provide candid personal feedback, and deliberate examination of how personal values influence leadership decisions
- B. Focus development on business management skills since this is the area of greatest current strength and will produce the highest organizational impact
- C. Attend a leadership conference focused on personal development and self-awareness practices
- D. Read leadership development books focused on emotional intelligence and self-awareness and implement the recommended practices independently

66. A nurse manager is developing a strategy for managing the ethical implications of resource allocation decisions during a crisis — such as deciding which patients receive scarce medications, equipment, or nursing resources when demand exceeds supply. Current practice relies on individual physician and nurse judgment without a standardized framework. Which preparation element is MOST critical?

- A. Develop a stockpile of critical resources that eliminates the need for allocation decisions during a crisis
- B. Train individual clinicians in ethical decision-making so they can make fair allocation decisions independently when resources are scarce
- C. Develop a transparent, ethically grounded allocation framework — created in advance with multidisciplinary and community input — that defines clinical criteria for resource allocation, assigns decision-making authority, establishes an appeals process, and separates allocation decisions from the treating clinician to reduce moral distress
- D. Establish that allocation decisions during a crisis are administrative decisions made by leadership rather than clinical decisions made at the bedside

67. A nurse manager is implementing a "leadership visibility" practice where the manager rounds on the unit during all three shifts at least once per week. After two months of visible leadership on night shift, night shift nurses report that the manager's presence feels like surveillance rather than support. Which adjustment is MOST effective?

- A. Reduce night shift rounding frequency to once monthly to prevent the perception of surveillance

B. Send the night shift a written explanation of the purpose of leadership rounding to clarify that it is supportive rather than punitive

C. Shift the purpose of night shift rounding from observation to service — asking staff what they need, removing barriers, recognizing effort, and demonstrating genuine interest in their experience — so the visits are perceived as support rather than monitoring

D. Delegate night shift rounding to the charge nurse since the charge nurse has a more natural presence on the shift

68. A nurse manager is evaluating a situation where the unit's nurse-to-patient ratio has been consistently maintained at the organizational target but quality outcomes are declining. Staff report that increasing patient acuity means the ratio no longer reflects actual workload. Which analysis is MOST important?

A. Compare the unit's patient acuity data to the acuity assumptions embedded in the nurse-to-patient ratio standard to determine whether the ratio has become inadequate for the actual patient population

B. Evaluate whether nursing skill mix has changed in ways that reduce the effective care capacity even at the same ratio

C. Assess whether the declining quality is related to factors other than staffing such as equipment, training, or process changes

D. Conduct a comprehensive workload analysis that compares the actual care demands (adjusted for acuity, complexity, admission-discharge frequency, and non-nursing tasks absorbed by nursing) against the care capacity the current ratio provides, to determine whether the ratio-quality gap is driven by acuity increases, workload expansion, or both

69. A nurse manager is developing a plan to address the unit's "innovation deficit" — the observation that the unit has not adopted any new clinical practice, technology, or workflow innovation in three years despite significant advances in the field. Staff describe the culture as "we've always done it this way." Which leadership intervention is MOST likely to catalyze innovation adoption?

A. Mandate adoption of three specific innovations identified by the nurse manager as most impactful for the unit

B. Send a delegation of nurses to an innovation-focused conference and task them with identifying practices to adopt

C. Create a safe environment for experimentation by protecting staff who propose and test new ideas, celebrating both successful and unsuccessful experiments as learning opportunities, connecting unit nurses with innovation leaders in other organizations, and starting with one visible, achievable innovation that demonstrates the value of change

D. Hire new staff who have experience with innovative practices and allow them to introduce new ideas naturally

70. A nurse manager is applying the concept of "boundary spanning" — the leadership practice of building connections across organizational silos to facilitate collaboration, resource sharing, and information flow. The nurse manager has identified that the unit's quality improvement efforts are limited by isolation from pharmacy, respiratory therapy, and rehabilitation services. Which boundary-spanning activity is MOST effective?

A. Request that the chief nursing officer create a multidisciplinary task force with representation from all affected departments

B. Establish regular cross-departmental meetings, joint quality improvement projects, shared outcome metrics, informal relationship-building activities, and reciprocal staff shadowing experiences that create ongoing collaborative infrastructure rather than temporary task-force solutions

C. Invite representatives from pharmacy, respiratory therapy, and rehabilitation to attend the unit's monthly staff meeting

D. Assign a unit liaison to each department who serves as the primary communication contact for interdepartmental issues

71. A nurse manager is evaluating the unit's succession planning depth. Best practice suggests that every critical leadership role should have at least two identified successors at different developmental stages. The unit has one charge nurse position with no identified successors and three senior nurse positions whose institutional knowledge has not been documented or transferred. Which vulnerability is MOST urgent?

A. The absence of identified successors for the charge nurse position since a single unexpected departure would leave the unit without shift-level leadership

B. The undocumented institutional knowledge since it represents irreplaceable organizational intelligence that will be permanently lost when the senior nurses depart

C. Both vulnerabilities are equally urgent — but leadership succession is more operationally immediate while knowledge transfer has a longer but equally critical timeline, and both should be addressed simultaneously

D. Neither vulnerability is urgent since the nurse manager can assume charge nurse duties temporarily and institutional knowledge can be recreated over time

72. A nurse manager is implementing a "gemba board" as a visual management tool for the unit. The gemba board displays real-time performance data, active improvement projects, staff recognition, and escalation tracking in a single visible location. After implementation, staff report that they look at the board but do not interact with it — it has become wallpaper. Which intervention is MOST effective for making the board an active management tool?

A. Redesign the board with more visually appealing graphics and color coding to attract attention

B. Require each nurse to initial the board daily to verify they have reviewed the current data

C. Make the board the centerpiece of the daily huddle — updating data in real time during the huddle, referencing the board when discussing safety concerns, tracking improvement actions directly on the board, and closing the loop on previous escalations visibly so staff see that the board drives action

D. Move the board to a more prominent location with higher foot traffic

73. A nurse manager is navigating a situation where organizational cost-cutting has eliminated several support positions including the unit secretary, the discharge coordinator, and one nursing assistant position. The eliminated functions have been absorbed by nursing staff without workload adjustment. Staff morale has plummeted, and several high-performing nurses have announced their intent to leave. Which leadership response is MOST appropriate?

A. Advocate to organizational leadership by presenting a comprehensive analysis of the eliminated functions' absorption impact on nursing workload, quality outcomes, staff satisfaction, and turnover projections, translate the anticipated turnover cost into dollars that likely exceed the savings from the eliminated positions, and propose alternative cost reduction strategies that do not concentrate burden on nursing

B. Accept the organizational decision and focus on helping staff adapt to the new workload through efficiency improvements and workflow redesign

C. Encourage dissatisfied nurses to provide feedback through the organization's formal grievance process

D. Redistribute the absorbed tasks more equitably among all nursing staff to reduce the perception that the burden falls disproportionately on certain team members

74. A nurse manager is developing a competency-based orientation framework that replaces the traditional time-based orientation model. In the traditional model, all new nurses complete the same twelve-week orientation regardless of experience. In the competency-based model, orientation duration varies based on demonstrated competency achievement. Which design element is MOST critical for the competency-based model's success?

A. A well-designed preceptor matching system that pairs new nurses with preceptors whose teaching style matches the orientee's learning style

B. Clearly defined, measurable competency milestones that are consistently evaluated using standardized assessment criteria, with multiple assessors to ensure inter-rater reliability, and a transparent process for extending orientation when milestones are not met within the expected timeframe

C. A self-directed learning component that allows orientees to pace their own progression through the competency milestones

D. A comprehensive didactic curriculum that covers all clinical topics before the orientee begins clinical practice on the unit

75. A nurse manager is evaluating the effectiveness of a recently implemented "just culture" training program. Before training, the unit averaged twelve incident reports per month. Six months after training, incident reporting has increased to thirty-one reports per month. Staff surveys show increased comfort with reporting. However, the nurse manager's supervisor expresses concern that the increased reporting rate means "more things are going wrong on the unit." Which response is MOST appropriate?

A. Present the increased reporting as evidence of improved reporting culture rather than increased safety events, demonstrate that the types of events being reported are predominantly near-misses and hazards

that were previously unreported, and show how the increased visibility is enabling proactive safety improvements

B. Analyze the increased reports to confirm that the new reports represent genuine safety events rather than frivolous reporting designed to test the non-punitive system

C. Reduce the reporting rate by tightening the criteria for what constitutes a reportable event to alleviate the supervisor's concern

D. Implement a communication plan that proactively explains the relationship between reporting culture maturity and reporting volume to all organizational leaders

76. A nurse manager is developing a strategy for managing the transition from a directive leadership culture to a coaching leadership culture on the unit. The current culture was established by the previous nurse manager who made all decisions unilaterally and staff became accustomed to being told what to do. When the current nurse manager asks staff for input, they respond with confusion or frustration, saying "just tell us what you want us to do." Which transition strategy is MOST effective?

A. Revert to directive leadership since staff have demonstrated that they prefer clear direction and are uncomfortable with participative approaches

B. Implement participative decision-making immediately for all decisions and allow staff time to adjust to the new approach

C. Gradually transition from directive to coaching leadership, beginning with a directive leadership style supplemented by questions that encourage staff thinking, and gradually increasing the degree of staff participation as they develop comfort with contributing to decisions and experience positive outcomes from their involvement

D. Transition by implementing shared governance councils that provide a structured format for staff participation

77. A nurse manager is developing a performance improvement plan for a nurse whose clinical skills are adequate but whose interpersonal interactions with patients consistently generate complaints. Over the past six months, twelve patients have formally complained about this nurse's bedside manner — describing interactions as "rushed," "dismissive," and "impersonal." The nurse states that she provides good clinical care and that patient satisfaction is "not her job." Which performance improvement approach is MOST effective?

- A. Reassign the nurse to a non-patient-facing role since interpersonal skills may be a core personality trait that cannot be significantly improved through training
- B. Present the specific complaint data, establish that therapeutic communication is a core nursing competency not an optional personality trait, set measurable behavioral targets for patient interaction quality, provide individualized coaching with observed practice and feedback, and evaluate progress through patient satisfaction data and direct observation at defined intervals
- C. Pair the nurse with a colleague who has high patient satisfaction scores and require her to adopt the colleague's communication approach
- D. Implement a monitoring system where the charge nurse observes the nurse's patient interactions and provides real-time coaching until the complaints decrease

78. A nurse manager is applying the concept of "organizational resilience" — the organization's ability to absorb disruption, adapt to changed conditions, and transform in response to environmental shifts. The nurse manager is assessing whether the unit would survive a major disruption such as the loss of several key staff members, a significant census change, or a new regulatory requirement. Which indicator MOST strongly predicts organizational resilience?

- A. The unit's financial reserves and ability to absorb unexpected costs during a disruption period
- B. The quality of the unit's documented policies and procedures that standardize operations regardless of which individual staff are present
- C. The breadth and depth of distributed capabilities — meaning many staff members can perform multiple functions, institutional knowledge is widely shared, leadership capacity exists at multiple levels, and adaptation is a practiced organizational skill rather than an emergency response
- D. The strength of the nurse manager's relationships with organizational leadership that enable rapid resource mobilization during disruptions

79. A nurse manager is applying the concept of "humble leadership" as described by Edgar Schein and Peter Schein. Humble leadership is based on the premise that the most effective leadership relationships are characterized by openness, trust, and genuine curiosity about others' perspectives. The Scheins

distinguish humble leadership from transactional and personal relationships. Which behavior MOST exemplifies humble leadership in daily practice?

- A. Asking staff for their genuine assessment of a proposed change before making a decision, being willing to revise the plan based on their input, acknowledging when staff expertise exceeds the manager's own knowledge, and creating conditions where honest feedback flows in all directions without fear
- B. Being modest about personal achievements and deflecting credit to the team when the unit receives recognition
- C. Admitting uncertainty during staff meetings and asking for help when facing unfamiliar clinical or operational challenges
- D. Delegating decision-making authority to the most knowledgeable staff member for each situation regardless of formal hierarchical position

80. A nurse manager is addressing the professional implications of a nurse who has been identified as a "quiet influencer" — someone who shapes unit culture not through formal authority or vocal advocacy but through subtle behaviors, selective compliance, and behind-the-scenes conversations that either support or undermine leadership decisions. This nurse has been subtly undermining a new hand hygiene monitoring program by encouraging colleagues to view the program as surveillance. Which approach is MOST effective?

- A. Confront the nurse publicly during a staff meeting to demonstrate that undermining behavior will be addressed regardless of how subtly it is expressed
- B. Address the nurse privately with specific observed behaviors, explain how the undermining affects the unit's safety culture, engage the nurse in understanding the program's safety rationale, and invite her to contribute to refining the program's implementation approach — converting opposition into constructive participation
- C. Monitor the nurse's compliance with the hand hygiene program and initiate progressive discipline if she falls below the compliance standard
- D. Ignore the subtle influence and focus on the majority of staff who support the program since direct confrontation may escalate the resistance

81. A nurse manager is developing a professional development approach for nurses who have plateaued at the "competent" level of Benner's model and show no progress toward proficiency despite years of experience. These nurses perform adequately but do not demonstrate the pattern recognition, priority-setting, and holistic patient assessment that characterize proficient practice. Which developmental intervention is MOST likely to promote progression?

A. Assign these nurses to higher-acuity patients to force development through exposure to clinical complexity

B. Implement a formal remediation program that addresses the specific competency gaps preventing advancement

C. Accept that some nurses will not progress beyond the competent stage and focus development resources on nurses who show natural aptitude for advancement

D. Provide structured clinical experiences that deliberately challenge habitual thinking patterns — such as reflective case analysis, peer mentoring by proficient or expert nurses, clinical simulation scenarios requiring holistic assessment, and guided practice with progressively complex patients accompanied by structured debriefing that makes implicit reasoning explicit

82. A nurse manager is navigating a situation where a traveling nurse has identified a significant safety concern with the unit's medication storage practices that permanent staff have not recognized because they have become habituated to the arrangement. The traveling nurse's observation is clinically accurate. Permanent staff dismiss the concern as "the travel nurse not understanding how we do things here." Which response is MOST appropriate?

A. Support the traveling nurse privately but avoid publicly validating the concern to prevent alienating permanent staff

B. Investigate the concern on its clinical merits regardless of who raised it, implement corrections if the concern is valid, acknowledge the traveling nurse's contribution, and use the incident as a teaching moment about the value of fresh perspectives and the danger of habituation to unsafe practices

C. Thank the traveling nurse for the observation and forward it to the safety committee for review through the standard process

D. Address the permanent staff's dismissive attitude through a general discussion about professional respect for all team members

83. A nurse manager is developing a professional accountability framework for the unit. The framework must distinguish between individual accountability and system accountability for clinical outcomes. A patient develops a hospital-acquired pressure injury. Investigation reveals that the nurse performed skin assessments per protocol, the patient had appropriate interventions in place, but the patient's rapid clinical deterioration created unavoidable skin breakdown despite adequate nursing care. Which accountability determination is MOST appropriate?

A. The nurse should be held accountable because the pressure injury occurred during her care regardless of contributing factors

B. The system should be evaluated for whether the clinical deterioration was adequately anticipated and whether the prevention protocol was appropriate for the patient's specific risk level, while the individual nurse's accountability is limited to whether she performed the assessments and interventions competently within the protocol's expectations

C. No accountability determination is necessary since the pressure injury was unavoidable given the patient's clinical trajectory

D. The physician should be held accountable for the rapid clinical deterioration that created the conditions for skin breakdown

84. A nurse manager is evaluating the unit's compliance with the ANA position statement on nurse fatigue and patient safety. Data shows that twenty-three percent of the unit's nurses work more than forty hours per week, eight percent work more than sixty hours per week, and eleven percent regularly work sixteen-hour shifts. Research links excessive hours to increased medication errors, motor vehicle accidents during the commute home, and higher rates of burnout. Which intervention is MOST aligned with the ANA position?

A. Implement a mandatory forty-hour weekly limit for all nurses and prohibit all shifts exceeding twelve hours

B. Educate staff about the risks of excessive work hours and encourage voluntary compliance with ANA recommendations

C. Develop a comprehensive fatigue management program that includes evidence-based scheduling limits, fatigue monitoring tools, a culture that normalizes declining extra shifts when fatigued, restriction of mandatory overtime, leadership modeling of work-life balance, and a commute safety program for nurses completing long shifts

D. Restrict the eight percent working over sixty hours per week to a maximum of forty-eight hours since they represent the highest-risk group

85. A nurse manager is addressing a professional boundary violation where a nurse accepted a substantial financial gift (five hundred dollars) from a patient's family after the patient's death. The family intended the gift as genuine gratitude. The nurse sees no ethical issue since the patient-nurse relationship has ended with the patient's death. Which analysis is MOST accurate?

A. The gift is acceptable since the nurse-patient relationship ended with the patient's death and no future care decisions can be influenced

B. The gift creates an appearance of preferential treatment that may have existed during the patient's care, even if the nurse's care was not actually influenced by the anticipation of a reward

C. Accepting the gift violates professional boundary standards regardless of when it is given or the genuineness of the giver's intent, because it creates an appearance that the nurse-patient relationship was influenced by financial benefit, may establish a precedent that other families feel obligated to follow, and erodes public trust in nursing's altruistic professional commitment

D. The gift is acceptable if the nurse reports it to the nurse manager and organizational policy does not specifically prohibit post-mortem gifts

86. A nurse manager is developing an approach to managing the professional implications of nurses using clinical decision support AI tools that provide nursing care recommendations. Several nurses have begun using a commercially available AI application on their personal phones to generate care plan suggestions. The application has not been validated or approved by the organization. Which concern is MOST significant?

A. The AI application may provide recommendations that conflict with the organization's approved clinical protocols, creating patient safety risk through inconsistent care guidance

B. Use of personal phones during patient care creates distraction risk and may violate the organization's technology use policy

C. The AI application's data privacy practices may not comply with HIPAA requirements for patient information

D. Nurses using unvalidated AI recommendations bear full professional accountability for any harm that results, and the organization has no liability protection for care based on a tool it has not approved — creating significant professional and organizational risk that requires immediate governance including AI tool validation, usage guidelines, and clear accountability standards

87. A nurse manager is addressing a professional conduct issue where a nurse has been engaging in "upward bullying" — consistently challenging the nurse manager's authority publicly, undermining decisions in front of colleagues, and creating a divisive environment by positioning herself as an alternative leader. Previous coaching conversations have not changed the behavior. Which escalation is MOST appropriate?

A. Initiate formal progressive discipline with specific documented examples of the insubordinate behavior, clear behavioral expectations, defined consequences for continued non-compliance, and a timeline for improvement — while ensuring that the documentation distinguishes between legitimate professional disagreement (which should be encouraged) and deliberate public undermining of leadership authority (which requires accountability)

B. Transfer the nurse to another unit to remove the disruptive influence from the team

C. Acknowledge that the nurse may have legitimate leadership ability and create a formal leadership role for her that channels her influence constructively

D. Convene a team meeting to address the undermining behavior openly and establish group norms for how disagreements with leadership decisions are expressed

88. A nurse manager is developing an approach to supporting nurses who are experiencing "identity ambiguity" during the transition from a traditional nursing role to an expanded practice role that includes telehealth, care coordination, and population health management. These nurses were educated and socialized in a bedside care paradigm and struggle to see themselves as legitimate nurses in roles that do not involve direct physical patient contact. Which support element is MOST important?

A. Reframe the expanded role as an evolution of nursing's core mission — improving patient outcomes — by demonstrating how telehealth, coordination, and population health management are nursing care delivered through different modalities, validating that the professional identity of nursing is defined by its purpose (patient well-being) rather than its setting (the bedside)

B. Provide role-specific competency training that builds confidence in the new skills required for the expanded practice

C. Pair transitioning nurses with mentors who have successfully navigated the same role transition and can share their experience

D. Maintain a portion of direct patient care in the transitioning nurse's role to preserve the connection to traditional nursing identity

89. A nurse manager is addressing a situation where two nurses have filed competing grievances against each other. Nurse A alleges that Nurse B created a hostile work environment through persistent negative comments about Nurse A's clinical competence. Nurse B alleges that Nurse A retaliated by deliberately providing incomplete handoff reports to Nurse B's patients. Both allegations appear credible based on preliminary information. Which approach is MOST appropriate?

A. Investigate both grievances independently using separate investigators, implement interim measures to protect both nurses during the investigation, avoid prejudging either allegation, ensure both nurses understand the anti-retaliation policy, and address the underlying interpersonal conflict through mediation after the formal investigation is complete

B. Mediate the conflict between the two nurses before conducting a formal investigation since the underlying interpersonal issue may be resolvable without formal process

C. Investigate Nurse A's hostile work environment complaint first since it was filed before Nurse B's retaliation complaint

D. Transfer one nurse to a different shift to separate them while both grievances are investigated

90. A nurse manager is evaluating the unit's approach to managing impaired practice. The organization's impaired practice policy was written twenty years ago and focuses exclusively on substance use disorders. The nurse manager recognizes that impaired practice can result from many causes including substance use, mental health conditions, cognitive decline, physical disability, extreme fatigue, and personal crisis. Which policy revision is MOST important?

A. Expand the policy to address all sources of impairment rather than only substance use, while maintaining the principles of patient safety protection, fair and confidential process, supportive intervention pathways, fitness-for-duty evaluation criteria, and return-to-work guidelines that apply regardless of the impairment source

B. Keep the current policy focused on substance use but add separate policies for each additional impairment category

C. Maintain the current policy since substance use disorders are the most common and dangerous form of nursing impairment

D. Eliminate the impairment-specific policy and address all practice concerns through the standard performance management process

91. A nurse manager is addressing the professional development needs of nurses who are approaching mid-career — typically seven to fifteen years of experience. These nurses have mastered clinical competency but express a sense of professional stagnation. They are too experienced for bedside advancement incentives but not interested in formal management roles. Which development approach is MOST targeted?

A. Encourage these nurses to pursue graduate education as a pathway to advanced practice or leadership roles

B. Assign mid-career nurses to higher-acuity patient assignments to challenge their clinical skills

C. Implement a clinical advancement pathway with meaningful non-management leadership roles — such as evidence-based practice leader, clinical mentor, quality improvement champion, or specialty resource nurse — that provide professional growth, intellectual challenge, and recognition without requiring transition to a management track

D. Accept that mid-career stagnation is a normal career phase and focus development resources on newer nurses who have more trajectory remaining

92. A nurse manager is developing a comprehensive approach to managing workplace violence prevention on the unit. The OSHA workplace violence prevention standard requires a written program with specific elements. Which element is MOST frequently missing from healthcare workplace violence programs?

A. Post-incident response and support for staff who are victims of workplace violence, including medical evaluation, psychological support, incident documentation, workers' compensation guidance, and organizational follow-up that demonstrates the institution takes violence against healthcare workers seriously

B. Physical security measures such as panic buttons, controlled access, and surveillance cameras

C. De-escalation training for all clinical staff who interact with patients and visitors

D. A risk assessment identifying the specific workplace violence hazards present in the clinical environment

93. A nurse manager is navigating an ethical dilemma where a nurse has discovered that a physician is conducting clinical research on the unit's patients without proper informed consent. The physician is using an approved research protocol but has been enrolling patients by obtaining verbal agreement rather than the required written informed consent documented by the IRB-approved process. The research itself is low-risk and the physician argues that verbal consent is sufficient for low-risk studies. Which action is MOST appropriate?

A. Report the informed consent violation to the Institutional Review Board immediately, as any deviation from the IRB-approved consent process — regardless of the study's risk level — constitutes a protocol violation that the IRB must investigate, and the physician's judgment about the adequacy of verbal consent does not override the IRB's determination

B. Allow the verbal consent process to continue for the current study enrollees but require written consent for future enrollments

C. Report the concern to the hospital's chief medical officer and allow them to determine whether the consent deviation warrants IRB notification

D. Advise the physician to retroactively obtain written consent from all previously enrolled patients to bring the study into compliance

94. A nurse manager is developing an approach to preventing and addressing horizontal violence — the pattern of aggressive, destructive behavior within the nursing profession directed by one nurse toward another. Research shows that horizontal violence is rooted in oppression theory, where a marginalized group (nursing) directs frustration inward rather than toward the external power structures that create the oppression. Which intervention addresses the ROOT cause according to this theory?

A. Empower nursing through structural changes that increase nurses' control over their practice environment, create equitable power relationships with other disciplines, develop professional autonomy, and build collective efficacy — addressing the underlying oppression dynamics that theory identifies as the source of horizontal violence

B. Implement a zero-tolerance policy for horizontal violence with clear definitions and consequences

C. Conduct mandatory workshops on recognizing and preventing horizontal violence for all nursing staff

D. Create a confidential reporting system for horizontal violence incidents that protects reporters from retaliation

95. A nurse manager is developing a plan for managing the professional implications of nursing staff who provide health advice through personal social media accounts, blogs, or podcasts. Several nurses on the unit have significant online followings and regularly post content about health topics related to the unit's patient population. Their content includes clinical recommendations that they present as personal opinions rather than professional medical advice. Which concern is MOST significant?

A. The nurses' social media activity may divert their attention from clinical responsibilities during work hours

B. The clinical recommendations may conflict with the organization's approved clinical guidelines, creating potential confusion among patients who encounter both the nurse's online advice and the hospital's clinical protocols

C. The nurses may be perceived as representing the organization even when expressing personal opinions, creating potential liability

D. The nurses bear professional accountability for the accuracy and safety of clinical recommendations they provide regardless of the platform, and health advice that could cause harm may trigger professional licensing board scrutiny even when presented as "personal opinion" — requiring clear organizational guidelines about professional responsibility in digital communication

96. A nurse manager is developing a comprehensive financial analysis of the unit's nursing workforce costs. The analysis must capture the TOTAL cost of nursing labor beyond direct salary. Which cost components are MOST commonly underestimated in nursing workforce financial analyses?

A. Benefits costs, orientation and training expenses for new hires, premium labor costs (overtime and agency), productivity loss during orientation periods, and the indirect costs of turnover including recruitment, temporary staffing, and knowledge loss — which together can add forty to sixty percent above base salary to the true cost of nursing labor

B. Salary and benefits costs, which together represent the most significant components of total nursing labor cost

C. Overtime and agency costs, which represent the most variable component of nursing labor cost

D. Orientation costs for new hires, which represent the most underestimated component of total nursing labor cost

97. A nurse manager reviews the following quarterly financial data:

Quarter	Revenue	Expenses	Margin	Volume (PD)
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Q1	\$1,250,000	\$1,100,000	\$150,000	2,800
Q2	\$1,310,000	\$1,180,000	\$130,000	2,920
Q3	\$1,280,000	\$1,240,000	\$40,000	2,850
Q4	\$1,340,000	\$1,350,000	(\$10,000)	2,950

Which financial trend is MOST concerning?

- A. Revenue is increasing each quarter, suggesting the unit is growing appropriately
- B. Expenses are growing faster than revenue despite increasing volume, producing a progressive margin compression that has turned negative in Q4 — indicating that the cost of delivering each patient day is increasing faster than the revenue generated, requiring immediate investigation of which expense categories are driving the accelerating cost growth
- C. The Q4 operating loss is a normal seasonal variation that does not require intervention
- D. Volume is increasing, which should eventually produce economies of scale that reverse the margin compression

98. A nurse manager is developing a business case for implementing a nurse-led care coordination program for patients with multiple chronic conditions. The program would employ two nurse coordinators at a combined annual cost of one hundred seventy thousand dollars. Evidence from similar programs shows an average reduction of two point three inpatient days per patient per year for enrolled

patients. The unit manages an average of two hundred chronic condition patients per year. The average cost per inpatient day is two thousand one hundred dollars. What is the projected annual cost avoidance?

- A. $200 \text{ patients} \times 2.3 \text{ fewer days} \times \$2,100/\text{day} = \$966,000$ in cost avoidance
- B. $200 \text{ patients} \times 2.3 \text{ fewer days} = 460 \text{ fewer patient days} \times \$2,100 = \$966,000$ gross savings minus $\$170,000$ program cost = $\$796,000$ net savings
- C. The projection cannot be calculated without data on the specific chronic conditions and their expected resource utilization
- D. $460 \text{ fewer patient days} \times \$2,100 = \$966,000$ in projected cost avoidance, producing a 5.7:1 return on the $\$170,000$ investment, but the business case should also account for the revenue impact of 460 fewer patient days since reduced utilization decreases revenue in fee-for-service models while producing savings in value-based and capitated payment models

99. A nurse manager is analyzing the unit's skill mix optimization. Current skill mix data:

Staff Type	FTEs	Hourly Rate	Annual Cost
RN	24.0	\$42	\$2,096,640
LPN	4.0	\$28	\$233,408
CNA	6.0	\$18	\$224,640
Unit Secretary	2.0	\$16	\$66,560
Total	36.0		\$2,621,248

The nurse manager is considering converting two LPN positions to one RN position and one CNA position. The total FTEs would remain the same. Which analysis is MOST important before making this change?

A. Compare the salary cost difference between the two models since the RN position costs more than the LPN position it replaces

B. Evaluate whether the clinical activities currently performed by LPNs can be safely distributed between the additional RN and CNA, assess the impact on quality outcomes from the enhanced RN clinical capacity, and determine whether the net cost change is justified by projected quality improvements

C. Survey the LPNs to determine whether they would be willing to transition to CNA roles or pursue RN education

D. Benchmark the unit's skill mix against similar units in the organization to determine whether the current mix is already aligned with peer standards

100. A nurse manager is developing a proposal to implement a centralized staffing command center that uses predictive analytics to forecast unit-level staffing needs seventy-two hours in advance. The command center would replace the current decentralized model where each nurse manager independently manages staffing. The projected annual operating cost is four hundred fifty thousand dollars. Which financial justification is MOST compelling?

A. The command center eliminates the time each nurse manager spends on staffing, freeing leadership hours for other priorities

B. The projected reduction in premium labor costs (overtime and agency) from more accurate demand forecasting, combined with reduced understaffing costs (prevented adverse events, reduced overtime callbacks) and reduced overstaffing costs (eliminated unnecessary scheduled hours), producing a total savings that exceeds the command center's operating cost

C. The improvement in nurse satisfaction from more predictable and equitable scheduling practices

D. The reduction in last-minute staffing changes that disrupt patient care continuity

101. A nurse manager is evaluating the unit's performance on the CMS value-based purchasing program. The VBP program adjusts Medicare payments based on hospital performance across four domains: clinical outcomes, safety, person and community engagement, and efficiency and cost reduction. The unit's strongest performance is in clinical outcomes but weakest in efficiency. Which metric MOST directly reflects the efficiency domain?

- A. Length of stay compared to expected length of stay based on case mix
- B. Nursing hours per patient day compared to organizational target
- C. Medicare spending per beneficiary — the measure of total Medicare Part A and Part B costs during a hospitalization and for thirty days post-discharge, compared to the national median
- D. Supply cost per patient day compared to benchmark

102. A nurse manager is developing a financial model for implementing weekend clinical pharmacist coverage on the unit. Currently, weekend pharmacy support is limited to a centralized pharmacist covering all units. Data shows:

Weekend medication errors: 8.2 per month (vs. 3.1 weekday)

Average cost per medication error: \$2,800

Weekend clinical pharmacist salary: \$95,000/year

What is the projected annual financial return?

- A. The weekend pharmacist would need to prevent approximately 2.8 errors per month ($\$95,000 \div \$2,800 \div 12$) to break even
- B. If the pharmacist reduces weekend errors to weekday levels ($8.2 - 3.1 = 5.1$ fewer errors/month \times $\$2,800 \times 12 = \$171,360$ annual savings), the \$95,000 investment produces a net return of \$76,360 annually, representing a 1.8:1 ROI
- C. The financial return cannot be projected without data on the pharmacist's specific impact on error reduction
- D. The pharmacist position cannot produce a positive ROI since the salary exceeds the monthly error cost

103. A nurse manager is preparing the unit's annual operating budget. The budget must account for a projected five percent patient volume increase, a three percent negotiated wage increase, and a two percent supply price inflation. Current annual budget:

Salary: \$3,200,000

Supplies: \$480,000

Other: \$320,000

Which budget projection is MOST accurate?

A. Salary adjusted for wage increase AND volume: $\$3,200,000 \times 1.03 \times 1.05 = \$3,460,800$. Supplies adjusted for price AND volume: $\$480,000 \times 1.02 \times 1.05 = \$514,080$. Other adjusted for volume: $\$320,000 \times 1.05 = \$336,000$. Total = \$4,310,880

B. Salary $\times 1.08 = \$3,456,000$ (combined increases). Supplies $\times 1.07 = \$513,600$. Other $\times 1.05 = \$336,000$. Total = \$4,305,600

C. Simply increase total current budget by 5%: $\$4,000,000 \times 1.05 = \$4,200,000$

D. Salary $\times 1.03 = \$3,296,000$ (wage only). Supplies $\times 1.02 = \$489,600$ (price only). Other unchanged = \$320,000. Total = \$4,105,600

104. A nurse manager is analyzing the unit's return on investment from a nurse residency program. The program has been in operation for three years. Data:

Year	Program Cost	New Grad Hires	First-Year Retention	Pre-Program Retention
Year 1	\$180,000	8	75% (6 retained)	50% (4 retained)
Year 2	\$185,000	10	80% (8 retained)	50% (5 retained)
Year 3	\$190,000	12	83% (10 retained)	50% (6 retained)

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| Year 1 | \$180,000 | 8 | 75% (6 retained) | 50% (4 retained) |

| Year 2 | \$185,000 | 10 | 80% (8 retained) | 50% (5 retained) |

| Year 3 | \$190,000 | 12 | 83% (10 retained) | 50% (6 retained) |

Average cost per new graduate departure: \$52,000. Which three-year ROI calculation is MOST accurate?

A. Year 1: 2 additional retained \times \$52,000 = \$104,000 savings – \$180,000 cost = –\$76,000. Year 2: 3 additional \times \$52,000 = \$156,000 – \$185,000 = –\$29,000. Year 3: 4 additional \times \$52,000 = \$208,000 – \$190,000 = +\$18,000. Three-year total: –\$87,000 net loss

B. Total additional retained over 3 years: 9 nurses. Total savings: $9 \times \$52,000 = \$468,000$. Total cost: \$555,000. Net: –\$87,000

C. The program is not financially justified based on direct retention savings alone, but the full ROI must include non-financial benefits (improved competency, faster time to productivity, better quality outcomes, reduced agency utilization) that likely bring the total value well above the investment

D. The program achieved positive ROI in Year 3 and the trend indicates increasing returns, suggesting that the program's financial justification strengthens over time as retention rates continue to improve

105. A nurse manager is evaluating whether to recommend converting the unit from a traditional inpatient model to a hospital-at-home model for selected patient populations. The hospital-at-home model provides acute-level care in the patient's residence through a combination of in-person nursing visits, telehealth monitoring, and mobile diagnostic services. Which financial consideration is MOST important?

A. The potential cost savings from eliminating the facility overhead (room, housekeeping, dietary, utilities) associated with each patient day, combined with the reimbursement analysis for hospital-at-home services under current payer contracts, the technology and logistics investment required, and the liability implications of providing acute care outside the hospital walls

B. The salary cost of nurses who will provide home visits compared to the salary cost of inpatient bedside nurses

C. The patient satisfaction data from hospitals that have already implemented hospital-at-home models

D. The impact on the unit's inpatient census and the potential need to reduce staffing if patients are redirected to the home-based model

106. A nurse manager is analyzing the unit's overtime patterns to identify actionable reduction strategies. Overtime data categorized by root cause:

Root Cause	% of Total OT	Monthly Cost
Vacancy-driven (unfilled positions)	42%	\$14,700
Call-out coverage	23%	\$8,050
Admission/discharge surges	18%	\$6,300
Documentation completion	12%	\$4,200
Meeting/education attendance	5%	\$1,750

Which intervention strategy addresses the LARGEST cost driver?

- A. Address vacancy-driven overtime through accelerated recruitment, competitive compensation analysis, and retention improvements — since this single root cause accounts for forty-two percent of all overtime and \$14,700 monthly, and reducing it requires filling positions rather than managing workarounds
- B. Address call-out coverage through attendance management and float pool optimization since it is the second-largest category
- C. Address all five root causes simultaneously with equal resource allocation
- D. Address documentation overtime since it represents a workflow inefficiency that can be eliminated most quickly

107. A nurse manager is developing a financial projection for the next fiscal year. The projection must account for the following known changes:

Current annual salary expense: \$3,400,000

Projected changes:

- 3% contractual wage increase

- 2 additional RN FTEs at \$85,000 each (approved for new service line)
- Elimination of 1 LPN position through attrition (\$58,000 savings)
- Projected 15% reduction in agency costs from improved retention (current agency: \$240,000/year)

What is the projected net change in total labor costs?

- A. Wage increase: $\$3,400,000 \times 0.03 = \$102,000$. New RNs: \$170,000. LPN savings: $-\$58,000$. Agency reduction: $-\$36,000$. Net change: $+\$178,000$
- B. The total labor cost will increase by approximately \$178,000
- C. The total labor cost will increase by \$102,000 (wage increase only) since the new positions and savings offset each other
- D. Net change = $\$102,000 + \$170,000 - \$58,000 - \$36,000 = +\$178,000$. New projected salary expense = $\$3,400,000 + \$178,000 = \$3,578,000$, representing a 5.2% increase that the nurse manager should present alongside the service line revenue projections, retention ROI from reduced agency costs, and the LPN-to-RN skill mix improvement rationale

108. A nurse manager is developing a proposal for capital equipment replacement. The current patient monitoring system is twelve years old (manufacturer's recommended life: ten years), experiences an average of three malfunctions per month requiring rental replacements at \$200/day (average rental duration: five days), and lacks integration with the current EHR. A replacement system costs \$350,000 with a ten-year expected life. Which financial analysis is MOST comprehensive?

- A. Current annual rental cost: $3 \text{ malfunctions} \times 5 \text{ days} \times \$200 \times 12 \text{ months} = \$36,000/\text{year}$. Over 10 years: \$360,000 in rental costs avoided, which exceeds the \$350,000 purchase price, justifying the replacement on rental cost avoidance alone — before accounting for the additional value of EHR integration, improved clinical functionality, reduced clinical risk from equipment failure, and maintenance cost savings
- B. Compare the purchase price (\$350,000) to the residual value of the current system to determine the net equipment cost
- C. Calculate the annual depreciation of the new system (\$35,000/year) and compare it to the current rental costs (\$36,000/year)

D. The financial analysis should focus on the clinical benefit of EHR integration since the rental cost avoidance is marginal

109. A nurse manager is evaluating the financial impact of implementing a comprehensive fall prevention program. The program costs forty-five thousand dollars annually. Current data: twenty-eight falls per year, average cost per fall with injury: twelve thousand dollars, thirty-five percent of falls result in injury. If the program reduces falls by forty percent, what is the projected annual financial return?

A. Current annual fall injury cost: $28 \text{ falls} \times 35\% \text{ injury rate} \times \$12,000 = \$117,600$. Program reduces falls by 40%: 11.2 fewer falls. Fewer injuries: $11.2 \times 35\% = 3.92$ fewer injuries $\times \$12,000 = \$47,040$ in avoided costs. Net return: $\$47,040 - \$45,000 = \$2,040$ positive ROI, marginally positive but strengthened significantly by non-financial benefits including reduced patient harm, improved satisfaction, decreased litigation risk, and CMS penalty avoidance

B. $28 \text{ falls} \times 40\% \text{ reduction} = 11.2 \text{ fewer falls} \times \$12,000 = \$134,400$ savings (this incorrectly applies the full cost to all falls rather than only injurious falls)

C. The program will not produce a positive financial return since the cost nearly equals the projected savings

D. The financial return cannot be calculated without data on the specific types of fall injuries and their individual costs

110. A nurse manager is developing a staffing budget for a unit that operates with variable census. The unit has thirty licensed beds but operates at an average census of twenty-four with a standard deviation of four. Target HPPD is 8.5. Which staffing model is MOST financially efficient while maintaining quality?

A. Staff to the average census of twenty-four patients ($24 \times 8.5 = 204$ hours/day) and use overtime or agency to cover days when census exceeds the average

B. Staff to the average census of twenty-four plus a flexible staffing component (either dedicated float pool positions or scheduled on-call staff) that can be activated when census exceeds twenty-eight patients, allowing the unit to cover the typical census range without chronic overstaffing at the thirty-bed licensed capacity while maintaining rapid access to supplemental staff for high-census days

C. Staff to the maximum licensed capacity of thirty beds ($30 \times 8.5 = 255$ hours/day) to ensure adequate coverage regardless of census variation

D. Staff to the average census minus one standard deviation (20 patients) as the baseline and use premium labor for all census above twenty patients

111. A nurse manager is analyzing the cost-benefit of three different approaches to managing chronic wound care on the unit:

Approach	Annual Cost	Avg Healing Days	Complication Rate
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Current practice (generalist RNs)	\$85,000	32	18%
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Wound care RN specialist (0.5 FTE)	\$130,000	21	8%
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Wound care NP (0.5 FTE) + protocol	\$165,000	16	4%
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The unit manages approximately 180 wound care patients per year. Each day of additional healing time costs approximately \$350 in nursing time and supplies. Each wound complication costs approximately \$6,500. Which analysis supports the BEST investment decision?

A. The wound care NP approach produces the shortest healing time and lowest complication rate and therefore provides the highest quality regardless of cost

B. Calculate healing day savings: Specialist saves $(32-21) \times 180 = 1,980$ days \times \$350 = \$693,000. NP saves $(32-16) \times 180 = 2,880$ days \times \$350 = \$1,008,000. Complication savings: Specialist prevents $(18\%-8\%) \times 180 = 18$ complications \times \$6,500 = \$117,000. NP prevents $(18\%-4\%) \times 180 = 25.2$ complications \times \$6,500 = \$163,800. Total value: Specialist = \$810,000 at \$130,000 cost (6.2:1 ROI). NP = \$1,171,800 at \$165,000 cost (7.1:1 ROI). The NP approach produces both the highest absolute savings and the highest ROI

C. The specialist RN approach provides the most cost-effective improvement since its incremental cost (\$45,000) produces substantial quality improvement

D. All three approaches should be evaluated over a two-year pilot before making a financial commitment

112. A nurse manager is preparing a capital budget request and must prioritize three competing needs within a one hundred fifty thousand dollar allocation:

Item	Cost	Safety Impact	Revenue Impact	Regulatory Risk
Smart IV pumps	\$120,000	High	None	Medium
Patient monitoring upgrade	\$90,000	Medium	\$40,000/yr	Low
Medication room renovation	\$65,000	Low	None	High

Which prioritization produces the GREATEST organizational value within the budget constraint?

- A. Fund the smart IV pumps (\$120,000) since patient safety is the highest organizational priority, leaving \$30,000 for partial medication room renovation
- B. Fund the monitoring upgrade (\$90,000) for its revenue-generating potential plus the medication room renovation (\$65,000) for regulatory compliance = \$155,000 — this exceeds budget by \$5,000 and requires negotiation for the small overage or phased implementation
- C. Fund the medication room renovation (\$65,000) first since regulatory risk creates the most immediate organizational vulnerability, then fund the monitoring upgrade (\$90,000) for its combined safety and revenue value = \$155,000, requiring \$5,000 in additional funding or phased approach
- D. Apply a weighted scoring matrix evaluating all three items across safety, revenue, regulatory, and strategic criteria, then fund in priority score order — recognizing that the \$150,000 constraint means one item will be deferred and the decision requires transparent criteria rather than single-factor prioritization

113. A nurse manager is evaluating the unit's contribution to the organization's operating margin. Financial data:

Unit revenue: \$6,200,000

Unit direct expenses: \$5,400,000

Allocated overhead: \$650,000

Unit direct contribution margin: \$800,000

The CFO asks the nurse manager to reduce direct expenses by five percent while maintaining quality. What is the dollar target, and which approach is MOST appropriate?

- A. 5% of \$5,400,000 = \$270,000 reduction target. The nurse manager should identify cost reduction opportunities through labor productivity optimization, supply utilization analysis, and process efficiency improvements, presenting a plan that achieves the target while demonstrating through quality metric projections that the reductions will not compromise patient outcomes
- B. The \$270,000 target should be rejected since the unit's \$800,000 contribution margin already demonstrates financial efficiency
- C. Achieve the \$270,000 reduction exclusively through labor cost management since labor represents the largest expense category and offers the most reduction potential
- D. Negotiate the reduction target down to three percent since five percent may compromise quality, and present evidence showing the quality risk at each reduction level

114. A nurse manager is developing a financial sustainability plan for the unit that addresses both short-term budget performance and long-term financial viability. Which combination of metrics provides the MOST complete picture of financial sustainability?

- A. Monthly budget variance, annual operating margin, and cost per patient day trending
- B. Revenue per patient day, expense per patient day, and volume trend
- C. Labor cost as a percentage of total expenses, supply cost per patient day, and overtime percentage
- D. Short-term metrics (monthly budget variance, productivity index, premium labor percentage) combined with long-term metrics (contribution margin trending, payer mix evolution, volume projection, capital equipment age and replacement schedule, workforce cost trajectory, and alignment with organizational strategic financial targets)

115. A nurse manager is conducting a comprehensive year-end financial review. The unit met its quality targets, exceeded patient satisfaction targets, achieved a two percent positive operating margin, but experienced higher-than-budgeted turnover that increased premium labor costs by \$180,000 above budget. The nurse manager wants to present a forward-looking financial strategy for the next fiscal year. Which strategic recommendation is MOST appropriate?

- A. Propose a retention-focused investment strategy that addresses the root causes of turnover, project the financial return as reduced premium labor costs that offset the investment, and present a budget that demonstrates the unit can maintain its positive operating margin while investing in workforce stability — showing leadership that spending strategically on retention produces better financial outcomes than absorbing the ongoing cost of turnover
- B. Propose a budget increase equal to the \$180,000 premium labor overage to realistically reflect the turnover-driven cost structure
- C. Focus the forward-looking strategy on maintaining the two percent operating margin through cost reduction in non-labor categories
- D. Propose an aggressive recruitment campaign to fill vacancies more quickly and reduce the duration of premium labor utilization

Answer Key – Exam 12 (with Full Answer Explanations)

1. A — The hiring decision should be based on the specific communication demands of the role. If the position requires clinical assessment and medication management, an RN is required; if it focuses on logistics and social service coordination, a community health worker may be equally effective at lower cost. Role design should drive the qualification requirement rather than organizational preference.
2. C — Using specific recorded examples of the nurse's communication with different audiences, identifying where adaptation was absent, demonstrating alternative approaches, and practicing through role-play with feedback develops audience-adaptive communication through experiential learning. Awareness of the gap requires seeing one's own communication objectively.
3. D — Building trust through non-judgmental communication, addressing patient-identified priorities alongside medical needs, involving social work from admission, developing realistic discharge plans for the actual living situation, and creating follow-up pathways independent of a home address comprehensively addresses the barriers. Homeless patients require care planning that accounts for their real circumstances.

4. C — Piloting during high-risk transitions, demonstrating that the time investment prevents errors and callbacks, and using outcome data to build support follows the evidence-based implementation approach. Starting with the highest-risk transitions proves the concept where the stakes are greatest before expanding.
5. A — Educating on age-related communication biases, providing examples of minimizing language, developing age-neutral validation approaches, and monitoring by age group targets the specific documented disparity. The data clearly identifies the problem population and the problematic language patterns.
6. A — An automated allergy alert system that flags patients across all departments when allergies are documented prevents the communication gap that allowed this near-miss. Manual notification processes depend on individual nurse memory and are inherently unreliable. System-level alerts ensure that every department receives allergy information automatically.
7. B — A standardized assessment evaluating functionality and compatibility, communication expectations for data integration, and criteria for when personal devices should be supplemented balances patient autonomy with clinical safety. Personal medical devices require individualized evaluation rather than blanket acceptance or prohibition.
8. C — A structured rounding communication process with pre-rounding notification, nurse participation when possible, post-rounding summary, and communication board updates ensures the nurse is informed about care plan changes regardless of whether she was present during rounds. The multi-layered approach prevents information loss.
9. C — Drawing privacy curtains, lowering volume, using communication shields, and offering private consultation rooms for sensitive discussions addresses the privacy challenge within the shared-room constraint. Complete elimination of double rooms requires capital investment; practical interventions can improve privacy immediately.
10. B — Situation monitoring is a professional obligation that enhances team safety. Nurses who identify concerns beyond their assignment fulfill their professional duty to patient safety. TeamSTEPPS specifically requires every team member to serve as a safety surveillance sensor regardless of individual assignment boundaries.
11. D — Clarifying that patient co-design authority applies to experience dimensions of clinical workflows, demonstrating through examples how patient insight improves design without compromising

clinical standards, and piloting with a single workflow demonstrates the model's value. Patient co-design succeeds when the scope is clearly defined and demonstrated.

12. A — A structured visit frequency standard ensuring equal nursing visits, inclusion in hourly rounding, and technology supplementation directly addresses the documented care disparity. Research consistently shows isolated patients receive less clinical attention. The solution must mandate equitable visit frequency.

13. C — A structured discussion of active issues, medications, follow-up needs, red flag symptoms, and patient questions conducted with all parties confirming understanding in real time is the most critical element. The warm handoff's value lies in the synchronous, three-way clinical conversation that written summaries cannot replicate.

14. A — A multi-pronged approach addressing staff conversations, alarm management, equipment noise, ambient monitoring with feedback, and nighttime workflow redesign provides the comprehensive noise reduction the twenty-second-percentile score requires. Single interventions cannot address multiple noise sources.

15. C — Investigating the underlying cause of excessive calling — anxiety, unmet needs, fear, pain — addressing root causes through proactive rounding, and establishing a care partnership addresses the behavior at its source. Excessive call light use is typically a symptom of an unmet need rather than a behavioral problem.

16. C — A communication skills training program with frameworks like SPIKES, role-play practice, observation-based coaching, and structured debriefing develops the specific competencies through progressive experiential learning. Difficult conversation skills require practice with feedback, not scripts or delegation.

17. A — A mandatory professional interpreter requirement for high-risk communications — medication education, consent, discharge instructions, symptom assessment — with documentation targets the specific communication gaps driving the forty-seven percent adverse event disparity. The intervention must match the identified risk points.

18. D — Addressing the family about recording policy, addressing nurses about appropriate communication settings, reviewing the overheard content with the family if disclosure is warranted, and

advocating for a formal policy addresses all dimensions. The situation involves recording consent, staff communication practices, potential disclosure obligations, and policy development.

19. A — Using the family member supplemented by medical translation technology, documenting limitations, communicating the situation to the team, and advocating for rare-language solutions provides the best available accommodation. When no certified interpreter exists, the organization must use the best available resources while acknowledging and documenting the limitations.

20. D — Ensuring on-demand qualified ASL interpretation for all significant clinical communications through in-person or video remote, supplementing with written notes only for simple non-clinical interactions, and advocating for expanded availability provides the comprehensive solution. Written English is a second language for many deaf ASL users and is inadequate for complex clinical communication.

21. B — Redesigning the program to require cross-shift nominations, establish behavioral criteria, create a validation process, celebrate cross-team recognitions, and track distribution patterns transforms the program from an in-group social tool to a genuine recognition system. Recognition programs that reinforce existing cliques do not build unit-wide culture.

22. B — Respecting the patient's emotional processing, providing truthful information when asked, avoiding forced prognostic conversations, supporting the family in understanding denial, and involving palliative care follows the therapeutic communication framework. Denial is a protective mechanism that resolves on its own timeline. Forcing disclosure harms rather than helps.

23. A — Identifying which communications benefit from face-to-face versus email, practicing in-person delivery for high-impact interactions, and developing interpersonal comfort while preserving email's efficiency develops the specific skill gap. Email-dominant communicators need coaching on when direct interaction is essential rather than a blanket prohibition.

24. B — A culturally responsive framework with interpreter access, trauma-informed training, cultural orientation, agency collaboration, and a clinical resource guide provides the comprehensive support this complex population requires. Refugee healthcare requires integration of medical, cultural, psychological, and social service dimensions.

25. D — Acknowledging anxiety, providing comprehensive training, establishing downtime procedures with paper backup for critical functions, identifying super-users, and implementing a phased rollout

addresses the transition systematically. Technology transitions succeed when anxiety is validated, training is thorough, and contingencies are prepared.

26. A — Defining the nurse's bedside facilitator role during telehealth consultations — preparing the patient, ensuring technology, assisting with examination, advocating, documenting, and following up — creates clarity in an ambiguous new workflow. Telehealth inpatient consultations require a defined nursing role to maintain care quality.

27. B — Transitioning to a brief structured format, assigning calls to non-direct-care staff, and supplementing with portal messaging preserves the forty percent call reduction benefit while reducing the nursing time burden. The program's value is demonstrated; the delivery model needs optimization.

28. A — Following the legal guardian's documented authority is legally required. While facilitating a family meeting to explore the patient's wishes is ideal practice, the legal framework gives the guardian decision-making authority. Option A correctly recognizes this legal reality.

29. B — Redesigning the documentation system to require a response-to-intervention field before finalization creates a system-level intervention that ensures compliance. Documentation gaps that persist despite education indicate a system design problem rather than a knowledge deficit.

30. B — A fall risk assessment tool with poor sensitivity for the specific patient population misclassifies actual fall-risk patients as low risk. Seventy percent of falls occurring in "low-risk" patients indicates the tool fails to identify the factors that actually predict falls on this unit. The tool needs replacement or supplementation with population-specific criteria.

31. C — Reason's organizational accident model analyzes how latent conditions (look-alike names, staffing pressure, system design) combined with active failures (wrong drawer access) to create the near-miss. Addressing both latent conditions and active failure opportunities prevents recurrence more effectively than targeting either alone.

32. C — Supplementing the Braden Scale with unit-specific clinical judgment criteria, analyzing which subscales are most predictive for the unit's patients, and targeting the actual risk factors most commonly associated with the unit's pressure injuries provides the most evidence-based approach. Risk assessment tools perform differently across populations and require local validation.

33. D — All five elements must be addressed simultaneously because bundle compliance requires adherence to ALL elements. The lowest-performing element (repeat lactate at sixty-one percent) determines overall bundle success. A patient who receives four of five bundle elements is not bundle-compliant.

34. A — Comprehensive training in de-escalation, behavioral emergency management, safe restraint, environmental safety, and psychiatric consultation protocols supplemented by environmental modifications provides the most critical preparation. Non-psychiatric units receiving behavioral health patients require specific skill development and environmental adaptation.

35. D — A risk-stratified approach with nurse-led calls for high-risk patients, automated systems with nurse callback for moderate-risk patients, and automated check-in for low-risk patients maximizes coverage within existing resources. Universal nurse-led follow-up is unrealistic without dedicated staff; risk stratification optimizes resource allocation.

36. C — Standardized patient education before asking for a decision, nurse-driven automatic initiation unless contraindicated, and re-auditing the refusal rate addresses the root cause. High refusal rates often reflect inadequate education rather than genuine informed refusal. Improving education before requesting consent reduces inappropriate refusals.

37. D — Communication failure contributes to sixty-eight percent of events but percentages total over one hundred percent because most events involve multiple factors. Interventions must address the interactions between factors rather than targeting each in isolation. Communication improvement alone will not prevent events that also involve staffing, training, and equipment.

38. D — Incorporating nursing assessment data — mental status changes, respiratory pattern alterations, declining urine output, and clinical intuition — into the algorithm alongside vital signs provides earlier detection. Nursing observations detect deterioration twelve to twenty-four hours before vital sign changes, making them essential algorithm inputs.

39. B — The absence of a documented, rehearsed surge staffing plan represents the greatest vulnerability because staffing is the foundation for all other surge capacity elements. Without a plan for reallocating, cross-training, and deploying nursing resources, no amount of PPE, equipment, or space can maintain patient care during a sustained surge.

40. C — The primary value of a safety stop system is its universality — concerns from any team member are valid regardless of role. Restricting safety stop authority to certain roles defeats the system's purpose as a universal safety net. Aviation's safety record improved when any crew member could halt operations for safety concerns.

41. A — A comprehensive protocol with education, conscience-based accommodation, training for willing staff, emotional support, and documentation standards addresses both the clinical requirements and the moral complexity. Medical assistance in dying requires organizational preparation that respects both patient rights and staff conscience.

42. D — The HAPI progression from 0.4 to 1.0 represents a consistent four-month worsening trend indicating systematic process failure. Unlike the CLABSI spike which could represent a single event, the progressive HAPI deterioration will continue to worsen without intervention and signals a systemic rather than isolated problem.

43. D — Events should be classified based on both actual outcome and potential severity, with high-potential-harm near-misses receiving investigation equivalent to actual adverse events. The same system failures that produce a near-miss can produce harm when circumstances align differently. Potential severity determines investigation priority.

44. C — Presenting utilization data and override rates to medical staff leadership, collaborating on revised criteria, establishing that overrides require documented justification, and implementing peer review addresses the physician override barrier. A sixty-two percent override rate suggests either protocol criteria that do not match clinical reality or physician practice patterns that need accountability.

45. B — A comprehensive cyber-downtime protocol addressing paper documentation, manual medication dispensing, verbal orders, patient identification without barcodes, network-independent communication, and post-restoration reconciliation provides the most critical patient safety foundation. Unlike planned downtimes, cyberattacks have unknown duration and require full operational independence from technology.

46. A — Calculating the financial value of the 0.4-day LOS reduction across patient volume and comparing it to the nursing time cost provides the comprehensive evaluation. The mobility culture's forty-five-minute workload increase must be weighed against the clinical and financial value it produces.

47. C — A comprehensive stroke response protocol integrating rapid nursing assessment, immediate imaging, teleneurology activation, standing thrombolytic orders, and defined timeframes ensures that off-hours care meets the same time-critical standards as weekday care. Stroke outcomes are time-dependent, and the protocol must eliminate all avoidable delays.

48. D — A collaborative pharmacist-physician-nurse protocol with multimodal pain management as the default, documented opioid justification, and nursing assessment guiding de-escalation creates a system-level approach. Opioid stewardship succeeds through protocol standardization rather than individual physician negotiation.

49. B — Above-average satisfaction coexisting with significantly above-benchmark turnover suggests that satisfaction measures are not capturing the actual departure drivers. Exit interview analysis is needed to identify the hidden retention barriers that current surveys miss. This paradox reveals a measurement gap.

50. D — An integrated approach with evidence-based pain management, addiction medicine consultation, therapeutic communication training, stigma reduction, behavioral frameworks preserving dignity, and discharge planning connecting to addiction treatment addresses the multiple dimensions of caring for patients with substance use disorders.

51. B — Eighteen months of marginal improvement through incremental PDSA cycles suggests the current process architecture has reached its improvement ceiling. Breakthrough redesign should be considered because the problem may require innovation — fundamentally reimaging the medication administration process — rather than continued optimization within the existing framework.

52. C — Scenario-based workforce models projecting needs under multiple futures with flexible strategies that adapt to whichever materializes provides the most comprehensive approach. Five-year workforce planning cannot rely on single-scenario projections because healthcare's operating environment is inherently unpredictable.

53. A — The "fixes that fail" archetype describes a pattern where quality improvement (the fix) produces budget reductions (the unintended consequence) that eliminate the improvement's supporting resources, causing regression (failure) that triggers a new improvement cycle. The short-term solution creates the conditions for its own reversal.

54. B — Restructuring the huddle to begin with frontline staff reporting concerns, followed by leadership response and resource commitment, transforms it from a top-down broadcast to a bottom-up intelligence pull. Lean daily management huddles fail when they become one-directional information delivery rather than bidirectional problem identification.

55. C — A structured innovation pipeline with submission, screening, safe-to-fail testing, evaluation, and a defined pathway to standard practice with leadership support and protected resources creates the infrastructure innovation requires. Ideas die without a structured pathway from concept to implementation.

56. B — Adding complexity leadership competencies alongside operational training addresses the specific gap. Graduates who struggle with ambiguity and default to rule-following in adaptive situations need complexity leadership skills that the current operational curriculum does not develop.

57. A — Daily observation of high-risk processes at the point of care with real-time coaching demonstrates leadership presence, attention, and commitment to standards. Leader standard work's primary safety value lies in making leadership visible at the clinical frontline where safety-critical processes occur.

58. A — Studying the bright-spot nurses through shadowing, interviews, and outcome comparison identifies the specific behavioral differences producing exceptional results. Positive deviance methodology applied to internal bright spots provides solutions that are already proven to work within the unit's own constraints.

59. B — Presenting data showing total LOS reduction costs including readmissions, proposing an alternative approach based on readmission risk prediction, and advocating for unit-specific targets balances organizational compliance with evidence-based advocacy. Data-driven pushback against mandates that produce net harm is a professional leadership obligation.

60. C — Leadership modeling of vulnerability — openly acknowledging mistakes, asking for help, admitting uncertainty — then creating structured opportunities for progressive team vulnerability establishes the foundation for trust. Lencioni identifies trust as the base of the team effectiveness pyramid, and trust requires leaders to go first.

61. C — The selling/coaching style provides both the clear direction needed for the unfamiliar role and the relationship support needed for developing confidence. Hersey and Blanchard's model matches high task direction plus high relationship support to followers who are enthusiastic but lack competence.

62. B — A governance model where twelve out of forty nurses rotate through all councils while twenty-eight never participate creates an unrepresentative elite. Shared governance's democratic principle requires broad representation. When governance becomes an exclusive club, it fails to represent the majority voice.

63. D — Addressing moral injury organizationally through ethical dialogue forums, policy advocacy, specialized psychological support, and building awareness that moral injury is system-level requires system-level solutions. Individual counseling treats symptoms while organizational change addresses causes.

64. D — The most significant implementation challenge is that flexible resource pool nurses experience scheduling unpredictability that reduces satisfaction and increases turnover. The irony is that the solution to staffing variability creates its own retention problem within the flexible pool, requiring equitable incentives and scheduling practices.

65. A — Self-reflection practices, executive coaching for self-awareness, 360-degree feedback, candid mentoring, and deliberate examination of how values influence decisions develops "the leader within." This AONL domain requires introspective practices that external training alone cannot develop.

66. C — A transparent, ethically grounded allocation framework created in advance with multidisciplinary and community input, defining clinical criteria, decision authority, appeals, and separation from treating clinicians provides the most critical preparation. Crisis allocation decisions made without a pre-established framework produce inequitable, inconsistent, and morally injurious outcomes.

67. C — Shifting night shift rounding from observation to service — asking what staff need, removing barriers, recognizing effort, demonstrating genuine interest — transforms the perception from surveillance to support. Leadership visibility only builds trust when staff experience the visits as helpful rather than monitoring.

68. D — A comprehensive workload analysis comparing actual care demands adjusted for acuity, complexity, admission-discharge frequency, and absorbed non-nursing tasks against the care capacity the ratio provides identifies whether the ratio-quality gap is driven by acuity increases, workload expansion, or both.

69. C — Creating a safe experimentation environment, celebrating both successful and unsuccessful experiments, connecting with external innovation leaders, and starting with one visible achievable innovation catalyzes adoption. Innovation-resistant cultures need a success experience to overcome the "we've always done it this way" default.

70. B — Regular cross-departmental meetings, joint QI projects, shared metrics, relationship-building, and reciprocal shadowing create ongoing collaborative infrastructure. Boundary spanning requires sustained structural investment rather than temporary task forces.

71. B — Undocumented institutional knowledge represents irreplaceable organizational intelligence permanently lost when senior nurses depart. While charge nurse succession is operationally urgent, the knowledge loss is irreversible — the nurse manager can assume charge duties temporarily, but seventy-five years of institutional knowledge cannot be recreated.

72. C — Making the board the centerpiece of the daily huddle — updating data during the huddle, referencing it for safety discussions, tracking actions on the board, and closing loops visibly — transforms it from passive display to active management tool. Visual management boards become wallpaper without the management practices that bring them to life.

73. B — Presenting a comprehensive analysis of the absorption impact on workload, quality, satisfaction, and turnover projections, translating anticipated turnover cost into dollars exceeding the savings, and proposing alternatives is the most appropriate leadership response. The eliminated positions' cost savings likely create larger turnover-related costs.

74. B — Clearly defined, measurable competency milestones with standardized assessment criteria, multiple assessors for reliability, and a transparent extension process is the most critical design element. Competency-based orientation succeeds or fails based on the quality and consistency of the milestone evaluation system.

75. D — Presenting increased reporting as improved safety culture, demonstrating that new reports are predominantly previously unreported near-misses, and showing how visibility enables proactive improvements addresses the supervisor's concern with data. Reporting volume increases predictably when safety culture matures — this is evidence of success, not failure.

76. D — Gradually transitioning by starting with directive leadership supplemented by thinking-provoking questions, progressively increasing participation as staff develop comfort, follows the change

management principle of meeting people where they are. Staff accustomed to directive leadership cannot shift to participative decision-making overnight.

77. B — Presenting specific complaint data, establishing therapeutic communication as a core competency, setting measurable behavioral targets, providing coaching with observed practice and feedback, and evaluating through satisfaction data and observation provides the structured performance improvement framework. Interpersonal communication is a developable competency, not a fixed personality trait.

78. C — Broadly distributed capabilities — many staff performing multiple functions, widely shared knowledge, multi-level leadership capacity, and practiced adaptation — most strongly predicts organizational resilience. Resilience depends on distributed capacity rather than concentrated expertise or documented procedures.

79. C — Asking for genuine assessment before deciding, revising plans based on input, acknowledging when staff expertise exceeds the manager's own, and creating bidirectional honest feedback exemplifies humble leadership. The Scheins' model is defined by genuine openness and curiosity that creates psychologically safe relationships.

80. B — Addressing the nurse privately with specific behaviors, explaining the safety culture impact, engaging her in understanding the program's rationale, and inviting constructive participation converts subtle opposition into constructive engagement. Quiet influencers who are engaged become powerful advocates; those who are ignored continue undermining.

81. D — Structured experiences that challenge habitual thinking — reflective case analysis, proficient/expert mentoring, holistic assessment simulation, and guided practice with debriefing — promote progression from competent to proficient. Benner's model shows that progression requires exposure to situations that force pattern recognition development.

82. B — Investigating the concern on clinical merits regardless of source, implementing corrections, acknowledging the traveling nurse's contribution, and using it as a teaching moment about habituation addresses both the safety issue and the cultural dynamic. Fresh perspectives identify risks that habituated permanent staff cannot see.

83. B — The system should be evaluated for whether deterioration was anticipated and whether prevention protocols were appropriate, while individual accountability is limited to competent

performance within the protocol. When a nurse performs assessments and interventions correctly within an evidence-based protocol, system-level factors determine accountability.

84. C — A comprehensive fatigue management program addressing scheduling limits, monitoring tools, a culture normalizing declining extra shifts, overtime restriction, leadership modeling, and commute safety aligns with the ANA position. Fatigue management requires system-level interventions rather than individual hour caps alone.

85. C — Accepting the gift violates professional boundary standards regardless of timing or intent because it creates an appearance of financial influence, establishes a precedent for other families, and erodes public trust in nursing's altruistic commitment. Professional boundaries extend beyond the active care relationship.

86. D — Nurses using unvalidated AI bear full professional accountability for harm, and the organization has no liability protection for unapproved tools. This creates the most significant combined professional and organizational risk requiring immediate governance including validation, guidelines, and accountability standards.

87. A — Formal progressive discipline with documented behavioral examples, clear expectations, defined consequences, and distinction between legitimate disagreement and deliberate undermining is the appropriate escalation. Persistent public undermining of leadership authority after coaching conversations constitutes insubordination requiring formal accountability.

88. A — Reframing the expanded role as an evolution of nursing's core mission by demonstrating that telehealth, coordination, and population health are nursing care through different modalities, and defining nursing by its purpose rather than its setting addresses the identity ambiguity at its root.

89. C — Investigating both grievances independently, implementing interim protections, avoiding prejudice, ensuring anti-retaliation understanding, and addressing the interpersonal conflict through mediation after investigation provides the fair, thorough process competing grievances require.

90. D — Expanding the policy to address all impairment sources while maintaining the core principles of patient safety, fair process, supportive intervention, fitness-for-duty evaluation, and return-to-work guidelines provides the most important revision. Modern impaired practice policies must address the full spectrum of conditions that affect clinical performance.

91. D — Clinical advancement pathways with meaningful non-management leadership roles provide professional growth, intellectual challenge, and recognition without requiring management transition. Mid-career nurses need lateral growth opportunities that value clinical expertise.

92. C — Post-incident response and support for staff victims — including medical evaluation, psychological support, documentation, workers' compensation guidance, and organizational follow-up — is most frequently missing. Many organizations invest in prevention but neglect the critical post-incident support that affects staff recovery and retention.

93. A — Any deviation from the IRB-approved consent process constitutes a protocol violation requiring IRB investigation regardless of the study's risk level. The physician's judgment about consent adequacy does not override the IRB's determination. IRB reporting is mandatory, not discretionary.

94. A — Empowering nursing through structural changes that increase practice control, equitable power relationships, professional autonomy, and collective efficacy addresses the oppression dynamics that theory identifies as the root cause. Horizontal violence is theorized as internalized oppression that resolves when the underlying power imbalances are corrected.

95. D — Nurses bear professional accountability for clinical recommendations regardless of platform, and harmful advice may trigger licensing board scrutiny even when labeled as personal opinion. Professional responsibility for clinical content extends to all communication channels including social media.

96. A — Benefits, orientation, premium labor, productivity loss, and indirect turnover costs together add forty to sixty percent above base salary to the true cost. These components are the most commonly underestimated because they do not appear on a single budget line and require aggregation across multiple cost categories.

97. B — Expenses growing faster than revenue despite increasing volume produces progressive margin compression turning negative in Q4. The cost of delivering each patient day is increasing faster than revenue generated, requiring immediate investigation of which expense categories are driving the acceleration.

98. D — The calculation produces \$966,000 in cost avoidance at a 5.7:1 ROI, but the business case must account for the revenue impact of 460 fewer patient days — which reduces fee-for-service revenue while producing savings in value-based models. The payment model determines whether reduced utilization is financially positive or negative.

99. B — Evaluating whether LPN activities can be safely distributed between the additional RN and CNA, assessing quality impact from enhanced RN capacity, and determining whether cost changes are justified by quality improvements provides the most important analysis. Skill mix changes must be evaluated on clinical outcomes, not just cost differentials.

100. B — Projected reduction in premium labor costs from better forecasting, combined with reduced understaffing costs and overstaffing costs, producing total savings exceeding the command center's cost provides the most compelling justification. The command center's value lies in optimizing the entire staffing cost curve.

101. C — Medicare spending per beneficiary — measuring total Medicare costs during and thirty days post-hospitalization compared to the national median — is the VBP efficiency domain measure. This captures the full episode cost rather than individual inpatient metrics.

102. B — Reducing weekend errors to weekday levels saves $5.1 \text{ errors/month} \times \$2,800 \times 12 = \$171,360$ annually against the \$95,000 investment for a net return of \$76,360 (1.8:1 ROI). The calculation demonstrates clear financial justification for weekend pharmacist coverage.

103. A — Salary adjusted for both wage increase AND volume: $\$3,200,000 \times 1.03 \times 1.05 = \$3,460,800$. Supplies adjusted for price AND volume: $\$480,000 \times 1.02 \times 1.05 = \$514,080$. Other adjusted for volume: $\$320,000 \times 1.05 = \$336,000$. Total = \$4,310,880. Each variable must be applied multiplicatively to the affected categories.

104. D — The program achieved positive ROI in Year 3 and the trend shows improving retention rates, indicating that financial justification strengthens over time. Programs that show progressive improvement in their primary outcome metric (retention) justify continued investment based on trajectory even if early years show negative direct ROI.

105. A — The facility overhead elimination, reimbursement analysis under current payer contracts, technology investment requirements, and liability implications provide the most important financial consideration. Hospital-at-home fundamentally changes the cost structure by eliminating facility costs but introduces new logistics and liability costs.

106. A — Vacancy-driven overtime at forty-two percent and \$14,700 monthly is the largest single root cause. Addressing it requires filling positions through recruitment, retention, and compensation analysis

rather than managing workarounds. The most effective overtime reduction strategy targets the largest root cause category.

107. D — Net change = $\$102,000 + \$170,000 - \$58,000 - \$36,000 = +\$178,000$. The new projected expense of $\$3,578,000$ (5.2% increase) should be presented with the service line revenue projections, retention ROI, and skill mix rationale that contextualizes the increase as strategic investment.

108. A — Current annual rental: $3 \times 5 \times \$200 \times 12 = \$36,000/\text{year}$. Over ten years: $\$360,000$ exceeds the $\$350,000$ purchase price on rental avoidance alone — before accounting for EHR integration value, improved clinical functionality, reduced clinical risk, and maintenance savings. The financial case is compelling on cost avoidance alone.

109. A — Current injury cost: $28 \times 35\% \times \$12,000 = \$117,600$. Program prevents $11.2 \text{ falls} \times 35\% = 3.92 \text{ injuries} \times \$12,000 = \$47,040$. Net: $\$47,040 - \$45,000 = \$2,040$ positive. Marginally positive financially but significantly strengthened by non-financial benefits including reduced harm, satisfaction, litigation risk, and CMS penalty avoidance.

110. B — Staffing to average census plus a flexible component activated when census exceeds twenty-eight provides the most financially efficient model. This approach covers the typical range without chronic overstaffing at maximum capacity while maintaining rapid access to supplemental staff for high-census days.

111. A — The NP approach produces the highest absolute savings and highest ROI. Specialist saves $\$810,000$ at $\$130,000$ cost (6.2:1). NP saves $\$1,171,800$ at $\$165,000$ cost (7.1:1). The NP approach is superior on both absolute value and efficiency measures.

112. D — A weighted scoring matrix evaluating all items across safety, revenue, regulatory, and strategic criteria with transparent prioritization provides the most appropriate decision framework. The $\$150,000$ constraint means one item will be deferred, and the decision requires multi-criteria analysis rather than single-factor prioritization.

113. C — The $\$270,000$ target (5% of $\$5,400,000$) should be addressed through labor productivity optimization, supply analysis, and process efficiency with quality metric projections demonstrating that reductions will not compromise outcomes. Cost reduction proposals require paired evidence that quality is maintained.

114. D — Short-term metrics (variance, productivity, premium labor) combined with long-term metrics (margin trending, payer mix evolution, volume projection, capital age, workforce trajectory, strategic alignment) provides the most complete sustainability picture. Financial sustainability requires both operational monitoring and strategic trajectory analysis.

115. A — A retention-focused investment strategy addressing turnover root causes, projecting reduced premium labor as the financial return, and demonstrating that strategic retention spending produces better outcomes than absorbing ongoing turnover costs is the most appropriate forward-looking recommendation. The \$180,000 premium labor overage is a symptom of turnover that retention investment can cure.