PRACTICE EXAM 13 — FULL-LENGTH SIMULATION (115 QUESTIONS)

1. A nurse manager is implementing trauma-informed communication practices on the unit. A core principle of trauma-informed care is to ask patients "What happened to you?" rather than "What is wrong with you?" — shifting from a pathology-based to an experience-based framework. Several nurses resist, stating this approach is intrusive and outside their clinical scope. Which response is MOST appropriate?

A. Allow nurses to opt out of trauma-informed questioning and apply the approach only with patients who have documented trauma histories

B. Implement the trauma-informed communication practices only during behavioral health consultations

C. Explain that trauma-informed communication is not about conducting trauma assessments but about creating a care environment that recognizes the pervasiveness of trauma, avoids practices that may re-traumatize patients, and integrates an awareness of trauma into all clinical interactions without requiring patients to disclose trauma histories

D. Require all patients to complete a trauma screening questionnaire upon admission so nurses know which patients need trauma-informed communication

2. A nurse manager is developing a communication framework for integrating patient-generated health data into clinical care. Patients are arriving with data from wearable fitness trackers, continuous glucose monitors, home blood pressure devices, and sleep tracking applications. Nurses report feeling overwhelmed by the volume and uncertain about the reliability of patient-generated data. Which approach is MOST appropriate?

A. Develop a structured process where nurses acknowledge patient-generated data, evaluate it within the context of clinically validated measurements, integrate relevant data into the assessment, and communicate with the patient about how the data will and will not be used in clinical decisions

B. Instruct nurses to disregard all patient-generated health data and rely exclusively on hospital-monitored clinical measurements

C. Accept all patient-generated data at face value and enter it into the medical record alongside hospital-collected clinical data

D. Refer all patients who bring personal health data to a clinical informatics specialist for data evaluation before nurses incorporate it into care planning

3. A nurse manager is addressing a communication challenge with a patient who is cognitively intact but non-verbal following a stroke. The patient communicates through eye blinks and subtle facial expressions. Staff report that clinical interactions are rushed because communication is slow, and the patient's care preferences are not being adequately captured. Which intervention is MOST appropriate?

A. Assign a speech-language pathologist to be present during all clinical interactions to facilitate communication between the nursing staff and the patient

B. Implement a multimodal communication plan that includes augmentative communication devices, a personalized communication board, allocated extra time for clinical interactions, staff training on interpreting non-verbal cues, and documentation of the patient's established communication preferences

C. Assign the patient's care exclusively to the two nurses who have demonstrated the best ability to communicate with non-verbal patients

D. Request a cognitive assessment to verify the patient's decision-making capacity before investing in specialized communication resources

4. A nurse manager discovers that nursing staff are routinely asking patients about their religious dietary restrictions only after the patient has received a meal tray containing foods that violate their religious practices. The delay occurs because the dietary restriction assessment is embedded deep within a lengthy admission assessment form and is often not reached until several hours after admission. Which improvement is MOST effective?

A. Provide all patients with a standard dietary restriction card at the time of admission that they can complete independently and place on their meal tray

B. Train the dietary department to contact each new admission directly to assess dietary preferences and restrictions

C. Move the religious dietary restriction question to the first section of the admission assessment so it is assessed early and communicated to dietary services before the first meal is delivered

D. Restructure the admission assessment to include a brief initial screening of immediate needs — including dietary restrictions, allergies, safety risks, and communication preferences — that is

completed within the first thirty minutes of admission, followed by the comprehensive assessment within the standard timeframe

5. A nurse manager is developing a strategy for communicating with patients who are accompanied by a caregiver who dominates all clinical conversations. The caregiver speaks for the patient, answers questions directed to the patient, and makes decisions without consulting the patient. The patient appears competent but passive. Which communication approach is MOST appropriate?

A. Address the patient directly using their name during clinical conversations, establish that the care team needs to hear from the patient personally for clinical accuracy, use techniques such as "I'd like to hear what you think about this" to invite the patient's voice, and privately assess whether the patient feels comfortable and safe in the caregiver relationship

B. Accept the caregiver as the patient's spokesperson since families often have established communication patterns that the healthcare team should respect

C. Ask the caregiver to leave the room during all clinical assessments so the nurse can communicate directly with the patient without interference

D. Document the caregiver's dominance in the medical record and alert social work to evaluate for potential undue influence or elder abuse

6. A nurse manager is implementing a health equity communication initiative after data reveals that patients from lower socioeconomic backgrounds receive fewer minutes of nurse communication per shift compared to patients from higher socioeconomic backgrounds. The disparity persists after controlling for acuity. Which intervention is MOST targeted?

A. Implement standardized nursing communication time expectations that require equivalent communication engagement for all patients regardless of socioeconomic indicators, train staff on implicit bias recognition in communication allocation, and audit communication time equity across demographic categories

B. Increase overall staffing levels to provide more nursing time available for communication with all patients

C. Implement hourly rounding for all patients to ensure minimum communication contact regardless of patient demographics

D. Present the disparity data to staff and allow them to self-correct their communication patterns based on increased awareness

7. A nurse manager is coaching a nurse who has excellent clinical skills but consistently fails to introduce herself to patients at the beginning of the shift. Patient experience data shows that this specific nurse's patients report significantly lower "nurse courtesy" scores than her colleagues' patients. Video observation reveals that the nurse begins clinical tasks immediately upon entering the room without greeting the patient or establishing personal connection. Which coaching intervention is MOST likely to change the behavior?

A. Send the nurse to a customer service training program focused on first impressions and professional introductions

B. Post a reminder sign at the entrance to each patient room prompting nurses to introduce themselves before beginning care activities

C. Integrate the introduction into the nurse's existing workflow as the first step in a standardized room-entry sequence — knock, introduce, explain purpose, assess needs — and practice the sequence through repeated role-play until it becomes habitual rather than an additional task

D. Include "patient introduction" as a documented performance expectation and evaluate compliance during the annual performance review

8. A nurse manager is developing a communication protocol for managing patients who refuse interpreter services and insist on communicating in limited English rather than through a professional interpreter. The patients report that interpreters slow down the interaction and make them feel dependent. Which response balances patient autonomy with communication safety?

A. Assess and document the patient's functional communication ability in English, establish which clinical interactions require professional interpretation regardless of preference based on risk level, respect the patient's preference for lower-risk routine communications, and re-evaluate the arrangement whenever clinical complexity changes

B. Require professional interpreter use for all clinical communications regardless of patient preference since the organization has a legal obligation to ensure effective communication

C. Accept the patient's refusal and communicate exclusively in English since respecting patient autonomy takes precedence over language access requirements

D. Offer a compromise where the interpreter is present in the room but does not actively interpret unless the patient or nurse requests assistance

9. A nurse manager is implementing a pre-operative anxiety communication protocol. Research shows that pre-operative anxiety increases post-operative pain, delays recovery, and reduces patient satisfaction. Current pre-operative communication consists of a standardized checklist reviewed by the nurse. Which enhancement is MOST evidence-based?

A. Replace the standardized checklist with an individualized conversation that allows patients to express their specific fears and concerns

B. Add a pre-operative educational video that explains the surgical procedure and expected recovery in patient-friendly language

C. Implement a pre-operative relaxation protocol using guided imagery or breathing exercises facilitated by the nursing staff

D. Supplement the standardized checklist with a brief anxiety assessment, targeted therapeutic communication addressing the patient's specific concerns, explanation of what to expect during each phase of the perioperative experience, and introduction of coping strategies that the patient can use during recovery

10. A nurse manager is developing a strategy for managing the communication challenges created by the increasing number of patients who research their conditions online before and during hospitalization. Some patients arrive with accurate information while others have been influenced by misinformation. Nurses report feeling challenged when patients question clinical recommendations based on internet research. Which approach is MOST effective?

A. Discourage patients from researching their conditions online and redirect them to hospital-provided educational materials exclusively

B. Train nurses to validate the patient's effort to understand their condition, ask what they have learned and from which sources, assess the accuracy of the information using evidence-based references, correct misinformation without dismissing the patient's research effort, and recommend reliable health information sources for ongoing learning

C. Instruct nurses to defer all patient questions about online research to the attending physician since addressing medical misinformation exceeds nursing scope

D. Provide patients with a curated list of approved health information websites at admission and instruct them to limit their research to those sources

11. A nurse manager is implementing a "goals of care huddle" — a brief interdisciplinary conversation about each patient's care goals that occurs at the beginning of each shift. The huddle ensures that every team member understands and can articulate the patient's goals for the day and the overall hospitalization goals. After implementation, some physicians complain that the huddle is redundant with morning rounds. Which response is MOST effective?

A. Eliminate the goals-of-care huddle on days when morning rounds occur to reduce perceived redundancy

B. Merge the goals-of-care huddle into the morning rounding process so both functions are accomplished in a single conversation

C. Maintain the huddle as a separate nursing and interdisciplinary function independent of physician rounds

D. Clarify that the huddle serves a different purpose than rounds — rounds focus on clinical decision-making while the huddle ensures that every team member including nurses, CNAs, therapists, and support staff can articulate and work toward the same patient goals — and adjust the huddle timing to complement rather than duplicate rounding

12. A nurse manager is responsible for a unit where a patient's family has been using a baby monitor to continuously monitor their elderly parent's room from the waiting area. The family states they want to ensure the patient receives prompt attention. Staff feel surveilled and uncomfortable. The organization does not have a specific policy about patient-side monitoring devices. Which action is MOST appropriate?

A. Address the family's underlying concern about response time by explaining the unit's monitoring and rounding practices, discuss the staff's comfort concerns, negotiate a compromise that addresses the family's anxiety while respecting the care team's professional environment, and advocate for the organization to develop a monitoring device policy

B. Allow the monitoring to continue since the family is monitoring their own family member and has the right to ensure quality care

C. Confiscate the baby monitor as an unauthorized electronic device in the patient care area

D. Assign a dedicated nurse to the patient to address the family's response time concerns and render the monitoring device unnecessary

13. A nurse manager is developing a communication plan for transitioning the unit's patient education from printed materials to an interactive digital platform delivered through bedside tablets. The digital platform includes videos, interactive quizzes, and teach-back verification. Staff are enthusiastic about the technology but concerned that elderly patients and patients with low digital literacy will be excluded. Which implementation approach ensures equity?

A. Maintain printed materials exclusively for patients over seventy years of age and implement the digital platform for younger patients

B. Implement the digital platform as the standard while training staff to identify patients who need assistance, providing one-on-one device orientation, and maintaining printed materials as an accessible alternative for patients who cannot use the digital platform

C. Delay the digital platform implementation until technology literacy rates improve among the patient population

D. Offer a multimedia patient education system that uses the digital platform as the primary delivery method, includes built-in accessibility features such as large fonts, audio narration, and simplified navigation, trains staff to provide hands-on digital assistance, maintains printed backup materials, and monitors education completion rates by age and literacy level to identify and address equity gaps

14. A nurse manager is addressing a situation where a patient has requested that no male nursing staff provide personal care. The request is based on the patient's cultural and religious background. The unit has both male and female nurses on every shift. Which response is MOST appropriate?

A. Accommodate the request by adjusting assignments to ensure female nursing staff provide personal care for this patient, document the accommodation, and distribute the workload adjustment equitably among the team so the accommodation does not burden any individual nurse

B. Inform the patient that gender-based assignment requests cannot be accommodated because they constitute discrimination against male nursing staff

C. Accommodate the request only if a female nurse volunteers to take the assignment and decline the accommodation if no volunteer is available

D. Refer the patient's request to the patient relations department for evaluation of whether the cultural basis is legitimate before making an accommodation decision

15. A nurse manager is developing a structured approach for nurses to communicate with patients about diagnostic uncertainty — situations where the diagnosis is unclear and the clinical team is investigating multiple possibilities. Patients and families report feeling anxious and frustrated when nurses respond to diagnostic questions with "I don't know" or "the doctor will explain." Which communication framework is MOST effective?

A. Train nurses to provide their own clinical assessment of the most likely diagnosis to give patients the information they need while waiting for official results

B. Implement a scripted response for nurses that redirects all diagnostic questions to the physician to avoid providing inaccurate information

C. Instruct nurses to avoid discussing diagnostic possibilities entirely until the physician has made a definitive determination

D. Train nurses to acknowledge uncertainty honestly by explaining what is known, what is being investigated, the expected timeline for results, and what the patient can expect during the diagnostic process — providing transparency about the process without overstepping the nursing scope by interpreting diagnostic findings

16. A nurse manager is implementing a "communication passport" — a patient-held document that travels with the patient across all care transitions and contains the patient's communication preferences, important personal information, care priorities, and key contacts. The passport is designed to prevent information loss during handoffs. Which implementation challenge is MOST significant?

A. Patients may lose the physical document during transfers between departments or units

B. Ensuring that clinical staff across all receiving departments actually read and integrate the passport information into their care rather than treating it as duplicative documentation that competes with the medical record for attention

C. The passport may contain information that contradicts what is documented in the electronic health record

D. Creating the passport adds documentation time to the admission process that nursing staff may resist

17. A nurse manager is developing a communication strategy for a patient who has been identified as a victim of human trafficking during the hospitalization. The patient is accompanied by a person who claims to be a family member but whom the clinical team suspects is the trafficker. The patient appears fearful and avoids eye contact with staff when the companion is present. Which communication approach is MOST appropriate?

A. Contact law enforcement immediately since human trafficking is a criminal matter that requires police intervention before the clinical team can safely communicate with the patient

B. Continue providing clinical care without addressing the trafficking concern until the patient discloses the situation independently

C. Create a legitimate clinical reason to separate the patient from the companion, use the private time to communicate with the patient using a trauma-informed approach, assess the patient's immediate safety, provide information about available resources without pressuring disclosure, and activate the organization's human trafficking response protocol

D. Ask the companion to leave the room and directly ask the patient whether they are being trafficked

18. A nurse manager is addressing a communication pattern where nurses document their assessments in the electronic health record but do not verbally communicate significant findings to the physician until asked during rounds. This documentation-without-communication pattern creates a delay between the nurse's identification of a clinical change and the physician's awareness. Which system improvement is MOST effective?

A. Implement a policy requiring nurses to call the physician for every documented assessment finding that deviates from normal parameters

B. Implement automated clinical surveillance that scans nursing documentation for significant findings and generates physician notifications

C. Establish clear criteria defining which assessment findings require immediate verbal physician notification versus documentation-only reporting, train nurses on the criteria, and integrate a "physician notification required" prompt into the documentation workflow that triggers when criteria are met

D. Require physicians to review nursing documentation every four hours rather than relying on verbal communication for clinical updates

19. A nurse manager is responsible for a unit where a patient's family member who is also a physician has been revising the nursing care plan without discussion, writing additional orders in the physician comments section of the EHR, and directing nursing care based on their own clinical assessment. The attending physician has not authorized these interventions. Which response is MOST appropriate?

A. Address the family member physician directly by acknowledging their clinical expertise and concern for their family member, explain that care orders must come through the attending physician, redirect their clinical input through the attending, and establish that nursing care is directed by the documented care plan rather than informal physician-family input

B. Allow the family physician's orders to stand since they are a licensed physician and their clinical recommendations may benefit the patient

C. Report the family physician to the medical staff office for practicing without authorization at this hospital

D. Instruct nursing staff to ignore any orders or care plan changes not signed by the attending physician and to contact the attending if the family physician persists

20. A nurse manager is implementing a "dignity rounds" program where the nurse manager personally rounds on patients specifically to assess whether their dignity is being maintained during hospitalization. Dignity rounds focus on whether patients feel respected, whether their privacy is protected, whether their autonomy is supported, and whether they feel valued as individuals. Which finding during dignity rounds would represent the MOST significant dignity violation requiring immediate intervention?

A. A patient reports that staff do not always knock before entering the room

B. A patient reports that nursing staff discuss clinical information about other patients within earshot of their room, that they are routinely left partially exposed during care activities, and that staff use the patient's room number rather than their name when discussing them at the nursing station

C. A patient reports that meal trays are not always delivered at the expected time

D. A patient reports that the television remote is out of reach and they have to wait for staff to change channels

21. A nurse manager is developing a structured approach to managing nurse-patient therapeutic boundaries in a long-stay rehabilitation unit where patients remain for weeks to months. Prolonged stays

naturally create closer nurse-patient relationships, and the boundary between professional engagement and personal relationship becomes blurred. Staff report uncertainty about appropriate boundaries for activities such as exchanging social media contacts, attending patient family events, and sharing personal life details. Which guideline framework is MOST appropriate?

A. Implement a strict prohibition against all personal sharing and social contact between nurses and long-stay patients

B. Develop a boundary awareness education program that helps nurses recognize the continuum between professional engagement and boundary violations, provides specific guidance on common boundary scenarios in long-stay settings, establishes that the nurse's responsibility is to maintain the professional frame regardless of relationship duration, and creates a confidential consultation process for boundary questions

C. Allow nurses to use their professional judgment about boundaries since long-stay patients benefit from more personal relationships with their care team

D. Assign nurses to rotate patients monthly so that prolonged relationships do not develop

22. A nurse manager is developing a communication strategy for managing patients who are in the active dying process. Nursing staff report feeling uncertain about what to say to dying patients and their families. Some nurses avoid the dying patient's room because they feel they "don't know what to say." Which education approach is MOST effective?

A. Provide nurses with a list of appropriate phrases to use with dying patients and their families such as "I'm sorry for what you're going through" and "Is there anything I can do for you?"

B. Assign only experienced nurses who are comfortable with death and dying to care for actively dying patients

C. Educate nurses that presence is more important than words — that sitting quietly, holding a hand, and being fully present often provides more comfort than any spoken language — and train staff in specific communication techniques for end-of-life care including acknowledging the family's experience, asking about the patient's meaningful wishes, and normalizing the dying process

D. Refer all end-of-life communication to the chaplaincy or palliative care team since they have specialized training in death and dying communication

23. A nurse manager is implementing a structured approach to managing "information overload" during patient discharge education. Research shows that patients retain only ten to twenty percent of discharge instructions. The unit's current discharge education session lasts an average of forty-five minutes and covers medications, activity restrictions, wound care, follow-up appointments, warning signs, and dietary instructions. Which modification is MOST evidence-based?

A. Reduce the discharge education session to fifteen minutes by covering only the most critical information and providing written materials for the remainder

B. Replace verbal discharge education with a video that patients watch independently before discharge

C. Spread the discharge education across multiple shorter sessions throughout the hospitalization rather than delivering everything in a single pre-discharge session

D. Prioritize the most critical information using a structured hierarchy, deliver it in multiple brief sessions throughout the hospitalization using teach-back verification at each session, supplement with visual aids and multimedia resources, provide a simplified written summary organized by urgency, and schedule a follow-up contact to reinforce key points after discharge

24. A nurse manager is developing a strategy for managing communication with patients who use medical cannabis in a state where it is legal. The hospital does not permit cannabis use on premises, and some prescribed medications may interact with cannabis. Nurses report uncertainty about whether to ask about cannabis use and how to communicate about potential interactions. Which approach is MOST clinically appropriate?

A. Integrate cannabis use screening into the standard medication reconciliation process, treat it as any other substance that may affect clinical care, educate nurses on common cannabis-medication interactions, establish clear communication expectations for discussing cannabis use non-judgmentally with patients, and document usage in the medication history

B. Avoid asking about cannabis use since the information is self-reported and unreliable, and patients may be reluctant to disclose use

C. Screen for cannabis use only for patients undergoing surgical procedures where anesthetic interactions are most clinically significant

D. Defer all cannabis-related clinical communication to the pharmacist since drug interaction assessment is within the pharmacy scope of practice

25. A nurse manager is addressing a situation where a nurse has been providing clinical advice through a hospital-sponsored online patient forum. The nurse responds to patient questions using her credentials and hospital affiliation. Some of her responses include specific medical recommendations. The nurse believes she is providing a valuable community service. Which concern is MOST significant?

A. The nurse's clinical recommendations create a nurse-patient relationship with forum participants that carries professional accountability, potential liability for both the nurse and the hospital, and risk of harm if recommendations are applied without the clinical context that an in-person assessment would provide

B. The nurse's forum activity may be consuming time that should be spent on direct patient care responsibilities during work hours

C. The forum responses may conflict with information provided by the patient's primary care provider, creating confusion for the patient

D. The nurse's use of hospital credentials implies organizational endorsement of her clinical recommendations without formal organizational review

26. A nurse manager is implementing a "communication rounding" practice where the nurse manager specifically rounds on patients to assess their perception of nursing communication quality. During rounding, a patient reports that a nurse said "I'll be right back" four hours ago and has not returned. The patient did not activate the call light because the nurse promised to return. Which response addresses BOTH the immediate situation and the systemic issue?

A. Apologize to the patient, address the immediate unmet need, and counsel the specific nurse about the importance of follow-through on promises to patients

B. Apologize, address the immediate need, educate the patient about using the call light when waiting becomes excessive, address the individual nurse's behavior, and implement a unit-wide expectation that all commitments to patients include a specific timeframe with instruction to call if the nurse does not return as promised

C. Address the individual nurse only since this appears to be an isolated incident rather than a systemic problem

D. Implement a timer system that alerts the nursing station when a nurse has been away from a patient's room longer than a defined interval

27. A nurse manager is developing a communication plan for informing staff that the organization has been acquired by a larger health system. The nurse manager has been told that no positions will be eliminated, but reporting structures, benefits, and organizational culture may change. Staff anxiety is high. Which communication principle is MOST important?

A. Focus communication exclusively on the positive aspects of the acquisition to reduce staff anxiety and maintain morale

B. Delay all communication until the acquisition details are finalized so staff receive only accurate, complete information

C. Communicate what is known, what is unknown, and when more information will be available, acknowledge the uncertainty honestly, create a regular communication cadence that staff can rely on for updates, and avoid making promises about outcomes that are not yet confirmed

D. Encourage staff to contact human resources directly with their individual concerns rather than addressing acquisition-related questions at the unit level

28. A nurse manager is addressing a pattern where night shift nurses routinely report clinical findings to the incoming day shift during handoff that were not communicated to the physician during the night. When asked why, night shift nurses report that they did not want to "bother" the on-call physician with findings they considered non-urgent. Which intervention is MOST effective?

A. Implement a policy requiring night shift nurses to contact the physician for every abnormal assessment finding regardless of perceived urgency

B. Develop clear clinical criteria that define which assessment findings require physician notification regardless of time of day, train night shift staff on the criteria, address the cultural norm that physician notification is "bothering" them, and reinforce that clinical communication is a professional obligation not a personal imposition

C. Assign the night shift charge nurse to screen all clinical findings and determine which warrant physician notification

D. Implement a secure messaging system that allows night shift nurses to send non-urgent clinical updates to the physician without making a phone call

29. A nurse manager is implementing a patient advisory panel for the unit. The first meeting is attended by twelve patients and family members. During the meeting, one participant dominates the conversation, making lengthy personal complaints about their hospitalization experience. Other participants appear frustrated and disengaged. Which facilitation intervention is MOST effective?

A. Allow the participant to finish speaking since patient voices should not be silenced in an advisory forum

B. Intervene privately after the meeting and ask the participant to limit their contributions in future meetings

C. Address the participant's concerns during the meeting by explaining that their feedback is valued and will be followed up individually, then redirect the group to the structured agenda topics

D. Acknowledge the participant's experience briefly, validate their frustration, redirect to the agenda by explaining that the advisory panel focuses on systemic improvement rather than individual complaint resolution, offer to connect the participant with the patient relations department for personal concerns, and establish ground rules for future meetings including time limits for individual contributions

30. A nurse manager is developing a unit-level antimicrobial stewardship initiative. The hospital's antimicrobial stewardship program is physician-and-pharmacist-led, but the nurse manager recognizes that nursing plays a critical role in stewardship through several activities. Which nursing activity has the GREATEST impact on antimicrobial stewardship outcomes?

A. Educating patients about the importance of completing prescribed antibiotic courses after discharge

B. Documenting antibiotic allergies accurately in the medical record during admission medication reconciliation

C. Reporting suspected adverse drug reactions from antibiotics to the attending physician

D. Ensuring timely collection of cultures before antibiotic administration, questioning antibiotic orders that lack documented indication, monitoring for clinical indicators of infection resolution that support de-escalation discussions with physicians, and communicating antibiotic-related assessment findings proactively

31. A nurse manager is developing a protocol for integrating social determinants of health screening into the unit's clinical workflow. The screening tool assesses food insecurity, housing instability,

transportation barriers, interpersonal violence, and utility needs. Several nurses express concern that asking patients about poverty and housing creates uncomfortable conversations. Which implementation approach is MOST effective?

A. Normalize the screening by framing it as a standard clinical practice that applies to all patients, train nurses in non-judgmental interviewing techniques, integrate the screening into the existing admission assessment workflow, establish referral pathways for identified needs, and demonstrate how addressing social determinants improves clinical outcomes

B. Assign the social determinants screening exclusively to social workers since they have more training in psychosocial assessment

C. Implement the screening only for patients who present with conditions known to be affected by social determinants such as poorly controlled diabetes or frequent readmissions

D. Use a self-administered screening form that patients complete independently to eliminate the uncomfortable nurse-patient conversation

32. A nurse manager is evaluating the unit's compliance with the AHRQ Patient Safety Indicators — a set of quality measures that use hospital administrative data to identify potentially preventable complications. The unit has been flagged for an elevated rate of PSI 03 (pressure ulcer rate) and PSI 12 (perioperative pulmonary embolism/deep vein thrombosis). Which understanding of PSIs is MOST accurate?

A. PSIs measure the quality of nursing care exclusively since the flagged indicators are both nurse-sensitive outcomes

B. PSIs are screening tools that identify potentially preventable complications through administrative data and require clinical validation to determine whether the flagged events were truly preventable or represent documentation and coding artifacts that inflate the apparent complication rate

C. PSIs are definitive measures of care quality that require immediate corrective action for each flagged event

D. PSIs are relevant only for public reporting purposes and do not provide actionable clinical improvement data at the unit level

33. A nurse manager is developing a plan for managing the clinical implications of extreme heat events related to climate change. The unit has experienced an increase in heat-related admissions including heat exhaustion, heat stroke, and exacerbation of chronic conditions during summer months. Which preparation element is MOST important at the unit level?

A. Stockpile cooling supplies and ice packs on the unit during summer months to manage heat-related admissions

B. Educate patients about heat safety during discharge to prevent readmission during heat events

C. Develop a surge capacity plan for heat-related admissions that includes clinical protocols for heat illness management, staff education on heat-related pathophysiology and treatment, identification of vulnerable patient populations for proactive monitoring, and community outreach during extreme heat advisories

D. Request that the facilities department ensure air conditioning reliability on the unit during summer months

34. A nurse manager is implementing a blood conservation program on the unit. Evidence shows that restrictive transfusion strategies — transfusing at a hemoglobin threshold of seven rather than ten — produce equivalent or better outcomes for most patient populations while reducing transfusion-related risks and costs. Nurses report that some physicians continue ordering transfusions at the higher threshold. Which intervention is MOST appropriate?

A. Implement a nursing education program on restrictive transfusion evidence so nurses can discuss the evidence with physicians when liberal transfusion orders are received

B. Request that the blood bank implement a mandatory approval process for all transfusion orders above the restrictive threshold

C. Allow physicians to maintain their individual transfusion practices since transfusion threshold decisions are within physician clinical judgment

D. Collaborate with the medical staff and transfusion committee to implement evidence-based transfusion guidelines with clinical decision support alerts for orders exceeding restrictive thresholds, establish a prospective review process for non-standard transfusion orders, and track transfusion practice variation across physicians

35. A nurse manager is evaluating the unit's performance on a CMS quality measure requiring documentation of a plan of care for each patient that reflects the patient's goals and preferences. Compliance is fifty-four percent. Analysis reveals that nurses document clinical plans but rarely incorporate patient-stated goals. Which barrier is MOST likely contributing to the low compliance?

A. Nurses may lack the time to conduct meaningful goal-setting conversations with patients

B. The electronic health record's care plan documentation may not have a structured field for patient-stated goals, making it difficult for nurses to document goals in a way that is captured by the quality measure

C. Patients may not understand what "goals of care" means and therefore cannot articulate meaningful goals when asked

D. The EHR documentation system likely lacks a prominent, structured field for patient-stated goals that is integrated into the care planning workflow, creating a documentation barrier even when nurses conduct goal-setting conversations — combining a system design problem with the possibility that nurses are not consistently asking patients about their goals

36. A nurse manager is developing a plan for managing oxygen safety on the unit. Several incidents have occurred where supplemental oxygen was administered to patients near open flames — including a patient who lit a candle in their room and a visitor who smoked near a patient on oxygen. Which safety intervention is MOST comprehensive?

A. Post "no smoking" and "no open flame" signs in every room where oxygen is administered

B. Implement a policy requiring that all ignition sources be removed from the room when oxygen is in use

C. Develop a comprehensive oxygen safety program that includes patient and family education about oxygen fire risks at the time of oxygen initiation, environmental assessment for ignition sources upon oxygen start and during rounding, signage, staff training on oxygen fire response, and discharge education for patients who will continue home oxygen therapy

D. Install oxygen concentration monitors in patient rooms that alarm when oxygen levels exceed ambient safety thresholds

37. A nurse manager is implementing a rapid diagnostic testing program that allows point-of-care testing for influenza, RSV, and strep pharyngitis on the unit. Previously, these tests required laboratory processing with a four-to-six-hour turnaround time. With point-of-care testing, results are available within fifteen minutes. Which workflow impact should the nurse manager anticipate?

A. Faster diagnostic results will accelerate treatment decisions, potentially reducing the time from symptom presentation to appropriate therapy initiation, which may decrease unnecessary empiric antibiotic use and enable faster isolation decisions — but will also require nursing competency in test performance, result interpretation, quality control procedures, and documentation

B. Point-of-care testing will reduce nursing workload since nurses will no longer need to collect and transport specimens to the laboratory

C. The laboratory department may resist point-of-care testing since it diverts testing volume away from the central laboratory

D. Point-of-care testing will increase nursing workload without clinical benefit since the same diagnostic information eventually becomes available through laboratory processing

38. A nurse manager is responsible for a unit where a hazardous materials exposure event has occurred — a patient's chemotherapy infusion bag ruptured, spilling cytotoxic medication on the floor, the patient's bedding, and the nurse's scrubs. Which action should the nurse manager take FIRST?

A. Contact the pharmacy department to report the chemotherapy spill and request replacement medication

B. Evacuate all patients from adjacent rooms to prevent secondary exposure to the cytotoxic medication

C. Document the exposure event in the incident reporting system and notify occupational health

D. Ensure the exposed nurse and patient are decontaminated and assessed for exposure effects, isolate the spill area, activate the hazardous materials spill cleanup protocol using the appropriate spill kit, and initiate the exposure reporting process for the affected nurse

39. A nurse manager is evaluating the unit's patient classification system and suspects it underestimates the nursing workload for patients with high psychosocial complexity. Patients with substance use disorders, mental health comorbidities, social isolation, and family conflict require significantly more

nursing time than their medical acuity alone would predict. Which validation approach is MOST appropriate?

A. Add a psychosocial complexity modifier to the existing patient classification system and validate the modifier against actual nursing time data

B. Conduct a time-motion study comparing actual nursing hours spent on patients with high psychosocial complexity versus those with similar medical acuity but low psychosocial complexity, and use the data to advocate for modifying the classification system to capture psychosocial workload

C. Request additional nursing staff specifically for patients with high psychosocial complexity and justify the request with anecdotal evidence from the nursing team

D. Adopt a different patient classification system that includes psychosocial factors in its acuity algorithm

40. A nurse manager is implementing a clinical pharmacy partnership where a clinical pharmacist is embedded on the unit during peak medication administration hours. Data shows that medication errors decrease by thirty-eight percent when the pharmacist is physically present on the unit compared to centralized pharmacy support. However, the pharmacy department can only provide this service for eight hours per day. Which hours are MOST strategically important for the embedded pharmacist?

A. The hours corresponding to the highest volume of new medication orders, typically eight o'clock in the morning through four o'clock in the afternoon when physician rounding and order entry are most active

B. The hours with the highest volume of medication administration events AND the highest rate of medication-related safety events, since the pharmacist's physical presence provides the most value during the periods of greatest clinical activity and risk

C. Evening hours when pharmacy staffing is reduced and nurses have the least access to pharmacist consultation for medication questions

D. Overnight hours when the least experienced nurses are working and the risk of medication errors may be highest due to fatigue and reduced supervision

41. A nurse manager reviews the following data on the unit's implementation of an early mobilization protocol:

Week	Patients Mobilized Day 1	Falls During Mobilization	Length of Stay
1	42%	0	4.8 days
4	68%	1	4.4 days
8	81%	2	4.0 days
12	85%	3	3.7 days

Staff are concerned about the increasing number of mobilization-related falls. Which interpretation is MOST appropriate?

A. The fall increase is proportional to the mobilization increase — as more patients are mobilized, the absolute number of falls increases even though the fall rate per mobilized patient may be stable or declining — and the 1.1-day LOS reduction demonstrates significant clinical benefit that outweighs the modest fall increase, provided each fall is individually investigated for preventability

B. The increasing falls indicate that the early mobilization protocol is unsafe and should be paused until the fall rate stabilizes

C. The mobilization target should be capped at sixty-eight percent since weeks one through four showed zero to one fall at that compliance level

D. The fall increase is acceptable and does not require investigation since falls are an expected consequence of mobilization programs

42. A nurse manager is developing a unit-level disaster preparedness plan for a mass casualty event. The plan must include a triage system for rapid patient assessment when the number of casualties exceeds the unit's normal capacity. Which triage principle is MOST critical for the nurse manager to understand?

A. Mass casualty triage uses the same assessment priorities as individual patient triage — assess airway, breathing, and circulation in sequence for each patient

B. Mass casualty triage differs from routine triage because the goal shifts from providing the best care for each individual to providing the greatest good for the greatest number

C. Mass casualty triage should be performed only by physicians since the severity of decisions exceeds nursing scope of practice during a disaster

D. Mass casualty triage should be avoided until sufficient resources arrive to provide a comprehensive assessment of each casualty

43. A nurse manager is evaluating the unit's compliance with the requirement to reconcile medications at every transition of care. Data shows:

Transition Point	Compliance
Admission	94%
Unit-to-unit transfer	52%
Procedure/OR return	61%
Discharge	88%

Which improvement strategy is MOST effective?

A. Analyze the specific workflow barriers at the two lowest-compliance transition points — unit-to-unit transfers and procedure returns — and develop targeted interventions that embed medication reconciliation into the transfer and post-procedure workflows rather than adding it as a separate step, since the compliance gap likely reflects process barriers rather than knowledge gaps

B. Re-educate all nursing staff on the medication reconciliation requirement at every transition of care

C. Implement a single comprehensive medication reconciliation at admission and discharge and eliminate the requirement at internal transitions

D. Assign a dedicated pharmacist to perform medication reconciliation at all internal transitions to relieve nursing of the responsibility

44. A nurse manager is developing a protocol for managing patients who present with symptoms of stroke but are subsequently diagnosed with a "stroke mimic" — a condition that produces stroke-like symptoms but has a non-vascular etiology such as seizure, migraine, or conversion disorder. Staff express frustration about "false alarm" stroke activations that consume significant resources. Which educational point is MOST important?

A. Stroke mimics represent an inherent and acceptable cost of maintaining an aggressive stroke identification system — the sensitivity required to catch every true stroke inevitably captures non-stroke conditions, and the clinical and financial consequences of missing a true stroke far outweigh the cost of evaluating mimics

B. Improving the specificity of the stroke screening tool will reduce the stroke mimic rate without compromising sensitivity

C. Stroke mimics should be identified before the full stroke activation is triggered to conserve resources

D. The percentage of stroke activations that are mimics should be tracked as a quality metric with a target reduction rate

45. A nurse manager is implementing a continuous glucose monitoring integration for diabetic patients during hospitalization. The hospital has approved the use of patients' own continuous glucose monitors alongside the traditional point-of-care glucose testing. Which nursing responsibility is MOST important?

A. Ensuring that the CGM data is entered into the medical record alongside point-of-care glucose results for comprehensive documentation

B. Understanding that CGM values measure interstitial fluid glucose rather than blood glucose, recognizing that CGM readings may differ from point-of-care measurements by ten to fifteen percent, verifying CGM readings with point-of-care testing before making insulin dosing decisions, and knowing when clinical conditions may cause CGM inaccuracy

C. Training all nursing staff to troubleshoot CGM device malfunctions and sensor calibration issues

D. Confirming with the endocrinology service that each patient's CGM is appropriate for inpatient use before allowing continued monitoring

46. A nurse manager is responsible for a unit that has been identified as having a higher-than-expected rate of patients developing delirium during hospitalization. Research identifies multiple modifiable risk

factors for hospital-acquired delirium including sleep disruption, immobility, dehydration, polypharmacy, and sensory deprivation. Which nursing intervention is MOST likely to reduce the incidence of hospital-acquired delirium?

A. Implement a multicomponent delirium prevention bundle that addresses all modifiable risk factors simultaneously — protecting sleep through nighttime noise and light reduction, promoting early mobilization, maintaining hydration and nutrition, advocating for medication review to minimize deliriogenic drugs, ensuring patients have their glasses and hearing aids, and implementing orientation protocols

B. Screen all patients for delirium every shift using a validated assessment tool such as the CAM and treat delirium promptly when identified

C. Request a geriatric psychiatry consultation for all patients over sixty-five years of age upon admission for proactive delirium prevention

D. Administer prophylactic low-dose haloperidol to all high-risk patients to prevent delirium onset

47. A nurse manager reviews the following data on healthcare-associated infection rates:

Infection	Unit Rate	Benchmark	SIR
CLABSI	0.4/1,000 CLD	0.8/1,000 CLD	0.52
CAUTI	2.3/1,000 CD	1.5/1,000 CD	1.53
SSI (colon)	3.8/100 procedures	2.1/100 procedures	1.81
C. diff	6.2/10,000 PD	8.1/10,000 PD	0.77

Which infection type represents the GREATEST quality improvement opportunity?

A. CLABSI, because maintaining the low rate requires continued vigilance to prevent regression

B. CAUTI, because it has a moderately elevated SIR indicating more infections than predicted

C. C. diff, because the rate is below benchmark and maintaining this performance should be prioritized

D. SSI (colon), because it has the highest SIR at 1.81, indicating the unit has eighty-one percent more surgical site infections than predicted based on the national baseline — the largest gap between observed and expected performance among all four infection types

48. A nurse manager is developing a plan for managing patients who are admitted with conditions related to intimate partner violence but who deny abuse when screened. Evidence shows that many IPV victims do not disclose during initial screening due to fear, shame, or the presence of the abuser. Which nursing practice is MOST appropriate?

A. Accept the patient's denial and do not screen again unless new injuries are identified during the hospitalization

B. Ensure the unit maintains a "universal education" approach where all patients — regardless of screening results — receive information about IPV resources including hotline numbers, safety planning materials, and community service locations, delivered privately and in a format the patient can access discreetly

C. Document the suspicion of IPV in the medical record even without the patient's disclosure so future providers are aware of the concern

D. Arrange for a social worker to interview the patient separately and ask more direct questions about IPV since social workers have specialized training in disclosure facilitation

49. A nurse manager is implementing a "zero harm" patient safety philosophy on the unit. The zero harm concept establishes an aspirational goal of eliminating all preventable patient harm. Staff express skepticism, stating that zero harm is unrealistic in complex clinical environments and that setting an unachievable goal creates frustration rather than motivation. Which response is MOST appropriate?

A. Acknowledge the skepticism and set a more realistic goal such as a twenty-five percent harm reduction over twelve months

B. Explain that zero harm is an aspirational philosophy rather than an operational target — it establishes that every preventable harm event is unacceptable and worthy of investigation and improvement, not

that perfection is immediately achievable, and that organizations pursuing zero harm consistently outperform those that accept "acceptable" harm rates

C. Implement the zero harm initiative as a mandatory organizational commitment and address the skepticism through progressive accountability for harm events

D. Replace the zero harm language with "continuous harm reduction" to maintain the improvement orientation without the perception of an impossible target

50. A nurse manager is evaluating the unit's performance on the National Database of Nursing Quality Indicators benchmarking data. The unit submits data on nursing hours per patient day, skill mix, falls, pressure injuries, and RN satisfaction. Which element of NDNQI participation provides the GREATEST value to the nurse manager?

A. The ability to benchmark the unit's nurse-sensitive indicator performance against similar units nationally, identifying whether the unit's outcomes are above or below expected performance for its specific unit type and patient population, and providing data-driven justification for staffing and quality improvement investment

B. Compliance with the organizational requirement to submit quality data to a national database

C. The unit's individual performance trends over time showing whether quality metrics are improving, declining, or stable

D. The ability to compare the unit's staffing levels to national averages to determine whether the unit is adequately staffed

51. A nurse manager is applying "design thinking" methodology to redesign the patient discharge process. Design thinking follows five stages: Empathize, Define, Ideate, Prototype, and Test. The nurse manager begins the Empathize stage by observing the discharge process from the patient's perspective — following a patient through every step from discharge order to departure. Which insight is design thinking MOST likely to reveal that traditional process improvement would miss?

A. The emotional experience of discharge — including the anxiety of leaving the hospital's safety net, confusion about medication changes, frustration with wait times, and the feeling of being rushed out — which reveals opportunities to redesign the process around patient emotions rather than only operational efficiency

B. The total time from discharge order to patient departure, which can be measured more precisely through time-motion study

C. The compliance rate with each discharge checklist element, which can be assessed through chart audit

D. The cost of the discharge process per patient, which can be calculated through activity-based costing analysis

52. A nurse manager is applying Otto Scharmer's Theory U to lead a transformational change on the unit. Theory U describes a leadership journey that moves through sensing (observing with fresh eyes), presencing (connecting to the deepest source of self and purpose), and realizing (prototyping the new). The theory suggests that most change fails because leaders apply old mental models to new challenges rather than allowing novel approaches to emerge. Which leadership behavior MOST demonstrates the "presencing" phase?

A. Conducting a comprehensive analysis of current performance data to identify specific improvement opportunities

B. Stepping back from the urgency of daily operations, creating space for deep reflection on what the unit is truly meant to become, letting go of preconceived solutions, and remaining open to possibilities that have not yet been imagined — allowing the future to emerge rather than forcing it from past experience

C. Developing a detailed implementation plan with milestones, metrics, and accountability structures

D. Benchmarking against top-performing units to identify best practices that can be adopted

53. A nurse manager is applying the concept of "followership theory" to improve unit performance. Robert Kelley identified five followership styles: alienated, conformist, pragmatist, passive, and exemplary. Exemplary followers think critically and act independently while remaining actively engaged with the organization. Assessment reveals that most nurses on the unit exhibit conformist followership — doing what they are told without critical thinking or independent initiative. Which leadership intervention is MOST likely to develop exemplary followership?

A. Implement a reward system that incentivizes independent thinking and initiative to motivate nurses beyond compliance

B. Assign nurses to quality improvement projects that require independent problem-solving and critical analysis

C. Create an environment where critical thinking is explicitly valued, independent initiative is rewarded rather than punished, questioning is framed as a professional obligation rather than insubordination, and nurses are given meaningful autonomy over their practice decisions — gradually building the trust and competence that conformist followers need to become exemplary followers

D. Replace conformist nurses with new hires who demonstrate exemplary followership traits during the interview process

54. A nurse manager is applying path-goal theory of leadership, developed by Robert House. Path-goal theory suggests that the leader's role is to clear the path for followers to achieve their goals by removing obstacles, providing support, and adapting leadership style to follower needs and task characteristics. A group of experienced nurses is working on a complex quality improvement project that is ambiguous and lacks clear direction. According to path-goal theory, which leadership style is MOST appropriate?

A. Supportive leadership — showing concern for well-being and creating a friendly work environment

B. Achievement-oriented leadership — setting challenging goals and expressing confidence in the team's ability to achieve them

C. Directive leadership — providing clear structure, expectations, and step-by-step guidance for the project

D. Participative leadership — consulting with the team, soliciting input, and involving them in decision-making, which is most effective when tasks are ambiguous because it leverages the team's collective expertise to clarify the path forward

55. A nurse manager is navigating the "paradox of leadership" — the recognition that effective leadership requires simultaneously holding contradictory tensions. For example, a nurse manager must be both decisive and collaborative, both empathetic and accountable, both strategic and operational, both confident and humble. Which approach to managing leadership paradoxes is MOST effective?

A. Develop the skill of integrative thinking — the ability to hold two opposing ideas simultaneously and find creative solutions that capture the benefits of both rather than choosing one at the expense of the other, recognizing that the tension between polarities is a source of creative energy rather than a problem to be resolved

B. Prioritize one side of each paradox based on the organizational context and commit fully to that approach

C. Alternate between paradox poles based on situational demands — being decisive when speed is needed and collaborative when buy-in is needed

D. Delegate one side of each paradox to subordinates so the nurse manager can focus on the complementary dimension

56. A nurse manager is implementing a "Blue Ocean Strategy" concept adapted for healthcare. Blue Ocean Strategy, developed by Kim and Mauborgne, suggests that organizations should create uncontested market space rather than competing in existing markets. Applied to a nursing unit, this means developing unique capabilities or service offerings that distinguish the unit from competitors. Which application BEST demonstrates Blue Ocean thinking?

A. Benchmarking against competing hospitals and implementing every best practice they use to ensure competitive parity

B. Reducing costs below competitor levels to attract patients and physicians through financial efficiency

C. Improving quality metrics to score above competitors on publicly reported quality measures

D. Developing a unique care model — such as an integrated nurse-led chronic disease management program, a specialty-focused patient experience initiative, or a technology-enabled care delivery innovation — that creates value no competitor currently offers and attracts patients, physicians, and nurses who seek that distinctive capability

57. A nurse manager is applying the concept of "managing up" — the skill of effectively influencing and communicating with one's own supervisor and organizational leadership. The nurse manager needs additional resources for the unit but has been unsuccessful in previous budget requests because the nursing director perceives the requests as complaints rather than strategic proposals. Which "managing up" approach is MOST effective?

A. Present resource requests in the language and framework the nursing director values — connecting the request to organizational strategic priorities, supporting it with quantitative data, framing it as an investment with projected returns rather than a cost, and timing the request to coincide with budget planning cycles when the director is making allocation decisions

B. Build a coalition of other nurse managers who share the same resource needs and present a unified request to the nursing director

C. Bypass the nursing director and present the resource request directly to the chief nursing officer

D. Accept that the current resource allocation reflects organizational priorities and optimize operations within the available resources

58. A nurse manager is applying the concept of "substitutes for leadership" developed by Kerr and Jermier. The theory identifies factors that make formal leadership unnecessary for certain tasks — including highly experienced staff, intrinsically motivating work, clear organizational policies, and cohesive teams. The nurse manager leads a unit with eighteen-year average nurse tenure, strong team cohesion, and standardized clinical protocols. According to the theory, which leadership adaptation is MOST appropriate?

A. Reduce leadership presence since the unit's characteristics substitute for many formal leadership functions

B. Shift leadership focus from directive supervision to strategic development, innovation facilitation, and boundary-spanning activities since the team's experience, cohesion, and protocols substitute for the directive and supportive leadership functions that less mature teams require

C. Maintain the same leadership approach regardless of the team's characteristics to ensure consistency across all situations

D. Use the reduced leadership demand to assume additional responsibilities such as managing a second unit or taking on organizational projects

59. A nurse manager is implementing an "after-action review" process that examines successful outcomes — not just failures. A patient who presented with atypical sepsis symptoms was recognized early by a nurse whose clinical intuition triggered a rapid response despite normal vital signs. The early recognition prevented deterioration. Which analysis approach MOST effectively captures the learning from this success?

A. Document the case as a positive example in the unit newsletter to recognize the nurse's clinical excellence

B. Add the nurse's assessment technique to the unit's orientation program as a best practice example

C. Conduct a structured analysis of the successful save using the same rigor as a root cause analysis for adverse events — identifying what the nurse observed, what cognitive processes led to the recognition, what environmental and system factors supported the response, and how these success factors can be systematically replicated across the team

D. Recommend the nurse for a clinical excellence award to reinforce the behavior through positive recognition

60. A nurse manager is developing a leadership development program specifically for nurses who have been identified as "reluctant leaders" — clinically excellent nurses who resist formal leadership roles because they equate leadership with administrative burden, political navigation, and distance from patient care. Which approach is MOST effective for engaging reluctant leaders?

A. Redefine leadership as an extension of clinical excellence rather than a departure from it — demonstrating that leadership activities such as mentoring, quality improvement, and evidence-based practice advancement are clinical activities that amplify the nurse's impact on patient outcomes beyond what bedside care alone can achieve

B. Offer financial incentives for assuming leadership roles to compensate for the perceived loss of clinical satisfaction

C. Allow reluctant leaders to observe experienced leaders in action before committing to a leadership development program

D. Accept that reluctant leaders prefer clinical practice and focus leadership development resources on nurses who have already expressed leadership interest

61. A nurse manager is applying the concept of "middle manager role ambiguity" to understand the stress associated with the nurse manager position. Middle managers in healthcare occupy a unique position — they receive directives from above that they must translate for the frontline while simultaneously advocating upward on behalf of their staff. This dual accountability creates role conflict. Which strategy MOST effectively manages middle manager role ambiguity?

A. Align exclusively with organizational leadership directives to reduce role conflict and present a consistent message to staff

B. Prioritize staff advocacy over organizational compliance since the nurse manager's primary obligation is to the nursing team

C. Develop "role clarity through role acceptance" — acknowledging that the tension between organizational directives and staff advocacy is inherent to the middle manager position rather than a problem to be eliminated, and building the skill of translating organizational decisions into language that acknowledges staff concerns while maintaining implementation commitment

D. Request a clearly defined job description that specifies which situations require organizational alignment and which permit staff advocacy

62. A nurse manager is applying the "strengths-based leadership" approach from the Gallup organization's research. The research suggests that leaders who focus on developing their natural strengths produce better outcomes than leaders who spend equal time addressing their weaknesses. Assessment reveals that the nurse manager's top strengths are strategic thinking and relationship building, while operational execution and influencing skills are weaknesses. Which development approach is MOST aligned with strengths-based leadership?

A. Focus development time on improving operational execution and influencing skills since these weaknesses create the greatest leadership vulnerability

B. Invest the majority of development effort in leveraging strategic thinking and relationship building to their fullest potential while developing systems and partnerships that compensate for operational and influencing weaknesses rather than attempting to develop those areas to strength level

C. Balance development equally between all four areas — strategic thinking, relationship building, execution, and influencing

D. Delegate all operational execution responsibilities to the charge nurse team and focus exclusively on strategic and relational leadership

63. A nurse manager reviews the following charge nurse leadership data:

Charge Nurse	Shifts Led	Staff Complaints	Patient Complaints	Safety Events
CN-A	52	0	3	2
CN-B	48	8	1	0

| CN-C | 50 | 2 | 1 | 1 |

| CN-D | 45 | 12 | 0 | 0 |

Which pattern requires the MOST investigation?

A. CN-A has zero staff complaints but the highest patient complaint and safety event rates, suggesting a potential disconnect between staff satisfaction and clinical performance

B. CN-B has eight staff complaints which may indicate a leadership style problem that affects team dynamics and morale

C. CN-D has twelve staff complaints and may need to be removed from the charge nurse role

D. CN-A's zero staff complaints combined with the highest safety event rate warrants investigation — zero complaints from staff may indicate that CN-A avoids the accountability conversations and clinical oversight that effective charge leadership requires, and the absence of staff friction may actually reflect absence of leadership rather than leadership excellence

64. A nurse manager is applying the concept of "transformational leadership" as distinguished from "transactional leadership." Burns originally described transformational leadership as raising both the leader and followers to higher levels of motivation and morality. The nurse manager identifies that the unit currently operates under a predominantly transactional model — staff comply with expectations in exchange for rewards and avoid behaviors that trigger consequences. Which intervention MOST effectively introduces transformational elements?

A. Increase the rewards for exceptional performance to create stronger incentive motivation

B. Develop a shared vision with staff that connects daily clinical work to a meaningful purpose beyond task completion, inspire excellence through personal example and genuine passion for patient care, invest in each team member's individual growth, and challenge conventional practices through innovative thinking that elevates the entire team's professional identity

C. Replace the current reward system with an intrinsic motivation model that eliminates external incentives

D. Implement a formal mentoring program that develops transformational leadership skills in all nursing staff

65. A nurse manager is developing a strategy for "leading from the middle" — a concept that recognizes middle managers as the critical link between organizational strategy and frontline execution. The nurse manager's unit is expected to implement an organizational strategic initiative that staff perceive as disconnected from clinical reality. Which leadership approach is MOST effective?

A. Implement the initiative exactly as designed by organizational leadership and manage staff resistance through accountability

B. Advocate upward by presenting the staff's clinical concerns to organizational leadership and request modification of the initiative

C. Translate the organizational initiative into clinically meaningful language that connects the strategic intent to the unit's daily patient care mission, involve staff in adapting the implementation approach to fit clinical workflow, and provide feedback to organizational leadership about implementation realities while maintaining commitment to the initiative's core objectives

D. Delay implementation until organizational leadership addresses the disconnect between the strategic initiative and clinical reality

66. A nurse manager is evaluating two leadership development models. Model A develops individual leadership competencies through courses, readings, and assessments. Model B develops leadership through experiential learning — placing aspiring leaders in progressively challenging real-world situations with coaching and reflection. Research on leadership development effectiveness consistently shows that seventy percent of leadership development occurs through experience, twenty percent through relationships, and ten percent through formal learning. Which conclusion is MOST appropriate?

A. Model A should be eliminated since formal learning contributes only ten percent of leadership development

B. Model B is superior and should replace Model A entirely since experiential learning produces the majority of development

C. Both models should be maintained but combined — with formal learning providing the theoretical foundation (ten percent), coaching and mentoring relationships providing ongoing support (twenty percent), and structured experiential assignments providing the primary developmental vehicle (seventy percent)

D. The 70/20/10 framework should be interpreted as a guideline rather than a prescription, and the nurse manager should assess which model best fits the unit's specific developmental needs and culture

67. A nurse manager is implementing a "leadership shadow" program where frontline nurses spend a day with the nurse manager observing leadership activities including meetings, budget reviews, staffing decisions, conflict resolution, and strategic planning. The goal is to demystify the management role and inspire leadership interest. After the first cohort, participants report surprise at the complexity and emotional demands of the nurse manager role. Several who previously expressed management interest now say they are no longer interested. Which interpretation is MOST appropriate?

A. The program has failed because it has discouraged rather than inspired leadership interest among potential future managers

B. The program is working as intended — informed decision-making about leadership career paths requires realistic understanding of the role, and candidates who self-select out after observing the reality are making a better-informed career decision than those who pursue management based on idealized expectations

C. The program should be redesigned to show only the positive aspects of the nurse manager role to maintain leadership pipeline interest

D. The program should be modified to include only the most rewarding aspects of leadership and exclude the emotionally draining components

68. A nurse manager is applying the concept of "authentic leadership" to daily practice. Authentic leadership theory identifies four components: self-awareness, internalized moral perspective, balanced processing of information, and relational transparency. A staff nurse challenges the nurse manager's decision about a scheduling change during a staff meeting. Which response BEST demonstrates authentic leadership?

A. Acknowledge the nurse's perspective, explain the reasoning behind the decision transparently including the constraints and trade-offs considered, invite alternative approaches that accomplish the same objective, and demonstrate willingness to modify the decision if a better option emerges — modeling that leadership decisions are open to honest scrutiny

B. Defend the decision firmly to maintain leadership authority and credibility during the public challenge

C. Thank the nurse for the feedback and promise to reconsider the decision privately after the meeting

D. Defer the decision to the team for a vote to demonstrate democratic leadership and avoid the appearance of unilateral decision-making

69. A nurse manager is developing a strategy for managing the "frozen middle" problem at the organizational level. As a middle manager, the nurse manager frequently receives change directives from senior leadership that must be translated into frontline practice. The manager notices that most organizational change initiatives stall at the middle management level because middle managers lack the authority to fully implement changes and the political capital to push back on unrealistic directives. Which strategy is MOST effective?

A. Build a coalition of middle managers who share common change implementation challenges and collectively advocate for the resources, authority, and timeline adjustments needed for successful implementation

B. Implement all change directives immediately and exactly as received from senior leadership to demonstrate reliability and build trust

C. Filter change directives by feasibility and implement only those that are realistic for the unit's current capacity

D. Request that senior leadership provide detailed implementation plans rather than expecting middle managers to translate high-level strategy into operational practice

70. A nurse manager is implementing a "learning from excellence" program that systematically captures and analyzes instances of exceptional clinical performance, not just errors and near-misses. The program asks staff to report moments of excellent care — a nurse who caught a subtle clinical change, a team that managed a crisis flawlessly, or a communication that prevented an error. Which outcome is MOST valuable?

A. Increased staff morale from the positive focus on what goes right rather than what goes wrong

B. A formal recognition program that celebrates reported excellence and motivates others to achieve similar performance

C. A systematic understanding of the conditions, behaviors, and system factors that produce excellent outcomes — creating an evidence base for replicating success rather than only preventing failure

D. Improved incident reporting rates as staff become more comfortable with reporting systems through the positive reporting experience

71. A nurse manager is applying the AONL competency of "foundational thinking" — which includes systems thinking, critical thinking, and evidence-based decision-making. A complex patient flow problem has been analyzed by three different groups: nursing recommends a staffing solution, administration recommends a technology solution, and medicine recommends a workflow solution. Each group's analysis is based on valid but incomplete data. Which leadership approach MOST demonstrates foundational thinking?

A. Select the nursing recommendation since the nurse manager has the most expertise in nursing staffing solutions

B. Integrate the three analyses by recognizing that each captures a different dimension of the problem, synthesize the valid insights from all three perspectives, and develop a comprehensive solution that addresses the staffing, technology, and workflow components identified by each group

C. Present all three recommendations to the chief nursing officer and request an executive decision

D. Implement the least expensive recommendation first and evaluate whether it resolves the problem before investing in more costly solutions

72. A nurse manager is responsible for developing a mentoring culture on the unit. Currently, mentoring occurs informally and inconsistently — some nurses have strong mentoring relationships while others have never been mentored. Research shows that mentored nurses have higher satisfaction, faster competency development, and lower turnover rates. Which approach MOST effectively creates a mentoring culture?

A. Assign each new nurse a formal mentor from the experienced staff and require monthly mentoring meetings

B. Create a mentoring resource guide and allow interested nurses to seek mentoring relationships independently

C. Train experienced nurses in mentoring skills but allow mentoring relationships to develop naturally based on interpersonal chemistry

D. Develop a comprehensive mentoring infrastructure that includes formal matching processes, mentor training programs, protected mentoring time, multiple mentoring modalities including traditional, peer, and group mentoring, evaluation of mentoring outcomes, and leadership commitment to mentoring as a valued organizational activity

73. A nurse manager is addressing a situation where the unit's governance council has developed a new patient education protocol that conflicts with a recently implemented organizational standardized education policy. The governance council's protocol is based on evidence and tailored to the unit's specific patient population, while the organizational policy is a generic standard applied across all units. Which leadership approach is MOST appropriate?

A. Implement the organizational policy as directed and dissolve the governance council's protocol to maintain organizational consistency

B. Implement the governance council's protocol since it is evidence-based and tailored to the patient population

C. Present the governance council's evidence-based protocol to organizational leadership as a proposed exception or alternative approach for this specific unit, advocate for the flexibility to implement unit-specific evidence-based practices within the organizational framework, and negotiate a resolution that maintains organizational standards while accommodating evidence-based unit-level innovation

D. Implement both protocols simultaneously and evaluate which produces better outcomes

74. A nurse manager is developing a comprehensive approach to managing nurse well-being that goes beyond individual resilience interventions to address organizational drivers of burnout. The National Academy of Medicine framework identifies six system-level factors that drive clinician burnout: excessive workload, workflow inefficiency, work-life integration challenges, organizational culture, social support deficits, and meaning in work erosion. Which intervention strategy is MOST aligned with the NAM framework?

A. Conduct a unit-level assessment of all six NAM factors, identify which factors are most problematic on this specific unit through staff input and data analysis, develop targeted interventions for the highest-priority system-level drivers, and measure both the system changes and their impact on staff well-being outcomes

B. Implement a comprehensive resilience training program that addresses all six factors through individual coping skill development

C. Focus exclusively on workload reduction since excessive workload is the most commonly cited burnout driver

D. Advocate for organizational-level changes since burnout is a system problem that cannot be solved at the unit level

75. A nurse manager is evaluating the unit's approach to error recovery — the process by which clinicians detect, correct, and mitigate errors before or after they reach the patient. Research shows that nurses intercept and correct approximately eighty-six percent of medication errors before they reach the patient, making error recovery a critical safety competency. Which strategy MOST effectively strengthens the unit's error recovery capacity?

A. Study the cognitive processes and environmental conditions that enable successful error recovery — such as vigilance patterns, verification habits, communication behaviors, and system design features — and design interventions that strengthen these recovery mechanisms rather than focusing exclusively on error prevention

B. Implement additional safety protocols to prevent errors from occurring in the first place since prevention is superior to recovery

C. Require double-checks for all medication administrations to increase the probability of error detection

D. Provide error recovery training through simulation scenarios that present common medication errors and require nurses to detect and correct them

76. A nurse manager is implementing a structured approach to managing the unit's "organizational knowledge" — the collective intelligence embedded in the team's clinical expertise, institutional history, informal processes, and relationship networks. Knowledge management theory distinguishes between explicit knowledge (documented, codifiable) and tacit knowledge (experiential, intuitive, difficult to articulate). Which knowledge management challenge is MOST significant for nursing units?

A. Explicit knowledge management — ensuring all policies, protocols, and procedures are documented, current, and accessible

B. The conversion of tacit clinical knowledge into explicit organizational knowledge — capturing the undocumented clinical intuition, decision-making heuristics, and relationship insights that experienced nurses carry but cannot easily articulate, making this knowledge accessible to the broader team before it is lost through turnover or retirement

C. Data management — ensuring that quality data is accurately collected, stored, and analyzed for decision-making

D. Information technology management — ensuring that the electronic health record and other systems adequately support knowledge sharing

77. A nurse manager is developing a strategy for the Magnet Recognition Program's "New Knowledge, Innovations, and Improvements" component. Which activity MOST directly demonstrates this component at the unit level?

A. Implementing evidence-based practice changes developed by other organizations and evaluating their effectiveness on the unit

B. Participating in multi-site research studies coordinated by the organization's nursing research department

C. Nurses on the unit identifying a clinical practice question, designing and conducting a unit-based research or evidence-based practice project that generates new knowledge applicable to the patient population, implementing the findings into practice, and disseminating the results through professional venues

D. Presenting the unit's quality improvement data at an organizational quality conference

78. A nurse manager is applying the concept of "network leadership" — the ability to lead through influence across organizational boundaries rather than through formal authority. The nurse manager needs to implement a care transitions initiative that requires cooperation from departments over which the nurse manager has no authority including pharmacy, social work, home health, and the emergency department. Which network leadership approach is MOST effective?

A. Request that the chief nursing officer mandate cooperation from all involved departments through an executive directive

B. Build relationships with key stakeholders in each department, identify shared interests and mutual benefits of the care transitions initiative, create cross-departmental working groups with shared accountability for outcomes, and leverage influence through demonstrated competence and collaborative credibility rather than positional authority

C. Present the care transitions initiative at each department's staff meeting and request voluntary participation

D. Implement the initiative within the nursing unit's scope and allow other departments to join when they recognize the value

79. A nurse manager is evaluating the unit's approach to managing high-reliability practices during periods of high stress — such as during census surges, staffing shortages, or crisis events. Research shows that safety behaviors are most vulnerable to degradation during exactly the periods when they are most needed. Which strategy MOST effectively maintains safety practices under stress?

A. Simplify safety protocols during high-stress periods to reduce the cognitive burden on staff, then restore full protocols when conditions normalize

B. Accept that some safety protocol degradation is inevitable during high-stress periods and focus on rapid recovery after the stress resolves

C. Implement additional safety monitoring during high-stress periods by assigning a dedicated safety observer to each shift

D. Design safety practices that are "stress-resistant" — simple enough to execute under cognitive load, embedded in workflows so they are automatic rather than discretionary, supported by technology that reduces dependence on human vigilance, and reinforced through brief safety checks that maintain awareness without adding workload

80. A nurse manager is developing a framework for evaluating the ethical implications of nursing innovations before implementation. A proposed innovation involves using predictive analytics to identify patients at high risk for readmission and targeting intensive nursing interventions to those patients. While the innovation is clinically sound, staff raise ethical concerns about resource allocation — specifically, whether concentrating nursing resources on high-risk patients reduces the care available to lower-risk patients. Which ethical principle is MOST directly at stake?

A. Autonomy — the patient's right to make decisions about their own care

B. Beneficence — the obligation to do good and provide benefit to patients

C. Justice — the fair and equitable distribution of nursing resources among all patients, where concentrating resources on one group may create inequitable care for another

D. Non-maleficence — the obligation to avoid causing harm to patients

81. A nurse manager is navigating the professional implications of the Interstate Nurse Licensure Compact. Several nurses on the unit hold multistate licenses and are providing telehealth nursing services to patients in other compact states during their off-duty hours. One nurse is providing telehealth

services to a patient in a non-compact state where she does not hold licensure. Which professional concern is MOST significant?

A. The nurses' telehealth activities during off-duty hours may create fatigue that affects their on-duty clinical performance

B. The telehealth services may conflict with the organization's secondary employment policy

C. Nurses providing telehealth to patients in non-compact states without individual state licensure are practicing nursing illegally in those states

D. The nurse providing telehealth to the non-compact state patient is practicing without a valid license in that jurisdiction, which constitutes a Nurse Practice Act violation that could result in disciplinary action, create personal and organizational liability, and jeopardize the nurse's multistate compact privilege

82. A nurse manager is developing an approach to supporting nurses in their role as patient advocates. The ANA Code of Ethics identifies patient advocacy as a fundamental nursing obligation. However, staff report that advocacy often puts them in conflict with physicians, administrators, and organizational policies. A nurse recently advocated for a patient's right to refuse a treatment that the physician considered essential, and the physician complained to the nurse manager that the nurse was "undermining medical authority." Which response is MOST appropriate?

A. Support the physician's concern since nurse advocacy should not extend to encouraging patients to refuse recommended medical treatment

B. Support the nurse's advocacy role by explaining to the physician that the nurse was fulfilling a professional obligation to ensure the patient's autonomy was respected, address the communication approach used during the advocacy interaction, and establish expectations for collaborative advocacy that maintains respectful interprofessional relationships

C. Instruct the nurse to defer all treatment refusal situations to the patient relations department to avoid interprofessional conflict

D. Review the specific situation to determine whether the nurse's advocacy was appropriate and counsel the nurse if the advocacy was overly aggressive

83. A nurse manager is developing a professional development plan for a nurse who has been certified as a legal nurse consultant and wants to use that expertise to serve as an expert witness in medical

malpractice cases. The nurse would testify during off-duty hours. The organization does not have a policy addressing expert witness testimony by employees. Which professional consideration is MOST important?

A. Whether the nurse's expert testimony could conflict with the organization's legal interests if she testifies against healthcare providers in malpractice cases

B. Whether the expert witness work creates a perception of professional disloyalty to the nursing profession by participating in malpractice litigation

C. Whether the nurse's expert witness activities could create a conflict of interest if she is called to testify about care provided at her own organization, and whether organizational policies should address employee expert witness activities including disclosure requirements, conflict-of-interest screening, and guidelines for when organizational approval is required

D. Whether the expert witness compensation creates a financial incentive that could bias the nurse's testimony

84. A nurse manager is addressing a professional conduct issue where a nurse has been providing clinical references for patients — writing letters to employers, insurance companies, and attorneys describing patients' clinical conditions and functional limitations. The nurse is not certified as a disability evaluator and the letters are not authorized by the attending physician. Which concern is MOST significant?

A. The nurse is practicing outside her scope by providing clinical opinions about functional limitations that require physician assessment and authorization, creating potential harm to patients if her assessments are inaccurate and potential liability for both the nurse and the organization

B. The nurse's reference letters may violate HIPAA if patients have not provided written authorization for the specific disclosures

C. The nurse's letters may contain subjective opinions that conflict with the attending physician's clinical assessment

D. The nurse may be accepting compensation from patients for the reference letters, creating a financial conflict of interest

85. A nurse manager is developing guidelines for nurses who are asked to participate as subjects in clinical research conducted on the unit. A researcher has asked nursing staff to wear continuous physiological monitoring devices during their shifts to study the impact of shift work on cardiovascular health. Participation is voluntary. Which ethical consideration is MOST important?

A. Whether the monitoring data could be used by the organization to make employment decisions about nurses whose physiological data reveals health conditions

B. Whether the monitoring devices will interfere with the nurses' ability to perform clinical duties safely

C. Whether the researcher has obtained appropriate IRB approval and informed consent that addresses the specific risks of workplace research including potential employer access to health data, the voluntary nature of participation without coercion, and the confidentiality protections for participants' physiological information

D. Whether the research results will be published in a peer-reviewed journal and contribute to nursing science

86. A nurse manager is navigating a professional ethics situation where a pharmaceutical company has offered to fund a "nursing excellence center" on the unit. The center would include a dedicated education room, simulation equipment, and annual continuing education conferences for nursing staff. The funding would be prominently branded with the pharmaceutical company's name. The company manufactures several medications used heavily on the unit. Which ethical analysis is MOST comprehensive?

A. Accept the funding since it benefits nursing education and professional development, which ultimately benefits patient care

B. Decline the funding to avoid any appearance of pharmaceutical industry influence on clinical practice

C. Accept the funding on the condition that the pharmaceutical company has no influence over the educational content provided in the center

D. Conduct a comprehensive ethical analysis evaluating whether the prominent branding creates an implicit obligation that could influence prescribing patterns, whether acceptance complies with organizational conflict-of-interest policies, whether the educational content can be maintained free of commercial bias, and whether alternative funding sources could achieve the same educational benefit without the industry affiliation — then present the analysis to organizational leadership for a decision

87. A nurse manager is developing an approach to managing the professional development implications of nursing scope of practice evolution. Several clinical activities that were historically exclusive to physicians — such as point-of-care ultrasound, suturing minor wounds, and prescribing certain medications — are being transferred to nursing through expanded scope legislation and organizational protocols. Experienced nurses express anxiety about assuming responsibilities they perceive as "medical" rather than "nursing." Which leadership approach is MOST effective?

A. Frame scope expansion as a natural evolution of professional nursing that has occurred throughout nursing's history, provide comprehensive education and competency validation for each expanded activity, create a supportive environment for developing confidence in new skills, and position scope expansion as a professional advancement that elevates nursing's clinical authority and patient care impact

B. Allow nurses to opt out of expanded scope activities until they feel comfortable assuming the new responsibilities

C. Implement expanded scope activities immediately to establish them as a standard expectation before resistance develops

D. Restrict expanded scope activities to nurses who hold advanced practice certifications

88. A nurse manager is evaluating the unit's approach to managing confidentiality in the age of electronic information sharing. A nurse discovered that a patient's sensitive HIV status was visible on the electronic tracking board at the nursing station, viewable by any staff member, visitor, or family member passing by. The display included the patient's name, room number, and isolation precautions that revealed the diagnosis to anyone with medical knowledge. Which system correction is MOST important?

A. Remove all clinical information from the electronic tracking board and display only patient names and room numbers

B. Move the electronic tracking board to a location that is not visible to non-clinical personnel

C. Implement privacy settings that shield sensitive diagnosis-related information from the public display while maintaining the clinical utility of the tracking board for authorized staff

D. Configure the tracking system to display sensitive clinical information such as isolation precautions using coded abbreviations or symbols that convey the necessary clinical information to authorized staff without revealing the underlying diagnosis to casual observers, and audit all public-facing clinical displays for similar confidentiality vulnerabilities

89. A nurse manager is developing a comprehensive approach to managing the professional implications of nurse fatigue. The unit operates with twelve-hour shifts, and data shows that thirty-two percent of nurses regularly work more than forty hours per week. Research demonstrates that error rates increase significantly after twelve consecutive hours of work and that cumulative sleep debt compounds fatigue risk across consecutive shifts. Which policy recommendation is MOST aligned with current evidence and professional guidelines?

A. Transition the entire unit to eight-hour shifts to eliminate the fatigue risks associated with twelve-hour shifts

B. Implement mandatory rest periods between shifts but maintain the twelve-hour shift model

C. Develop a fatigue risk management system that includes evidence-based scheduling practices limiting consecutive shifts and total weekly hours, mandatory inter-shift rest periods, fatigue self-assessment tools, a culture supporting the right to decline extra shifts without stigma, and organizational monitoring of fatigue-related performance indicators

D. Provide caffeine and energy resources for nurses working extended shifts to mitigate fatigue effects

90. A nurse manager is addressing a professional practice concern where nurses routinely defer to physician judgment even when nursing assessment data contradicts the physician's clinical conclusion. Multiple cases exist where nurses documented assessment findings suggesting clinical deterioration but did not escalate because the physician had previously reviewed the patient and stated the patient was stable. Which cultural intervention is MOST foundational?

A. Implement a rapid response team activation policy that bypasses physician notification

B. Require nurses to obtain a second nursing opinion before deciding whether to escalate clinical concerns

C. Train nurses on specific escalation techniques such as CUS and DESC

D. Develop a culture where nursing clinical judgment is valued as an independent and essential contribution to patient safety rather than subordinate to physician assessment — establishing through education, policy, leadership modeling, and practice examples that nurses have both the authority and the obligation to escalate concerns based on their own clinical findings regardless of whether a physician has recently assessed the patient

91. A nurse manager is addressing the professional implications of "moral courage" — the willingness to act ethically despite personal risk or organizational pressure. A nurse recently refused to administer a medication she believed was contraindicated, contacted the pharmacy for verification, and was confirmed correct — the order was erroneous. However, the physician who wrote the order filed a formal complaint about the nurse's "insubordination." Which response MOST demonstrates organizational support for moral courage?

A. Acknowledge the physician's complaint, explain that the nurse's action prevented a medication error, reinforce that questioning orders is a professional expectation supported by the organization, address the physician's perception of insubordination through respectful dialogue, and publicly recognize the nurse's actions as an example of the professional courage the organization values

B. Mediate between the physician and the nurse to restore the working relationship before addressing the broader implications

C. Advise the nurse to use a less confrontational approach next time while acknowledging that the clinical outcome was correct

D. Document the incident as evidence that the rapid response escalation system works and use it as a training example without identifying the individuals involved

92. A nurse manager is developing a plan for managing the professional development needs of nurses who serve in dual roles — such as staff nurse and union steward, staff nurse and nursing instructor, or staff nurse and organizational committee chair. Dual-role nurses face competing time demands, potential conflicts of interest, and identity confusion about which role takes priority in specific situations. Which management approach is MOST appropriate?

A. Require dual-role nurses to choose one role and relinquish the other to eliminate the potential for conflict

B. Develop clear guidelines defining how dual roles are managed including time allocation expectations, conflict-of-interest protocols, communication about when each role takes precedence, and organizational support for the professional value that dual-role perspectives provide

C. Allow dual-role nurses to manage the balance independently based on their professional judgment

D. Limit dual-role participation to nurses with more than ten years of experience who have demonstrated the maturity to manage competing obligations

93. A nurse manager is developing guidelines for nursing staff participation in social media advocacy related to healthcare policy. Several nurses want to use their professional expertise to advocate publicly for healthcare policy changes including staffing ratios, workplace safety regulations, and expanded nursing scope of practice. Their advocacy would identify them as nurses at the organization. Which guideline is MOST appropriate?

A. Prohibit all healthcare policy advocacy that identifies the nurse as an employee of the organization

B. Allow unrestricted policy advocacy since nurses have First Amendment rights to express political opinions

C. Develop guidelines that support nurses' right to professional policy advocacy while establishing expectations that advocacy represents personal professional opinion rather than organizational position, avoids disclosure of confidential organizational information, maintains professional tone and evidence-based arguments, and includes a disclaimer that views are personal rather than employer-endorsed

D. Require nurses to obtain organizational approval before engaging in any public healthcare policy advocacy

94. A nurse manager is evaluating a situation where a nurse has been consistently documenting vital signs at times that do not match the actual measurement times recorded by the monitoring equipment timestamps. The discrepancy suggests the nurse is entering vital signs from memory at the end of the shift rather than at the time of measurement. The vital sign values documented are clinically accurate. Which response is MOST appropriate?

A. Address the documentation practice directly as a professional accountability issue — accurate timestamps are a legal and clinical requirement regardless of value accuracy, explain that time-stamped entries create the medical-legal record of when clinical assessments occurred, and investigate whether the practice reflects individual behavior or a workflow barrier that prevents real-time documentation

B. Accept the practice since the vital sign values are accurate and patient care is not affected

C. Implement automated vital sign documentation that captures the measurement time digitally to eliminate the timestamp discrepancy

D. Issue a written warning for falsifying medical record timestamps

95. A nurse manager is developing a comprehensive approach to managing the professional and personal well-being of the nursing team during a period of sustained crisis — such as a pandemic, natural disaster, or prolonged staffing emergency lasting more than three months. Research on sustained crisis response shows that well-being interventions effective during acute crisis become insufficient during prolonged operations as compassion fatigue, moral distress, and burnout compound over time. Which approach is MOST appropriate for sustained crisis well-being management?

A. Rotate nurses out of the crisis environment periodically to prevent cumulative stress from exceeding individual tolerance thresholds

B. Provide weekly mental health check-ins for all staff and require participation in a resilience building program

C. Focus well-being efforts on the nurses who are showing the most visible signs of distress and allow others to continue without intervention

D. Implement a comprehensive sustained-crisis well-being program that evolves over time — addressing immediate safety and logistical needs in the acute phase, transitioning to emotional processing and peer support as the crisis continues, incorporating long-term strategies such as schedule flexibility, meaning-restoration activities, and professional identity reinforcement as the crisis becomes protracted, and planning for post-crisis recovery including re-integration and delayed-onset distress monitoring

96. A nurse manager is applying the concept of "marginal cost analysis" to a staffing decision. The unit is considering adding one additional RN on the evening shift. The marginal cost is the cost of adding one more unit of a resource — in this case, one additional nursing FTE. The marginal benefit is the incremental quality improvement produced by the additional nurse. Which analysis is MOST appropriate?

A. Compare the additional RN's salary to the average salary of nurses currently on the evening shift to determine whether the position is competitively priced

B. Calculate the marginal cost of the additional RN (salary, benefits, orientation) and compare it to the marginal benefit — the projected incremental improvement in quality outcomes, patient satisfaction, and safety events that the additional nurse would produce — to determine whether the incremental value exceeds the incremental cost

C. Calculate the total cost of the evening shift staffing model with and without the additional RN and compare both models to the organizational benchmark

D. Determine whether the current evening shift outcomes are below benchmark, since the additional RN is only justified if current performance is inadequate

97. A nurse manager is applying the concept of "opportunity cost" to a resource allocation decision. The unit has been allocated fifty thousand dollars for quality improvement. Two competing proposals have been submitted: Proposal A is a technology upgrade for medication safety, and Proposal B is a nurse education program for sepsis recognition. Both are projected to improve patient outcomes. The opportunity cost concept states that the true cost of any choice is the value of the best alternative forgone. Which analysis MOST effectively incorporates opportunity cost?

A. Select the proposal with the lower implementation cost since it preserves more of the quality improvement budget for future use

B. Evaluate each proposal not only on its own projected value but also on the value that will be lost by not implementing the alternative — if Proposal A is selected, the opportunity cost is the prevented sepsis deaths that Proposal B would have achieved, and this forgone benefit must be weighed against Proposal A's medication safety gains

C. Implement both proposals at half-funding each to avoid the opportunity cost entirely

D. Select the proposal with the highest projected return on investment since ROI already accounts for the investment cost

98. A nurse manager is developing a business case for a clinical innovation using a cost-effectiveness analysis. Cost-effectiveness analysis differs from cost-benefit analysis in that it measures outcomes in clinical units (lives saved, infections prevented) rather than converting all outcomes to dollar values. The innovation costs one hundred twenty thousand dollars annually and is projected to prevent eight hospital-acquired pressure injuries per year. The alternative is enhanced staff education costing thirty thousand dollars annually with a projected prevention of three pressure injuries. Which cost-effectiveness calculation is MOST appropriate?

A. Innovation: $120,000 ÷ 8 prevented = $15,000 per prevented HAPI. Education: $30,000 ÷ 3 prevented = $10,000 per prevented HAPI. The education program is more cost-effective at $10,000 per prevented pressure injury, but the innovation prevents more total injuries — making the choice dependent on whether the organization prioritizes cost-efficiency or maximum harm prevention

B. The innovation should be selected because it prevents more total pressure injuries regardless of cost-per-prevention

C. The education program should be selected because it has the lower cost per prevented injury and the lower total cost

D. Both programs should be implemented since they address different dimensions of pressure injury prevention

99. A nurse manager is evaluating the unit's labor elasticity — the degree to which nursing labor costs change in response to changes in patient volume. Perfectly elastic labor costs would increase proportionally with volume increases and decrease proportionally with volume decreases. Analysis reveals that when the unit's census drops by fifteen percent, labor costs decrease by only four percent. Which interpretation is MOST accurate?

A. The unit's labor costs are largely inelastic — meaning they do not respond proportionally to volume changes — because fixed staffing minimums, orientation costs, and benefit expenses create a cost floor that persists regardless of volume reduction, limiting the manager's ability to reduce costs during low-census periods

B. The unit is overstaffed during low-census periods and the nurse manager should implement more aggressive census-based staffing adjustments

C. The four percent cost reduction demonstrates that the nurse manager is successfully managing costs in response to volume changes

D. Labor elasticity should not be a concern since patient volume fluctuations are temporary and costs will naturally align with volume over time

100. A nurse manager is developing a financial model for a proposed nurse-led wellness clinic that would operate three days per week within the hospital campus. The clinic would serve hospital employees and generate revenue through employee health insurance billing. Which financial planning element is MOST critical for the proposal's credibility?

A. A realistic revenue projection based on expected visit volume, reimbursement rates for preventive services, and the proportion of employees likely to use the clinic — validated against utilization data from similar employer-based wellness programs — combined with a comprehensive cost analysis including staffing, space, supplies, and overhead

B. A comparison of the wellness clinic's projected costs to the current cost of employee absenteeism and workers' compensation claims

C. A survey of employee interest in a workplace wellness clinic to project demand

D. A benchmark analysis of employer wellness clinic financial performance at other hospitals in the region

101. A nurse manager is analyzing the unit's performance on a value-based contract with a major commercial payer. The contract includes bonus payments for meeting quality targets and penalty payments for failing to meet efficiency targets. Current performance data shows that the unit meets quality targets but exceeds the efficiency target for average length of stay by 0.6 days. The penalty for exceeding the LOS target is estimated at forty-five thousand dollars annually. Which improvement strategy is MOST targeted?

A. Focus on reducing length of stay for all patients by 0.6 days through accelerated discharge planning

B. Analyze which specific DRGs or patient populations are contributing most to the LOS excess, identify the modifiable factors driving extended stays for those populations, and implement targeted interventions for the highest-impact groups rather than applying a uniform LOS reduction across all patients

C. Negotiate with the payer to adjust the LOS target upward based on the unit's patient acuity data

D. Accept the forty-five thousand dollar penalty as a cost of delivering the quality care that the unit's patient population requires

102. A nurse manager is developing a proposal to implement activity-based costing for the unit's nursing services. Activity-based costing assigns costs to specific clinical activities rather than distributing costs evenly across all patients. Traditional costing treats all patient days as equivalent, while ABC recognizes that different patients consume different amounts of nursing resources. Which advantage does ABC provide over traditional costing?

A. ABC provides a more accurate picture of the true cost of caring for each patient population, enabling the nurse manager to identify which services are underpriced and which are overpriced relative to their actual resource consumption

B. ABC provides a simpler cost accounting system that is easier for nursing staff to understand and use

C. ABC enables the nurse manager to identify which patient populations generate the highest profit margins and to prioritize those populations, and reveals which clinical activities consume

disproportionate resources relative to their contribution to patient outcomes — enabling both financial optimization and resource reallocation

D. ABC provides better compliance with CMS cost reporting requirements than traditional costing methods

103. A nurse manager is developing a financial justification for a nurse-led rapid assessment clinic that would divert appropriate emergency department patients to a lower-cost, faster-service clinic staffed by nurse practitioners. The clinic would operate twelve hours per day and is projected to divert forty patients per day from the ED. ED cost per visit: $580. Clinic cost per visit: $185. Annual clinic operating cost: $1,200,000. Which calculation provides the MOST compelling financial justification?

A. Annual visits diverted: 40 × 365 = 14,600. Cost savings per visit: $580 − $185 = $395. Gross savings: 14,600 × $395 = $5,767,000. Net savings: $5,767,000 − $1,200,000 = $4,567,000

B. The financial justification should focus on the revenue implications since diverted ED visits may reduce ED revenue that the hospital depends on

C. Annual diverted visits × cost differential = gross savings, minus clinic operating costs = net savings. However, the analysis must also account for the ED revenue impact of diversion, the patient safety implications of diverting patients to a lower-acuity setting, and the potential for the clinic to attract new patient volume that would not have presented to the ED — making the net financial impact more complex than simple cost substitution

D. The financial justification should be based on patient satisfaction improvement rather than cost savings since patient experience drives long-term revenue through reputation and loyalty

104. A nurse manager is developing a flex staffing model that adjusts nursing hours based on real-time census and acuity data. The model uses a "core and flex" structure where core staff provide baseline coverage and flex staff are added or removed based on demand signals. Which design element is MOST critical for the flex model's success?

A. A sophisticated acuity measurement tool that provides real-time patient classification data

B. A reliable source of flex staff — either an internal float pool, per diem nurses, or a rapid-response staffing agency — who can be deployed within a defined response time when demand signals indicate the need for additional resources, and conversely, a fair and transparent process for releasing staff when demand decreases

C. An automated staffing algorithm that adjusts staffing levels without requiring nurse manager decision-making

D. A financial model that demonstrates the cost savings of flex staffing compared to fixed staffing

105. A nurse manager is evaluating the financial impact of a "no overtime" policy that was implemented three months ago. Before the policy, the unit spent an average of twenty-eight thousand dollars per month on overtime. After the policy, overtime spending decreased to eight thousand dollars per month. However, agency spending increased from twelve thousand dollars to thirty-five thousand dollars per month during the same period. Which financial conclusion is MOST accurate?

A. The no-overtime policy is successful because it reduced overtime spending by twenty thousand dollars per month

B. The no-overtime policy reduced premium labor costs by twenty thousand dollars in overtime but increased agency costs by twenty-three thousand dollars, producing a net three-thousand-dollar monthly increase in total premium labor costs — demonstrating that the policy shifted spending from one premium category to another without reducing total premium labor

C. The agency increase is unrelated to the no-overtime policy and reflects seasonal staffing challenges

D. The no-overtime policy should be continued because overtime is more controllable than agency costs in the long term

106. A nurse manager is developing a grant proposal to fund a nurse-led chronic disease self-management program for heart failure patients. The program would provide telephonic nurse coaching for twelve weeks after discharge. Which grant proposal element is MOST important for funding success?

A. A detailed budget that accounts for all program costs including staffing, technology, supplies, and indirect costs

B. Letters of support from organizational leadership and community partners demonstrating institutional commitment

C. A comprehensive literature review demonstrating the evidence base for telephonic nurse coaching in heart failure management

D. A clearly defined measurable outcome objective — such as a twenty percent reduction in thirty-day heart failure readmissions — with a rigorous evaluation methodology that demonstrates the program's impact, a realistic budget, evidence-based program design, and a sustainability plan for continuing the program after grant funding ends

107. A nurse manager is analyzing the unit's contract labor utilization and discovers the following:

Contract Type	Monthly Cost	Quality Index
Travel nurses (13-week contracts)	$45,000	78/100
Per diem agency (daily contracts)	$22,000	65/100
Internal float pool	$18,000	88/100
Overtime (permanent staff)	$15,000	92/100

Which staffing strategy provides the BEST value when considering both cost and quality?

A. Eliminate all contract labor and cover gaps exclusively with permanent staff overtime since it has the highest quality index

B. Prioritize internal float pool utilization over other contract labor sources since it provides the best balance of cost-effectiveness and quality, supplement with targeted overtime when float pool is insufficient, use travel nurses for prolonged vacancies where the thirteen-week investment in orientation produces adequate quality returns, and minimize per diem agency use due to its low quality index

C. Invest in converting travel nurse positions to permanent FTEs since the long-term cost is lower and quality is likely to improve with tenure

D. Increase per diem agency use since it has the lowest daily cost and provides scheduling flexibility

108. A nurse manager is developing a proposal for implementing a clinical decision support system for sepsis screening. The system costs ninety-five thousand dollars annually. Current sepsis-related data:

Annual sepsis cases identified on the unit: 85

Average additional LOS for sepsis patients: 4.2 days

Average additional cost per sepsis day: $3,200

Published evidence shows CDS systems improve early sepsis identification by 25%, reducing additional LOS by an average of 1.8 days for identified patients.

Which calculation provides the MOST compelling financial justification?

A. Total current sepsis cost: 85 × 4.2 × $3,200 = $1,142,400. Twenty-five percent improvement = $285,600 savings

B. Additional patients identified early: 85 × 25% = 21.25. LOS reduction for early-identified patients: 21.25 × 1.8 days × $3,200 = $122,400. Net: $122,400 − $95,000 = $27,400 net benefit

C. The CDS system would improve early identification of approximately 21 additional patients, reducing their additional LOS by 1.8 days each, saving approximately $122,400 annually against a $95,000 cost for a net benefit of $27,400 — but the full value must also account for reduced mortality, decreased ICU transfers, and improved sepsis bundle compliance that produce additional financial and clinical returns beyond the direct LOS savings

D. The financial justification should focus on the mortality reduction rather than LOS savings since preventing deaths is the primary clinical benefit of early sepsis identification

109. A nurse manager is developing a five-year capital equipment replacement plan. The unit has thirty-two pieces of major clinical equipment with varying ages, maintenance costs, and remaining useful lives. Which planning methodology is MOST systematic?

A. Replace equipment as it fails and maintain a contingency budget for emergency purchases

B. Develop a prioritized replacement schedule using a weighted scoring matrix that evaluates each piece of equipment against criteria including age relative to useful life, maintenance cost trends, clinical functionality gaps compared to current technology, patient safety risk from malfunction, regulatory compliance requirements, and replacement cost — then sequence replacements within projected annual capital budgets over the five-year horizon

C. Replace all equipment that has exceeded its manufacturer-recommended useful life within the first year of the plan

D. Prioritize replacements based solely on the frequency of equipment malfunctions as documented in the biomedical engineering repair log

110. A nurse manager reviews the following monthly financial data:

Month	Revenue	Expenses	Margin	Patient Days
Jan	$520,000	$485,000	$35,000	780
Feb	$495,000	$490,000	$5,000	740
Mar	$540,000	$505,000	$35,000	810
Apr	$510,000	$520,000	($10,000)	770

Which metric MOST accurately identifies the unit's underlying financial performance independent of volume variation?

A. The margin per patient day (revenue minus expenses divided by patient days) reveals the unit's financial performance normalized for volume: Jan $44.87, Feb $6.76, Mar $43.21, Apr −$12.99 — showing that February and April had structural financial problems beyond what volume decline alone would explain, since the margin per patient day collapsed disproportionately to the volume change

B. The total monthly margin since it shows the actual financial contribution regardless of volume

C. The revenue per patient day since it indicates the unit's revenue generation efficiency

D. The expense per patient day since it shows whether costs are being managed appropriately regardless of volume

111. A nurse manager is developing a financial sustainability plan that addresses the projected impact of value-based payment models on the unit's financial performance. Under fee-for-service, the unit generates revenue from each patient day, procedure, and service. Under value-based payment, the unit generates revenue from achieving quality outcomes and managing total cost of care. Which strategic adaptation is MOST critical?

A. Reduce staffing costs to maintain financial performance as fee-for-service revenue declines

B. Increase patient volume to compensate for per-case reimbursement reductions under value-based models

C. Focus on improving publicly reported quality metrics to maintain competitive positioning

D. Shift the unit's operational focus from volume-driven efficiency to value-driven outcomes — investing in care coordination, readmission prevention, patient education, and post-discharge follow-up that reduce total cost of care and earn value-based incentive payments, even when these investments increase per-case costs that would have been penalized under fee-for-service

112. A nurse manager is evaluating the total cost of implementing a new nurse residency program. Beyond the direct program costs, which cost component is MOST commonly overlooked in residency program financial projections?

A. The reduced productivity of preceptors during the preceptorship period when they carry fewer patients to accommodate teaching responsibilities

B. The cost of simulation equipment and supplies used during the residency curriculum

C. The salary cost of the residency program coordinator who manages the curriculum and logistics

D. The opportunity cost of the preceptor's reduced patient assignment — including the revenue lost from having the preceptor care for fewer patients during precepting shifts, the additional staffing needed to cover the preceptor's reduced workload, and the cumulative productivity impact across all preceptors over the residency period

113. A nurse manager is preparing for a budget negotiation with the CFO. The CFO has proposed a four percent across-the-board budget reduction for all nursing units. The nurse manager's unit has already been operating at or below budget for three consecutive years and has achieved above-benchmark quality outcomes. Which negotiation strategy is MOST effective?

A. Accept the four percent reduction since organizational financial health requires shared sacrifice across all departments

B. Present data showing that further reductions will compromise the quality outcomes that are currently generating value-based purchasing revenue for the organization

C. Present a comprehensive analysis demonstrating the unit's track record of fiscal responsibility, the relationship between current resource levels and above-benchmark quality outcomes, the projected quality and financial risks of further reduction, and propose an alternative contribution such as identifying efficiency savings that achieve the organizational cost target without across-the-board cuts that penalize already-efficient units

D. Request an exemption from the reduction based on the unit's superior financial performance record

114. A nurse manager is calculating the unit's cost per quality-adjusted patient day — a metric that adjusts the raw cost per patient day for the quality of outcomes delivered. Two units have identical costs per patient day ($2,400), but Unit A achieves a quality composite score of 92/100 while Unit B achieves 74/100. Which interpretation is MOST meaningful?

A. Both units have equal financial performance since their costs per patient day are identical

B. Unit A delivers higher value per dollar spent because each $2,400 patient day produces a higher quality outcome — the cost per quality-adjusted patient day is effectively lower for Unit A ($2,400 ÷ 0.92 = $2,609 adjusted) versus Unit B ($2,400 ÷ 0.74 = $3,243 adjusted), demonstrating that equal spending does not produce equal value and that quality-adjusted cost analysis reveals the true efficiency of resource utilization

C. Unit B needs additional resources to improve quality since its outcomes lag despite equal spending

D. The quality scores should not be factored into financial analysis since quality and finance are separate performance dimensions

115. A nurse manager is developing the unit's annual strategic plan and must align unit-level objectives with the organization's strategic priorities. The organizational strategy emphasizes three priorities: clinical excellence, operational efficiency, and workforce development. The nurse manager must translate these broad priorities into specific, measurable unit-level objectives. Which approach MOST effectively achieves strategic alignment?

A. Adopt the organizational priorities verbatim as the unit's strategic objectives to ensure perfect alignment

B. Survey staff about which organizational priorities are most relevant to the unit and focus the strategic plan on those areas

C. Develop unit-specific objectives for each organizational priority that are measurable, time-bound, and directly connected to the unit's unique patient population and operational context — such as translating "clinical excellence" into a specific CLABSI reduction target, "operational efficiency" into a defined LOS improvement for the unit's top DRGs, and "workforce development" into a certification rate goal — ensuring that each unit objective demonstrably contributes to the organizational priority it supports

D. Focus the unit strategic plan exclusively on the organizational priority where the unit has the greatest opportunity for improvement

Answer Key — Exam 13 (with Full Answer Explanations)

1. C — Trauma-informed communication is not about conducting trauma assessments but about creating an environment that recognizes trauma's pervasiveness, avoids re-traumatization, and integrates awareness into all interactions without requiring disclosure. The approach is universal — applied to every patient — not selective based on known trauma history.

2. A — A structured process where nurses acknowledge patient-generated data, evaluate it within the context of clinical measurements, integrate relevant findings, and communicate how the data will be used provides balanced governance. Patient-generated health data is increasingly common and requires a framework that neither dismisses nor uncritically accepts it.

3. B — A multimodal communication plan with augmentative devices, personalized communication boards, allocated extra time, staff training on non-verbal cues, and documented preferences addresses the comprehensive needs of cognitively intact non-verbal patients. Communication barriers do not indicate cognitive deficits, and the care plan must support the patient's full decisional capacity.

4. D — A brief initial screening of immediate needs within the first thirty minutes — including dietary restrictions, allergies, safety risks, and communication preferences — followed by the comprehensive assessment addresses the timing problem. Religious dietary violations occur because the question is reached too late in a lengthy form.

5. A — Addressing the patient directly, establishing the need for the patient's own voice, using invitation techniques, and privately assessing the caregiver relationship balances respect for family dynamics with the clinical and ethical need to hear from the patient directly. Caregiver dominance may reflect cultural norms, habit, or concerning dynamics requiring different responses.

6. A — Standardized communication time expectations, implicit bias training, and demographic-stratified auditing directly addresses the documented inequity. The communication time disparity persists after acuity adjustment, indicating that unconscious bias rather than clinical need drives the difference.

7. C — Integrating the introduction into a standardized room-entry sequence and practicing until habitual makes the behavior automatic rather than dependent on conscious effort. Behavioral change is most durable when the desired action becomes part of an existing workflow rather than an additional task.

8. A — Assessing functional communication ability, establishing risk-based criteria for mandatory interpretation, respecting preferences for routine communication, and re-evaluating when complexity changes balances autonomy with safety. Not all clinical interactions carry equal risk, and a risk-stratified approach accommodates patient preference while protecting high-stakes communication.

9. D — Supplementing the checklist with anxiety assessment, targeted therapeutic communication, explanation of perioperative phases, and coping strategies addresses pre-operative anxiety comprehensively. Research shows that addressing specific fears and providing predictive information about what to expect reduces anxiety more effectively than generic information delivery.

10. B — Training nurses to validate the patient's research effort, assess information accuracy, correct misinformation without dismissing the effort, and recommend reliable sources creates a collaborative approach. Patients who research their conditions are engaging in their care, and the nurse's role is to guide rather than discourage that engagement.

11. D — Clarifying that the huddle serves a different purpose than rounds — ensuring all team members can articulate goals versus clinical decision-making — and adjusting timing to complement rounding addresses the redundancy concern. The huddle reaches staff who do not participate in rounds, making it a distinct communication function.

12. A — Addressing the family's underlying response time concern, discussing staff comfort, negotiating a compromise, and advocating for organizational policy development addresses all stakeholders. Baby monitor surveillance by families signals unmet communication needs that direct engagement can resolve.

13. D — A multimedia system with the digital platform as primary, built-in accessibility features, staff digital assistance training, printed backup, and equity monitoring by demographics ensures inclusive implementation. Technology-driven education must actively address the digital divide rather than assuming universal access.

14. A — Accommodating the cultural and religious request through assignment adjustment, documentation, and equitable workload distribution respects the patient's values while maintaining operational fairness. Cultural and religious accommodation for personal care is a recognized patient right that nursing operations should support.

15. D — Training nurses to acknowledge uncertainty honestly by explaining what is known, what is being investigated, the expected timeline, and what to expect provides transparency without overstepping scope. Patients tolerate uncertainty better when they understand the process rather than receiving deflection or silence.

16. B — Ensuring clinical staff actually read and integrate passport information rather than treating it as duplicative documentation is the most significant challenge. Communication tools that travel with patients add value only if receiving providers use them — and the primary barrier is attention competition with existing documentation.

17. C — Creating a legitimate clinical reason for separation, using trauma-informed communication during private time, assessing safety, providing resource information without pressuring disclosure, and activating the response protocol follows evidence-based trafficking response. Direct questioning or law enforcement contact without patient safety assessment may endanger the victim.

18. C — Establishing clear criteria for which findings require immediate verbal notification versus documentation-only, training on criteria, and integrating a notification prompt into the documentation workflow addresses the documentation-without-communication pattern systematically. The intervention must define the threshold between document-and-notify and document-only.

19. A — Acknowledging the family physician's expertise, explaining that care orders must come through the attending, redirecting clinical input through proper channels, and establishing that nursing follows the documented care plan addresses the boundary violation respectfully. Family members who are physicians require clear boundaries between their family role and clinical authority.

20. B — Multiple concurrent dignity violations — overheard clinical information, routine exposure during care, and depersonalized reference by room number — represent the most significant finding requiring immediate intervention. Individual privacy lapses are less concerning than a pattern of systematic dignity erosion affecting multiple dimensions simultaneously.

21. B — A boundary awareness education program with continuum recognition, specific long-stay guidance, professional frame maintenance regardless of duration, and a confidential consultation process provides the framework long-stay settings require. Extended relationships naturally test boundaries, and proactive education prevents violations that retrospective correction cannot undo.

22. C — Educating that presence is more important than words, training in specific end-of-life techniques including acknowledging family experience and normalizing the dying process, reduces avoidance by removing the performance pressure of "saying the right thing." Nurses avoid dying patients primarily because they fear inadequacy, not because they lack compassion.

23. D — Prioritized critical information, multiple brief sessions with teach-back throughout hospitalization, visual and multimedia supplements, simplified written summaries, and post-discharge reinforcement addresses information overload through evidence-based learning principles. Single forty-five-minute sessions exceed human retention capacity for medical information.

24. A — Integrating cannabis screening into standard medication reconciliation, treating it as any clinical substance, educating on interactions, establishing non-judgmental communication expectations, and documenting in the medication history normalizes a clinically relevant assessment. Cannabis use affects anesthesia, pain management, and multiple drug interactions that require clinical documentation.

25. A — Clinical recommendations through a hospital-affiliated forum create a nurse-patient relationship carrying professional accountability and liability. The forum creates individual patient reliance on the nurse's clinical guidance without the assessment context that in-person care provides, creating both personal and organizational risk.

26. B — Apologizing, addressing the immediate need, educating about call light use during waits, addressing the individual nurse, and implementing a unit-wide expectation with specific timeframes and call-light instruction addresses both the individual situation and the systemic pattern. "I'll be right back" without a timeframe creates unfulfillable expectations.

27. C — Communicating what is known, what is unknown, and when more information will be available with honest uncertainty acknowledgment, a reliable update cadence, and avoidance of unconfirmed promises provides the communication foundation organizational transitions require. Staff trust depends on honest communication rather than premature reassurance.

28. B — Clear clinical criteria for physician notification regardless of time, staff training on the criteria, and addressing the cultural norm that notification is "bothering" the physician addresses the root cause. Night shift underreporting reflects a cultural belief rather than a clinical judgment — the intervention must change the norm.

29. D — Acknowledging the participant briefly, validating frustration, redirecting to the agenda's systemic focus, offering individual follow-up through patient relations, and establishing ground rules for future meetings provides comprehensive facilitation. Advisory panels require structured facilitation that values individual voices while maintaining group productivity.

30. D — Ensuring timely pre-antibiotic cultures, questioning orders lacking documented indication, monitoring for infection resolution supporting de-escalation, and communicating assessment findings proactively represents nursing's greatest stewardship impact. These activities span the antibiotic lifecycle from initiation through discontinuation.

31. A — Normalizing the screening as standard practice, training in non-judgmental interviewing, integrating into admission workflow, establishing referral pathways, and demonstrating outcome improvement addresses the implementation comprehensively. Social determinants screening becomes routine when it is framed as clinical practice rather than social inquiry.

32. B — PSIs are screening tools using administrative data that require clinical validation to determine whether flagged events were truly preventable or represent documentation and coding artifacts. PSIs identify potential quality concerns but are not definitive quality measures — clinical chart review is required to confirm each flagged event.

33. C — A surge capacity plan with clinical protocols, staff education, vulnerable population identification, and community outreach provides the comprehensive preparation climate-related health events require. Heat-related admissions are predictable seasonal events that benefit from proactive planning rather than reactive response.

34. D — Collaborating with medical staff and the transfusion committee to implement evidence-based guidelines with clinical decision support, prospective review, and practice variation tracking addresses the transfusion practice through the appropriate governance structure. Individual nurse-physician conversations about transfusion thresholds are less effective than systematic clinical decision support.

35. D — The EHR likely lacks a prominent structured field for patient-stated goals combined with inconsistent goal-setting conversations. When both system design and practice gaps contribute, the solution must address both — creating the documentation infrastructure and establishing the clinical practice of asking patients about their goals.

36. C — A comprehensive oxygen safety program with patient education at initiation, environmental assessment during rounding, signage, staff fire response training, and home oxygen discharge education addresses all oxygen fire risk dimensions. Oxygen-enriched environments create fire risk that requires continuous rather than one-time intervention.

37. A — Faster results accelerating treatment, reducing unnecessary empiric antibiotics, and enabling faster isolation decisions represent the primary clinical benefits, but implementation also requires nursing competency in test performance, interpretation, quality control, and documentation. Point-of-care testing adds clinical capability and nursing responsibility simultaneously.

38. D — Ensuring decontamination and assessment of exposed individuals, isolating the spill, activating the hazmat cleanup protocol with appropriate spill kit, and initiating exposure reporting addresses the immediate safety priorities. Cytotoxic medication spills require specific cleanup procedures that differ from standard spill management.

39. B — A time-motion study comparing actual nursing hours for high versus low psychosocial complexity patients at similar medical acuity provides the objective evidence needed to advocate for classification system modification. Anecdotal evidence is insufficient for system change; quantified workload data demonstrates the gap.

40. B — The hours with the highest volume of medication administration AND the highest rate of medication-related safety events maximize the pharmacist's impact. The embedded pharmacist adds the most value during periods of highest clinical activity and risk, where their real-time intervention prevents the most errors.

41. A — The fall increase is proportional to mobilization increase — more mobilized patients means more absolute falls even if the rate per mobilized patient is stable. The 1.1-day LOS reduction demonstrates significant clinical benefit that outweighs the modest fall increase, provided each fall is individually investigated for preventability.

42. C — Mass casualty triage uses a validated rapid assessment tool that categorizes patients by survivability and resource needs, accepting that some patients who would receive maximum effort in normal operations may receive limited or no intervention during mass casualty events. This philosophical shift from individual optimization to population optimization is the most critical concept.

43. A — Analyzing workflow barriers at the two lowest-compliance transition points and embedding reconciliation into transfer and post-procedure workflows targets the specific gaps. The admission compliance demonstrates staff knowledge of the requirement; the lower compliance at other transitions reflects process barriers specific to those workflows.

44. A — Stroke mimics are an inherent cost of maintaining aggressive stroke identification — the sensitivity required to catch every true stroke inevitably captures non-stroke conditions. The consequences of missing a true stroke (permanent disability, death) far outweigh the costs of evaluating mimics.

45. B — Understanding that CGM measures interstitial glucose (not blood glucose), recognizing the ten-to-fifteen percent potential variance, verifying with POC testing before insulin dosing, and knowing when conditions cause CGM inaccuracy are the essential nursing competencies. CGM technology has specific clinical limitations that affect inpatient use.

46. A — A multicomponent delirium prevention bundle addressing all modifiable risk factors simultaneously — sleep protection, mobilization, hydration, medication review, sensory aid access, and orientation — produces the most significant delirium reduction. Research consistently shows that multicomponent non-pharmacological interventions are more effective than any single intervention.

47. D — SSI (colon) has the highest SIR at 1.81, indicating eighty-one percent more infections than predicted. The SIR directly compares observed to expected performance, making 1.81 the largest gap among all four infection types and the greatest improvement opportunity.

48. B — A universal education approach providing all patients with IPV resources regardless of screening results ensures that victims who do not disclose still receive actionable information. Universal education removes the burden of disclosure from the patient and provides resources that can be accessed when the patient is ready.

49. B — Zero harm is an aspirational philosophy establishing that every preventable harm is unacceptable and worthy of investigation — not that perfection is immediately achievable. Organizations pursuing zero harm consistently outperform those that accept "acceptable" harm rates because the philosophy drives continuous improvement rather than complacency at any achieved level.

50. A — National benchmarking against similar units identifying whether outcomes are above or below expected performance for the specific unit type and population provides the greatest value. NDNQI's power lies in peer comparison that contextualizes performance within relevant reference groups rather than generic benchmarks.

51. A — Design thinking's Empathize stage reveals the emotional experience of discharge — anxiety, confusion, frustration, and feeling rushed — which traditional process improvement focused on operational metrics would miss. Design thinking's distinctive contribution is understanding the human experience dimension that efficiency-focused methodologies overlook.

52. B — Presencing requires stepping back from urgency, creating reflective space, letting go of preconceived solutions, and remaining open to unimagined possibilities. Theory U's presencing phase is fundamentally about allowing the future to emerge from deep reflection rather than projecting past experience onto new challenges.

53. C — Creating an environment where critical thinking is valued, initiative is rewarded, questioning is framed as professional obligation, and meaningful autonomy is granted develops exemplary followership. Conformist followers need safety and trust before they will risk independent thinking, and only the organizational environment can provide those conditions.

54. D — Participative leadership — consulting the team and involving them in decision-making — is most effective for ambiguous tasks because it leverages collective expertise to clarify the path forward.

Path-goal theory matches leadership style to task characteristics, and ambiguity calls for participative input.

55. A — Integrative thinking — holding opposing ideas simultaneously and finding creative solutions that capture both — manages paradoxes most effectively. Leadership paradoxes are not problems to solve through choosing sides but tensions to manage through creative integration.

56. D — Developing a unique care model or capability that no competitor offers creates uncontested space. Blue Ocean Strategy's core insight is that competing on the same dimensions as rivals produces diminishing returns, while creating distinctive value attracts stakeholders who seek what only this unit provides.

57. A — Presenting requests in the director's valued language — connected to strategy, supported by data, framed as investment with projected returns, and timed to budget cycles — adapts the message to the audience. Managing up requires understanding what the supervisor values and framing communications accordingly.

58. B — Shifting to strategic development, innovation facilitation, and boundary-spanning activities leverages the leadership surplus created by the team's self-sufficiency. When experience, cohesion, and protocols substitute for directive and supportive functions, the leader's value shifts to activities the team cannot self-provide.

59. C — Structured analysis of the successful save using the same rigor as adverse event investigation captures the conditions, behaviors, and system factors that enabled success. Learning from excellence requires systematic analysis, not just recognition — understanding why success happened enables replication.

60. D — Redefining leadership as an extension of clinical excellence — demonstrating that mentoring, QI, and EBP amplify patient impact beyond bedside care — addresses the specific identity concern that leadership means abandoning clinical work. Reluctant leaders need to see leadership as clinical practice at a larger scale.

61. C — Developing "role clarity through role acceptance" — acknowledging the tension as inherent rather than solvable and building translation skills — provides the most realistic coping strategy. Middle managers who accept the dual-accountability tension as a feature rather than a bug develop the adaptive capacity the role demands.

62. C — Investing primarily in leveraging strategic thinking and relationship building while developing systems and partnerships that compensate for execution and influencing weaknesses follows strengths-based leadership. The research shows that developing strengths to their fullest potential produces better results than bringing weaknesses to average.

63. B — CN-A's zero staff complaints combined with the highest safety event rate warrants investigation. Zero complaints may indicate avoidance of the accountability conversations that effective charge leadership requires, and the safety events may result from insufficient clinical oversight.

64. B — Developing shared vision connecting daily work to meaningful purpose, inspiring through personal example, investing in individual growth, and challenging conventional thinking through innovation introduces transformational elements. Burns defined transformational leadership as raising both leader and followers to higher levels of motivation and morality.

65. C — Translating the organizational initiative into clinically meaningful language, involving staff in adapting implementation, and providing feedback to leadership while maintaining commitment demonstrates effective "leading from the middle." The middle manager's unique value is bridging the gap between strategy and clinical reality.

66. D — The 70/20/10 framework is a guideline, and the nurse manager should assess which model best fits specific developmental needs and culture. While the research supports experiential learning dominance, context determines the optimal blend.

67. D — The program is working as intended — informed decision-making about leadership careers requires realistic understanding. Candidates who self-select out after observing reality make better-informed decisions than those who pursue management based on idealized expectations. Realistic job previews improve both selection quality and retention.

68. A — Acknowledging the nurse's perspective, explaining reasoning transparently including constraints and trade-offs, inviting alternatives, and demonstrating willingness to modify the decision models authentic leadership's four components: self-awareness, internalized moral perspective, balanced processing, and relational transparency.

69. B — Building a coalition of middle managers who share implementation challenges and collectively advocate for resources, authority, and timeline adjustments creates the collective influence that

individual middle managers lack. The frozen middle problem is structural, and structural problems require collective solutions.

70. C — A systematic understanding of the conditions, behaviors, and system factors that produce excellent outcomes creates an evidence base for replicating success. Learning from excellence provides actionable insights for designing systems that produce more successful outcomes rather than only preventing failures.

71. B — Integrating the three analyses by recognizing each captures a different dimension, synthesizing valid insights from all perspectives, and developing a comprehensive solution demonstrates foundational thinking. Systems thinking, critical thinking, and evidence-based decision-making require integration of multiple valid but partial perspectives.

72. D — A comprehensive mentoring infrastructure with matching processes, mentor training, protected time, multiple modalities, outcome evaluation, and leadership commitment creates a mentoring culture rather than individual mentoring relationships. Culture requires infrastructure that sustains mentoring independently of any individual champion.

73. C — Presenting the evidence-based protocol to organizational leadership as a proposed exception, advocating for unit-level innovation flexibility within the organizational framework, and negotiating a resolution navigates the governance-organization tension productively. The nurse manager must advocate for evidence-based practice while respecting organizational governance.

74. A — Conducting a unit-level assessment of all six NAM factors, identifying the most problematic through staff input and data, developing targeted system-level interventions, and measuring outcomes provides the most aligned approach. The NAM framework specifically requires assessment-driven, system-level interventions rather than generic programs.

75. A — Studying the cognitive processes and environmental conditions that enable successful error recovery and designing interventions to strengthen recovery mechanisms focuses on an underutilized safety strategy. Nurses recover eighty-six percent of errors, making recovery capacity a critical complement to prevention strategies.

76. C — Converting tacit clinical knowledge into explicit organizational knowledge addresses the most significant challenge. Explicit knowledge (policies, protocols) is already managed through documentation systems. Tacit knowledge — clinical intuition, decision heuristics, relationship insights — is far more valuable and far more difficult to capture.

77. C — Nurses identifying a clinical question, designing a unit-based project generating new knowledge, implementing findings, and disseminating results most directly demonstrates the Magnet "New Knowledge" component. The component requires nurses to generate new knowledge, not just implement others' findings.

78. B — Building relationships, identifying shared interests, creating cross-departmental groups with shared accountability, and leveraging influence through competence and collaborative credibility provides the network leadership approach. Network leadership operates through influence rather than authority, requiring relationship investment.

79. A — Designing stress-resistant safety practices that are simple under cognitive load, embedded in workflows as automatic, technology-supported to reduce human vigilance dependence, and reinforced through brief checks maintains safety when it matters most. Safety practices must be designed for worst-case cognitive conditions rather than optimal conditions.

80. C — Justice — the fair and equitable distribution of nursing resources — is most directly at stake when concentrating resources on high-risk patients potentially reduces care available to lower-risk patients. Resource allocation decisions inherently involve justice considerations about who receives what level of care.

81. D — The nurse providing telehealth to a non-compact state patient is practicing without a valid license in that jurisdiction, constituting a Nurse Practice Act violation with potential disciplinary action, liability, and compact privilege jeopardy. The Nurse Licensure Compact authorizes practice only in compact states.

82. B — Supporting the nurse's advocacy role, explaining to the physician that the nurse fulfilled a professional obligation to respect patient autonomy, addressing the communication approach, and establishing collaborative advocacy expectations balances both perspectives. Patient advocacy is a fundamental nursing obligation under the ANA Code of Ethics.

83. C — Whether expert witness activities could create a conflict of interest regarding care at the nurse's own organization and whether organizational policies should address disclosure, conflict screening, and approval requirements represents the most important professional consideration. Expert testimony about one's own organization creates the most significant potential conflict.

84. A — Providing clinical opinions about functional limitations without proper certification or physician authorization constitutes practicing outside nursing scope, creating potential patient harm and liability. Clinical reference letters describing diagnoses and functional limitations require physician authorization because they carry clinical and legal weight.

85. C — Whether the researcher obtained IRB approval with informed consent addressing employer data access risk, voluntary participation without coercion, and confidentiality protections represents the most important ethical consideration. Workplace research creates unique vulnerability because the employer relationship introduces coercion and privacy risks that standard research contexts do not.

86. D — A comprehensive ethical analysis evaluating branding influence on prescribing, conflict-of-interest policy compliance, educational content independence, and alternative funding availability — presented to organizational leadership for decision — provides the most thorough approach. The decision requires multidimensional ethical analysis rather than blanket acceptance or rejection.

87. A — Framing scope expansion as natural professional evolution, providing comprehensive education with competency validation, creating a supportive confidence-building environment, and positioning expansion as professional advancement addresses the resistance constructively. Nursing scope has expanded throughout its history, and current expansion follows the same pattern.

88. D — Configuring the tracking system to display sensitive information using coded abbreviations or symbols that convey clinical information to authorized staff without revealing diagnoses to casual observers, and auditing all public displays, addresses the confidentiality vulnerability systematically. Clinical information systems must balance staff access with patient privacy in their visual design.

89. C — A fatigue risk management system with evidence-based scheduling limits, mandatory rest periods, self-assessment tools, culture supporting shift decline, and organizational performance monitoring provides the comprehensive approach current evidence and professional guidelines recommend.

90. D — Developing a culture where nursing clinical judgment is valued as independent and essential — establishing authority and obligation to escalate based on nursing findings regardless of physician assessment — addresses the foundational cultural problem. Deference to physician judgment when nursing data contradicts it reflects a hierarchical culture that undermines patient safety.

91. B — Acknowledging the complaint, explaining the error prevention, reinforcing that questioning orders is an organizational expectation, addressing the physician's perception through dialogue, and recognizing the nurse's actions publicly demonstrates comprehensive organizational support for moral courage.

92. B — Clear guidelines defining time allocation, conflict-of-interest protocols, role precedence communication, and organizational support for dual-role value provides the appropriate management framework. Dual roles provide unique organizational perspectives that benefit from structured support rather than elimination.

93. C — Guidelines supporting advocacy rights while establishing that positions represent personal opinion, avoiding confidential information disclosure, maintaining professional tone, and including disclaimers provides balanced governance. Nurses have the right to advocate for healthcare policy while maintaining appropriate organizational boundaries.

94. A — Addressing timestamp accuracy as a professional accountability issue, explaining the legal and clinical importance of accurate timing, and investigating whether the practice reflects individual behavior or workflow barriers provides the appropriate response. Accurate timestamps are a medical-legal requirement regardless of value accuracy.

95. D — A comprehensive program evolving over time — from acute safety needs through emotional processing to long-term meaning restoration and post-crisis recovery planning — addresses the compounding nature of sustained crisis impact. Well-being interventions effective during acute crisis become insufficient during prolonged operations.

96. B — Comparing the marginal cost of the additional RN to the marginal benefit — projected incremental quality, satisfaction, and safety improvement — determines whether the incremental value exceeds the incremental cost. Marginal analysis evaluates whether the next unit of investment produces proportional value, not whether total staffing levels are appropriate.

97. B — Evaluating each proposal on its own value AND the value lost by not implementing the alternative incorporates opportunity cost. The true cost of selecting Proposal A includes both the $50,000 investment and the sepsis deaths that Proposal B would have prevented — making the decision more nuanced than simple ROI comparison.

98. A — Innovation costs $15,000 per prevented HAPI; education costs $10,000 per prevented HAPI. Education is more cost-effective per unit of outcome, but the innovation prevents more total injuries. The choice depends on organizational priorities — maximum efficiency versus maximum harm prevention.

99. C — The unit's labor costs are largely inelastic — fixed minimums, orientation costs, and benefits create a cost floor persisting regardless of volume reduction. Understanding labor elasticity helps the nurse manager communicate realistic cost management expectations to finance and plan for low-census periods.

100. A — A realistic revenue projection validated against utilization data from similar programs combined with comprehensive cost analysis provides the essential credibility for the wellness clinic proposal. Financial proposals require evidence-based projections rather than aspirational estimates.

101. D — Identifying which specific DRGs or populations contribute most to the LOS excess and implementing targeted interventions for high-impact groups is more effective than uniform LOS reduction. The penalty-driving excess is concentrated in specific clinical populations, and targeted intervention produces the greatest impact per improvement dollar.

102. C — ABC reveals which services are underpriced and overpriced relative to actual resource consumption AND which activities consume disproportionate resources relative to their outcomes contribution. This dual insight enables both financial optimization and resource reallocation that traditional costing cannot provide.

103. C — The net savings calculation must also account for ED revenue impact of diversion, patient safety implications, and potential for the clinic to attract new volume not previously presenting to the ED. Simple cost substitution analysis overstates the financial benefit by ignoring these additional variables.

104. B — A reliable flex staff source deployable within defined response time when demand increases and a fair process for releasing staff when demand decreases provides the essential operational component. The flex model fails without both the ability to add and the ability to release staff based on demand signals.

105. D — The no-overtime policy reduced overtime by $20,000 but increased agency by $23,000, producing a net $3,000 monthly increase in total premium labor. The policy shifted spending between

premium categories without reducing total premium labor, demonstrating that overtime restrictions without addressing the underlying staffing gap simply redirect premium spending.

106. D — A clearly defined measurable outcome objective with rigorous evaluation methodology, realistic budget, evidence-based design, and a sustainability plan provides the most important grant proposal element. Funders evaluate whether their investment will produce measurable impact and continue beyond the funding period.

107. B — Internal float pool provides the best cost-quality balance (88/100 quality at $18,000), supplemented by targeted overtime for short gaps, travel nurses for prolonged vacancies where orientation investment yields quality returns, and minimized per diem agency due to its low quality index. The strategy should prioritize higher-quality, lower-cost options first.

108. C — The CDS system identifies approximately 21 additional patients early, reducing LOS by 1.8 days each for $122,400 in direct savings against $95,000 cost ($27,400 net), but the full value includes mortality reduction, ICU transfer prevention, and bundle compliance improvement beyond direct LOS savings.

109. B — A prioritized replacement schedule using a weighted scoring matrix evaluating age, maintenance costs, functionality gaps, safety risk, regulatory compliance, and replacement cost sequenced within projected budgets provides the most systematic approach. Capital planning requires multi-criteria evaluation within budget constraints.

110. A — Margin per patient day normalizes financial performance for volume variation: Jan $44.87, Feb $6.76, Mar $43.21, Apr −$12.99. This reveals that February and April had structural financial problems beyond volume decline alone, since margin per patient day collapsed disproportionately to volume changes.

111. D — Shifting from volume-driven efficiency to value-driven outcomes — investing in coordination, readmission prevention, education, and follow-up that reduce total cost and earn incentive payments — represents the fundamental strategic adaptation. Value-based payment rewards outcomes and cost management rather than volume.

112. D — The opportunity cost of the preceptor's reduced patient assignment — revenue lost, additional staffing for workload coverage, and cumulative productivity impact — is most commonly overlooked.

Direct program costs (coordinator, simulation, materials) are typically included, but the indirect productivity impact across all preceptors is frequently underestimated.

113. C — Presenting fiscal responsibility track record, the quality-resource relationship, projected reduction risks, and alternative contributions that achieve cost targets without penalizing efficient units provides the most effective negotiation strategy. Across-the-board cuts penalize already-efficient units while sparing inefficient ones.

114. B — Unit A's $2,400 at 92/100 quality produces a lower cost per quality-adjusted patient day ($2,609) versus Unit B's $2,400 at 74/100 ($3,243). Equal spending does not produce equal value, and quality-adjusted cost analysis reveals the true efficiency of resource utilization that raw cost comparisons miss.

115. C — Developing unit-specific measurable, time-bound objectives connected to the unit's unique context — translating broad priorities into specific targets like CLABSI reduction, LOS improvement for top DRGs, and certification rate goals — ensures each unit objective demonstrably contributes to the organizational priority it supports.