# PRACTICE EXAM 14 — FULL-LENGTH SIMULATION (115 QUESTIONS)

1. A nurse manager is developing a "service recovery" protocol for the unit. Service recovery refers to the actions taken to restore patient trust after a service failure — such as a missed medication time, an extended wait, or a perceived rudeness. Research shows that effective service recovery can actually increase patient loyalty beyond pre-failure levels, a phenomenon called the "service recovery paradox." Which service recovery element is MOST critical for activating this paradox?

A. Providing a tangible compensation such as a meal voucher or upgraded room to demonstrate organizational acknowledgment of the failure

B. Responding immediately to the failure with a genuine acknowledgment, sincere apology, explanation of what happened, concrete action to correct the problem, and follow-up to verify the patient's satisfaction with the resolution — demonstrating that the organization values the patient enough to invest significant effort in making things right

C. Documenting the service failure in the patient relations database and including it in the unit's quality improvement trending data

D. Notifying the patient relations department to manage the service recovery process using their specialized training

2. A nurse manager is developing a communication strategy for managing a patient whose divorced parents disagree about treatment decisions for their hospitalized adolescent child. The mother has primary legal custody and consents to a surgical procedure. The father, who has visitation rights, arrives and demands the surgery be cancelled. The adolescent is fourteen years old and states she wants the surgery. Which action is MOST appropriate?

A. Follow the custodial parent's consent since legal custody determines decision-making authority, verify the custody documentation, communicate the hospital's position to the non-custodial parent respectfully, assess whether the adolescent's assent has been obtained, and involve social work if the parental conflict escalates

B. Delay the surgery until both parents agree since proceeding with parental disagreement creates legal risk for the organization

C. Allow the adolescent to make the final decision since she is old enough to express an informed preference about her own healthcare

D. Contact the hospital's legal department before proceeding with the surgery to obtain legal clearance

3. A nurse manager is coaching a nurse who excels at building rapport with patients but consistently avoids documenting negative findings or delivering bad news. The nurse's documentation omits uncomfortable truths — such as a patient's non-compliance, family conflict observations, or concerning behavioral patterns — because the nurse does not want to "put anything negative in the chart." Which coaching approach is MOST effective?

A. Require the nurse to have a senior nurse co-sign all documentation to ensure completeness and accuracy

B. Explain that objective clinical documentation of all findings — including uncomfortable observations — is a professional obligation that protects both the patient and the nurse, demonstrate how to document sensitive findings using factual, non-judgmental language, and practice with specific examples from the nurse's own patient encounters

C. Assign the nurse to a documentation workshop focused on legal defensibility in nursing records

D. Accept the nurse's documentation style since rapport-building is a valuable clinical skill and forcing negative documentation may damage the nurse-patient relationship

4. A nurse manager is implementing a communication protocol for managing patients who present with developmental disabilities. Staff report uncertainty about how to communicate with patients who have varying levels of cognitive ability, sensory processing differences, and communication preferences. Some staff default to communicating exclusively through the caregiver rather than the patient. Which approach is MOST appropriate?

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

B. Educate staff on person-first communication principles, train on adapting communication to individual cognitive and sensory abilities, establish that all communication should be directed to the patient first regardless of disability level, involve the caregiver as a communication partner rather than a substitute, and document each patient's specific communication needs and preferences

C. Request an occupational therapy consultation for all patients with developmental disabilities to assess communication needs and develop individualized communication plans

D. Implement a standardized communication approach for all patients with developmental disabilities based on best-practice guidelines for this population

5. A nurse manager is responsible for communicating during a hospital-wide power outage that has disabled the electronic health record, nurse call system, patient monitoring equipment, and lighting. Emergency generators have activated for critical systems, but the nursing unit has limited power. Staff are anxious and patients are frightened. Which communication priority is MOST critical in the first fifteen minutes?

A. Conduct an immediate census verification accounting for every patient's location and status, activate the chain of communication by briefing charge nurses who brief their teams, communicate a calm and factual assessment to staff about what systems are operational and what is not, assign specific roles for manual monitoring, and provide reassurance to patients about their safety

B. Contact the facilities department to obtain an estimated timeline for power restoration so staff and patients can be informed about the expected duration

C. Begin transcribing all current patient information from the EHR backup systems to paper so clinical data is accessible during the outage

D. Activate the unit's disaster communication plan and await instructions from the hospital's incident command system before taking unit-level action

6. A nurse manager is addressing a situation where a patient's family member who serves as the healthcare power of attorney appears to be exhibiting signs of cognitive decline. The family member is making inconsistent decisions, forgetting previous conversations about the care plan, and becoming confused about the patient's diagnosis. The patient is incapacitated and unable to participate in decisions. Which action is MOST appropriate?

A. Continue following the POA's decisions since the legal document remains valid regardless of the POA agent's cognitive status

B. Document the observations of the POA agent's inconsistent decision-making and cognitive concerns, consult with social work and the ethics committee about the POA agent's capacity to fulfill their role,

identify whether a successor agent is named in the POA document, and involve the organization's legal counsel in determining the appropriate next steps

C. Contact other family members and ask them to assume decision-making responsibility for the patient

D. Request a formal cognitive evaluation of the POA agent through the hospital's psychiatric consultation service

7. A nurse manager is developing a communication approach for a patient who has explicitly refused all digital communication — declining the patient portal, electronic discharge instructions, text message follow-up, and email communication. The patient states she does not trust digital technology and wants all information provided on paper or in person. The hospital's workflow is designed around digital communication channels. Which response is MOST appropriate?

A. Accommodate the patient's preference by providing all information through paper-based and in-person channels, ensure discharge instructions are printed rather than electronic, develop a follow-up plan using telephone rather than portal communication, and document the preference so all care team members respect the patient's communication choice

B. Explain the benefits of digital communication and encourage the patient to try the portal since it provides more comprehensive access to health information

C. Accommodate the paper preference during hospitalization but require the patient to activate the portal before discharge since post-discharge communication requires electronic access

D. Follow standard digital communication protocols and note the patient's preference in the chart without modifying the workflow

8. A nurse manager is facilitating a team meeting where a heated disagreement has erupted between two senior nurses about the best approach to a clinical protocol change. The disagreement has become personal, with each nurse questioning the other's clinical competence. Other staff are visibly uncomfortable and some are taking sides. Which facilitation intervention is MOST appropriate in the moment?

A. Allow the disagreement to continue since passionate clinical debate leads to better decisions and stifling the conversation would suppress important perspectives

B. Ask both nurses to stop and redirect the conversation to the specific clinical evidence supporting each position

C. End the meeting immediately and schedule individual conversations with both nurses to address the personal attacks privately

D. Acknowledge the passion behind both positions, name the shift from clinical debate to personal attack, redirect the conversation to the evidence, establish that clinical disagreement is valued but personal attacks are not acceptable, and model how to debate a clinical position without questioning a colleague's competence

9. A nurse manager is developing a communication strategy for a situation where the unit will be sharing nursing staff with an adjacent unit during low-census periods. Nurses will float to the adjacent unit when their home unit census drops below a threshold. Staff on both units are anxious — home unit nurses fear losing their team identity, and receiving unit nurses are concerned about float nurses' competency with their patient population. Which communication element is MOST important for both groups?

A. Present the staffing change as a temporary measure that will be re-evaluated after a trial period to reduce anxiety about permanent role changes

B. Address both units' concerns simultaneously by explaining the clinical rationale, establishing competency standards for float assignments, defining which patients float nurses can and cannot be assigned, creating a buddy system for orientation support, and involving staff from both units in developing the cross-unit float guidelines

C. Communicate the staffing change as a leadership directive that is not open for discussion since the decision has been made by organizational leadership

D. Focus communication on the home unit nurses since they are the ones being displaced and the receiving unit's concerns will resolve once they experience the float nurses' competency

10. A nurse manager is implementing a "communication board" standardization project. Currently, each patient room has a whiteboard with inconsistent information — some boards display the nurse's name, others include the care plan, and many are blank or outdated. Research shows that consistently updated communication boards improve patient satisfaction and reduce call light use. Staff report that updating boards is time-consuming and low-priority during busy shifts. Which implementation approach is MOST sustainable?

A. Assign the unit secretary to update all communication boards every four hours using information from the electronic health record

B. Install digital communication boards that auto-populate from the EHR, eliminating manual updates while maintaining real-time accuracy

C. Require charge nurses to audit all boards at the beginning of each shift and hold individual nurses accountable for incomplete boards

D. Integrate board updates into existing clinical workflows — updating the nurse's name and contact method during the introduction, care goals during the assessment, and discharge information during the planning conversation — so board maintenance becomes part of routine care rather than a separate task, supplemented by a simple standardized format that minimizes the information required

11. A nurse manager is managing communication during an active investigation of a staff member suspected of patient abuse. The investigation has not been completed, and the nurse manager cannot disclose the nature of the investigation to other staff. However, the suspected nurse has been suspended pending investigation, and colleagues are asking questions and speculating about the reason. Which communication approach is MOST appropriate?

A. Confirm that a personnel investigation is underway without disclosing details, explain that confidentiality protects all employees during investigations, redirect staff focus to patient care responsibilities, and establish that speculation is discouraged since it may compromise the investigation's integrity

B. Tell staff that the suspended nurse is on personal leave to prevent speculation about the true reason for the absence

C. Disclose the general nature of the investigation (without specifics) so staff can be vigilant about similar behaviors on the unit

D. Decline to discuss the matter entirely and instruct staff to direct all questions to human resources

12. A nurse manager is developing a structured approach to conducting "stay interviews" — proactive conversations with current employees designed to understand what keeps them engaged and what might cause them to leave. The manager plans to conduct stay interviews with all thirty-two nurses on the unit. Which approach maximizes the quality of information gathered?

A. Use a standardized online survey with the same questions as a stay interview to gather data more efficiently from all thirty-two nurses simultaneously

B. Conduct individualized face-to-face conversations using a consistent set of open-ended questions, create psychological safety by assuring confidentiality, listen without becoming defensive about critical feedback, take notes, and follow up with visible action on the most common themes — demonstrating that the information gathered leads to tangible change

C. Delegate stay interviews to the charge nurses since they have more direct daily interaction with staff and may elicit more honest responses

D. Conduct group stay interviews with four to five nurses at a time to maximize efficiency and allow nurses to build on each other's responses

13. A nurse manager is responsible for communicating cross-cultural death notification to a family whose cultural practices around death differ significantly from Western hospital norms. The family is from a culture where the eldest male family member must be the first to receive the death notification, where specific mourning rituals must begin immediately, and where the body must not be left alone after death. These practices may conflict with standard hospital post-mortem procedures. Which approach is MOST culturally responsive?

A. Follow standard hospital death notification procedures and explain to the family that hospital protocols must be followed regardless of cultural preferences

B. Contact the hospital chaplain to manage the death notification and cultural accommodation since chaplains have the most training in diverse death practices

C. Ask the family about their cultural preferences before the death occurs whenever possible to prepare for culturally appropriate notification

D. Identify the family's cultural practices in advance whenever possible, arrange for the death notification to be delivered to the designated family member, accommodate mourning rituals within the clinical environment, coordinate with hospital procedures to avoid leaving the body unattended, and document the cultural accommodation plan so all staff can support it

14. A nurse manager is implementing a communication improvement initiative based on HCAHPS data. The unit scores at the eighty-eighth percentile on "nurse communication" but at the forty-first percentile on "doctor communication." The nurse manager wants to improve the overall communication experience. Which action is MOST within the nurse manager's scope and influence?

A. Present the physician communication scores to the medical staff and request that they implement communication improvement strategies

B. Focus exclusively on maintaining and improving the nursing communication scores since physician communication is outside nursing's scope of influence

C. Develop a collaborative strategy where nursing actively supports physician communication — including preparing patients for physician visits with a list of questions, facilitating physician-patient conversations by being present during rounding, and following up with patients after physician visits to clarify information and assess understanding

D. Implement a patient communication training program that is required for both nurses and physicians on the unit

15. A nurse manager is addressing a communication pattern where nurses routinely give patients overly optimistic timelines for discharge. Nurses tell patients "you'll probably go home tomorrow" based on their clinical assessment, but physician discharge decisions frequently differ, resulting in patient disappointment and complaints. Which intervention is MOST appropriate?

A. Instruct nurses to refrain from discussing discharge timing with patients and redirect all discharge questions to the physician

B. Implement a policy requiring nurses to add a disclaimer such as "but the doctor makes the final decision" whenever they discuss discharge timing

C. Implement a scripted response for nurses that redirects discharge timing questions without providing estimates

D. Establish a communication standard where nurses discuss discharge readiness criteria with patients rather than predicting specific dates, using language such as "these are the milestones we need to reach before discharge can be considered" — shifting from time-based predictions to goal-based preparation that is within nursing's scope

16. A nurse manager is developing a plan to improve interprofessional communication on the unit by implementing a daily interprofessional huddle. Currently, each discipline — nursing, medicine, pharmacy, therapy, and social work — conducts their own planning processes independently. Information silos result in fragmented care planning. The nurse manager has convened the huddle but

attendance is inconsistent, with physicians being the most frequent non-attenders. Which strategy is MOST effective for improving physician participation?

A. Request that the chief medical officer mandate physician attendance at the daily huddle

B. Redesign the huddle to occur at a time and location that aligns with physician workflow, limit the huddle to ten minutes with a focused agenda, demonstrate that physician participation prevents downstream callbacks and clarifications that consume more time than the huddle itself, and track the impact on physician workflow efficiency

C. Allow physicians to send a representative or submit their patient updates in writing when they cannot attend in person

D. Eliminate the interprofessional huddle and replace it with a nursing-only huddle supplemented by individual discipline-to-discipline communication as needed

17. A nurse manager is preparing to deliver difficult feedback to a high-performing nurse who has developed a pattern of making clinical decisions independently that should involve physician notification. The nurse's decisions have been clinically sound, but the failure to notify the physician violates the notification protocol and creates legal and professional risk. The nurse views the protocol as unnecessary since her decisions are consistently correct. Which feedback approach is MOST effective?

A. Acknowledge the nurse's excellent clinical judgment while explaining that the notification protocol exists for situations where clinical judgment may not be correct, and that the legal and professional risk of independent decision-making extends beyond clinical accuracy to include documentation, accountability, and scope-of-practice requirements

B. Present the notification protocol as non-negotiable and require strict compliance going forward without discussing the clinical judgment dimension

C. Allow the nurse to continue making independent decisions for low-risk clinical situations and restrict the notification requirement to high-risk decisions only

D. Implement a chart audit of the nurse's independent decisions to evaluate whether her clinical accuracy justifies a modified notification approach

18. A nurse manager is developing a communication plan for a unit that will be transitioning from a geographic assignment model (nurses assigned by room location) to an acuity-based assignment model

(nurses assigned by patient complexity). The change means nurses will care for patients scattered across the unit rather than clustered in adjacent rooms. Staff are concerned about increased walking time, reduced team proximity, and communication challenges with patients in distant rooms. Which communication element is MOST important for staff buy-in?

A. Present the evidence showing that acuity-based assignments reduce workload inequity and improve patient outcomes compared to geographic models

B. Allow staff to pilot both models and vote on their preferred assignment approach

C. Acknowledge the workflow concerns, demonstrate how the acuity-based model addresses the current inequity where geographic assignment creates disproportionate workload for nurses in high-acuity room clusters, present solutions for the communication and mobility challenges including mobile technology and team-based coverage, and involve staff in designing the transition workflow

D. Implement the acuity-based model on a trial basis and evaluate staff satisfaction after thirty days before making it permanent

19. A nurse manager is responsible for a unit where a patient has been identified as a registered sex offender through a background check triggered by the patient's behavioral patterns. The patient has not committed any inappropriate behavior during the hospitalization. Staff have learned about the patient's history through informal channels and some nurses have requested to not be assigned to this patient. Which communication and assignment approach is MOST appropriate?

A. Address the staff's concerns by acknowledging their discomfort while establishing that patients are assigned based on clinical need rather than criminal history, ensure appropriate safety measures are in place for vulnerable patient populations on the unit, provide emotional support for nurses who are uncomfortable, and establish that professional care is provided equitably regardless of the patient's background

B. Accommodate all reassignment requests to prevent staff from providing care while emotionally distressed, which could compromise care quality

C. Transfer the patient to another unit where staff are unaware of the criminal history to provide a fresh start

D. Restrict the patient's visitors and implement enhanced monitoring throughout the hospitalization

20. A nurse manager is implementing a "communication escalation pathway" for nurses who feel their clinical concerns are not being adequately addressed by the responding physician. The pathway defines progressive escalation steps from bedside nurse to charge nurse to nurse supervisor to chief nursing officer. Several nurses report that activating the escalation pathway feels like "going over the physician's head" and damages their working relationship with the doctor. Which response is MOST effective?

A. Reframe the escalation pathway not as "going over the physician's head" but as "bringing additional clinical resources to the patient's bedside" — emphasizing that escalation is a patient advocacy tool that brings more expertise to bear on a clinical concern rather than a criticism of the physician's judgment, and that organizations with healthy escalation cultures have better patient outcomes than those where nurses defer to avoid conflict

B. Allow nurses to skip the escalation pathway and contact the attending physician's supervisor directly when they feel their concerns are not addressed

C. Implement an anonymous escalation system so nurses can raise concerns without the physician knowing who escalated

D. Restrict the escalation pathway to situations where the nurse can document objective clinical evidence supporting their concern

21. A nurse manager is addressing a situation where the unit's patient experience scores have declined specifically among patients who speak English as a second language. The decline is isolated to the "communication about medicines" domain. Analysis reveals that medication education is provided at the same speed and complexity level for all patients regardless of language proficiency. Which intervention is MOST targeted?

A. Require professional interpreter use for all medication education with patients who speak English as a second language

B. Implement a medication education protocol that assesses each patient's health literacy and language proficiency, adapts the complexity and pace of education accordingly, uses visual aids and demonstration for all patients, verifies understanding through teach-back in the patient's preferred language, and provides written medication instructions in the patient's primary language

C. Provide all medication education materials in the five most common languages spoken by the unit's patient population

D. Assign bilingual nursing staff to patients who speak English as a second language for all medication-related communication

22. A nurse manager is implementing a patient communication preference assessment upon admission that identifies how each patient prefers to receive clinical information — including preferred level of detail (brief overview versus comprehensive explanation), preferred communication format (verbal, written, visual), family involvement preferences, and timing preferences (morning versus evening discussions). The assessment adds three minutes to the admission process. Staff question whether the time investment is justified. Which response is MOST compelling?

A. Present the additional time as a regulatory requirement that cannot be modified to eliminate the staff objection

B. Demonstrate that the three-minute investment eliminates the repetitive communication attempts that occur when information is delivered in a format that does not match the patient's preference

C. Explain that communication preference assessment is a patient-centered care best practice that improves satisfaction scores, reduces the time nurses spend on repeated explanations, decreases patient anxiety from information overload or insufficient information, and enables personalized communication that builds trust — making the three-minute investment a net time savings over the hospitalization

D. Implement the assessment on a trial basis and compare patient satisfaction scores and nursing communication time for assessed versus non-assessed patients

23. A nurse manager is developing a strategy for communicating with a patient who is a healthcare professional — a physician admitted for a medical condition. The physician-patient frequently challenges nursing assessments, questions medication timing, and requests direct access to her laboratory results before nursing review. Several nurses report feeling intimidated and uncertain about how to maintain their professional authority while caring for a colleague who outranks them in the medical hierarchy. Which guidance is MOST appropriate?

A. Assign the most experienced and confident nurses to the physician-patient to minimize the intimidation factor

B. Coach nurses to maintain their professional nursing role regardless of the patient's professional background — conducting assessments, providing education, and documenting findings with the same rigor applied to any patient — while acknowledging the physician-patient's expertise by including her in clinical discussions and providing access to her own clinical data within organizational policy

C. Allow the physician-patient to self-manage her care to the extent she desires since her medical knowledge enables informed self-management decisions

D. Request that the attending physician establish boundaries with the physician-patient about the appropriate role of a patient versus a clinician during hospitalization

24. A nurse manager is responsible for a unit where a patient has expressed a preference for "no bad news" — stating that she does not want to be told about any negative test results, complications, or prognosis changes. She wants her husband to receive all clinical information and decide what she should be told. The patient is alert, oriented, and competent. Which response is MOST ethically and legally appropriate?

A. Respect the patient's autonomous choice to delegate information receipt to her husband, document the preference clearly, establish a communication pathway with the husband for clinical updates, and continue to assess whether the patient's preference changes over time — while ensuring that clinical care is not compromised by the information delegation

B. Override the patient's preference since informed consent requires that the patient personally understand her clinical condition

C. Contact the ethics committee since the patient's request to not receive her own medical information raises ethical concerns about informed decision-making

D. Follow the patient's preference for now but require that she personally receive information about any decision that requires her consent

25. A nurse manager is developing a communication protocol for managing the transition conversation when a patient's condition changes from curative-intent to comfort-focused care. Currently, this transition is communicated abruptly — often by a physician stating "there is nothing more we can do" — leaving patients and families feeling abandoned. Which communication framework is MOST effective for this transition?

A. Implement a mandatory palliative care consultation for all patients transitioning to comfort-focused care

B. Train physicians to use different language when communicating the transition to avoid the "nothing more we can do" phrasing

C. Develop a structured transition conversation framework that reframes the shift from "stopping treatment" to "changing the goals of care," involves the patient and family in defining what matters most

during this phase, introduces the palliative team as new partners rather than replacements, and ensures continuity of the nursing relationship throughout the transition

D. Provide patients and families with written materials about comfort-focused care and hospice options before the transition conversation occurs

26. A nurse manager is addressing a pattern where nurses on the unit communicate differently with patients based on the patient's insurance status. Data shows that nurses spend an average of twelve minutes per interaction with commercially insured patients and seven minutes per interaction with Medicaid patients. The communication content is also different — commercially insured patients receive more detailed explanations and more frequent proactive check-ins. Which response is MOST appropriate?

A. Present the communication disparity data to staff without attributing motive, establish that equitable communication is a professional standard, implement standardized communication expectations that apply regardless of insurance status, and monitor the disparity through ongoing audits

B. Require all nurses to complete an implicit bias training program focused on socioeconomic bias in healthcare communication

C. Implement a minimum communication time standard for all patients to ensure equitable contact regardless of insurance status

D. Accept that some variation in communication time is natural since commercially insured patients may ask more questions and engage more actively in their care

27. A nurse manager is implementing a "patient story" program where patients share their hospitalization experiences with the nursing staff during unit meetings. The program aims to humanize quality data and motivate improvement through emotional connection to patient experiences. After three successful sessions, a patient shares a story that includes criticism of a specific nurse by name. The named nurse is present and visibly upset. Which facilitation response is MOST appropriate?

A. Thank the patient for sharing, immediately redirect the conversation away from the individual nurse, and process the feedback with the named nurse privately after the session

B. Allow the patient to finish their story without interruption since authentic patient voices should not be censored

C. Acknowledge the patient's experience, clarify that the program focuses on system improvement rather than individual performance, redirect the conversation to the systemic factors that contributed to the patient's experience, ensure the named nurse receives support after the session, and establish ground rules for future sessions that protect individual staff while preserving authentic patient voice

D. Discontinue the patient story program since the risk of individual staff being named creates a hostile environment

28. A nurse manager is developing a communication standard for managing patients who are actively withdrawing from substances during their medical hospitalization. These patients may exhibit agitation, paranoia, mood lability, and perceptual disturbances that affect their ability to communicate coherently. Staff report difficulty distinguishing between withdrawal symptoms and deliberate uncooperative behavior, leading to communication breakdowns. Which education element is MOST important?

A. Training on the pharmacological management of withdrawal syndromes so nurses can administer appropriate symptom-management medications

B. Education on behavioral management techniques for managing agitated patients safely during withdrawal episodes

C. Training on recognizing that withdrawal is a medical condition, not a behavioral choice, and providing clinical assessment tools that help nurses distinguish between withdrawal-related communication impairment and deliberate behavior

D. Educate staff that withdrawal-induced communication impairment is a medical condition requiring clinical management rather than behavioral correction, train on withdrawal-specific communication techniques including calm and simple language during agitation, frequent reorientation during confusion, validation during paranoia, and reassessment of communication capacity as withdrawal symptoms cycle through intensity levels

29. A nurse manager is responsible for communicating a decision to permanently close one of the unit's two medication preparation rooms to create space for a new clinical function. Nurses rely on the proximity of the second preparation room and are angry about the closure. The nurse manager agrees with the decision but understands the staff's frustration. Which communication approach is MOST effective?

A. Communicate the decision transparently including the rationale, acknowledge the legitimate workflow impact, involve staff in redesigning the medication preparation workflow to accommodate the

single-room configuration, and commit to evaluating whether the workflow changes maintain medication safety and efficiency

B. Implement the closure without discussion since staff resistance will not change the organizational decision

C. Express personal disagreement with the decision to demonstrate solidarity with staff while implementing it as directed

D. Delay the closure until a workflow analysis can demonstrate that a single preparation room will not compromise medication safety

30. A nurse manager is evaluating the unit's barcode medication administration system compliance. Audit data shows ninety-three percent scanning compliance, but a closer analysis reveals that seven percent of doses are administered without barcode scanning. When nurses bypass the scanning step, they lose the system's ability to detect wrong-patient, wrong-medication, and wrong-dose errors. Investigation reveals three primary reasons for bypass: scanner malfunction, patient armband unavailable, and time pressure during emergencies. Which improvement is MOST effective?

A. Address each bypass reason with a targeted solution — ensuring backup scanners are available, implementing a process for replacing missing armbands before medication administration, and developing an emergency medication protocol that maintains verification without slowing emergent care — to reduce bypass without creating new workarounds

B. Implement a zero-tolerance policy for barcode scanning bypass and discipline nurses who administer medications without scanning

C. Accept the seven percent bypass rate since ninety-three percent compliance is above the national average

D. Replace the barcode scanning system with a facial recognition system that eliminates the armband dependency

31. A nurse manager is reviewing the unit's smart pump drug library compliance data. The smart pump drug library contains pre-programmed dose limits that prevent nurses from administering dangerously high or low medication doses. Analysis shows that nurses override the drug library soft limits (advisory alerts that can be bypassed) for eighteen percent of infusions. Which investigation is MOST important?

A. Determine whether the soft limit parameters in the drug library are appropriately set for the unit's patient population or whether they are generating excessive alerts that do not reflect genuine dosing concerns

B. Identify the specific nurses who override most frequently and provide targeted re-education

C. Tighten all soft limits to reduce the override rate below ten percent

D. Analyze the override data to determine whether overrides are clinically appropriate (the drug library parameters are too restrictive for the patient population) or clinically inappropriate (nurses are bypassing valid safety alerts), and use this distinction to either adjust library parameters or address the override behavior

32. A nurse manager is developing a surgical count discrepancy management protocol. During a bedside procedure, the post-procedure instrument count reveals one sponge unaccounted for. The physician states the sponge was not used and wants to close the wound without further investigation. Which action is MOST appropriate?

A. Accept the physician's assertion and close the wound since the physician has the best visibility of the procedural field

B. Complete the wound closure and order a post-procedure X-ray to verify no retained sponge

C. Notify the charge nurse and document the count discrepancy for post-procedure follow-up

D. Refuse to accept an incorrect count, communicate the discrepancy clearly to the physician using assertive language, insist on a recount and search of the procedural field, and if the sponge cannot be located, request radiographic imaging before wound closure — following the established retained foreign body prevention protocol

33. A nurse manager is implementing a blood product wastage reduction program. Data shows that twelve percent of blood products issued to the unit are wasted — primarily because they are not transfused within the required time window after removal from controlled storage. The most common reason is that the blood arrives on the unit but the nurse is unavailable to begin the transfusion within the thirty-minute window. Which intervention is MOST targeted?

A. Request that the blood bank deliver products only after the nurse confirms readiness to begin the transfusion

B. Implement a pre-transfusion readiness checklist that the nurse completes before requesting blood products from the blood bank

C. Coordinate blood product delivery timing with nursing workflow by implementing a nurse-initiated request system where the blood bank releases the product only after the nurse signals readiness, combined with a real-time tracking system that alerts the nurse when the time window for transfusion initiation is approaching

D. Assign a dedicated transfusion nurse on each shift who manages all blood product administration and ensures timely initiation

34. A nurse manager is evaluating a clinical pathway variance report for total knee arthroplasty patients. The pathway specifies day-of-surgery mobilization, a targeted two-day length of stay, and discharge to home with home health services. Data shows:

| Variance | Frequency | Impact |

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

| Delayed mobilization (Day 1 instead of Day 0) | 38% | +0.8 day LOS |

| Pain management requiring IV opioids beyond Day 1 | 22% | +0.5 day LOS |

| Discharge to SNF instead of home | 18% | +1.2 day LOS |

| Post-op nausea delaying oral medication transition | 15% | +0.3 day LOS |

Which variance should receive the HIGHEST improvement priority?

A. Post-operative nausea since it is the most easily preventable through prophylactic antiemetic protocols

B. Pain management since opioid reduction is both a clinical and regulatory priority

C. Discharge disposition since it adds the most days to length of stay per occurrence

D. Delayed mobilization because it has the highest frequency AND adds the most total excess days across all patients (38% × 0.8 = 0.304 excess days per patient, compared to discharge disposition at 18% × 1.2 = 0.216), making it the variance with the greatest overall LOS impact

35. A nurse manager is implementing a patient safety culture survey action plan based on results from the AHRQ Hospital Survey on Patient Safety Culture. The survey reveals that the unit scores in the bottom quartile on "nonpunitive response to error" — meaning staff believe that errors are held against them and that reporting events goes in their personnel file. All other safety culture dimensions score above average. Which finding MOST accurately explains why strong performance on other dimensions may not protect patient safety?

A. A punitive error response culture undermines all other safety dimensions because staff who fear punishment underreport events, hide near-misses, avoid asking for help when uncertain, and do not participate honestly in safety improvement activities — creating an invisible foundation of unreported risk beneath the surface of apparently healthy safety metrics

B. The bottom-quartile score on nonpunitive response is an outlier that may reflect a single recent disciplinary event rather than a true cultural pattern

C. The survey results should be validated with focus groups before developing an action plan since surveys may not accurately capture safety culture

D. The strong scores on other dimensions compensate for the nonpunitive response weakness, suggesting the overall safety culture is adequate

36. A nurse manager is developing an infection prevention sustainability strategy. The unit recently completed a CLABSI reduction project that achieved a seventy percent decrease in infections over six months. However, the nurse manager is aware that quality improvement gains frequently regress to baseline after the project's focused attention ends. Which sustainability element is MOST critical?

A. Assign a dedicated infection prevention champion who maintains focus on CLABSI prevention after the formal project ends

B. Continue monthly reporting of CLABSI rates to maintain staff awareness of performance

C. Embed the successful prevention practices into standard work documentation, orientation content, competency validation, and daily leadership standard work so the practices become the default operating standard rather than a project-dependent initiative

D. Celebrate the achievement publicly to reinforce the team's commitment to maintaining the gains

37. A nurse manager is evaluating the effectiveness of the unit's rapid response team utilization. Data shows:

| Metric | Unit | Benchmark |
|---|---|---|
| RRT activations/1,000 patient days | 12.8 | 8.5 |
| Unplanned ICU transfers/1,000 PD | 3.2 | 5.1 |
| Code Blue events/1,000 PD | 0.4 | 1.2 |

Which interpretation is MOST accurate?

A. The higher-than-benchmark RRT activation rate combined with lower-than-benchmark ICU transfer and code blue rates suggests that the unit is effectively using rapid response to identify and manage deterioration early, preventing the need for ICU transfer and cardiac arrest — the pattern indicates appropriate utilization rather than over-activation

B. The RRT activation rate is too high and the unit should implement stricter activation criteria to reduce unnecessary activations

C. The low ICU transfer rate may indicate that the unit is managing patients who should be in the ICU, creating a hidden safety risk

D. The data suggests the unit should reduce RRT activations to align with the benchmark since the higher rate may be consuming organizational resources unnecessarily

38. A nurse manager is implementing a comprehensive smoke-free campus policy that prohibits tobacco use anywhere on hospital property — including outdoor areas, parking lots, and personal vehicles parked on hospital grounds. Several patients become agitated and threaten to leave against medical advice because they cannot smoke. Staff are unsure how to manage patients experiencing nicotine withdrawal symptoms. Which approach is MOST comprehensive?

A. Allow exceptions for patients who become agitated and designate a specific outdoor area for patient tobacco use to prevent AMA discharges

B. Implement the policy strictly and offer nicotine replacement therapy as the standard alternative

C. Focus enforcement efforts on visitors and staff while allowing inpatients to use tobacco in designated outdoor areas

D. Implement the smoke-free policy alongside a comprehensive nicotine dependence management protocol that includes assessment of nicotine dependence upon admission, proactive nicotine replacement therapy initiation, staff training on managing nicotine withdrawal, compassionate communication about the policy, and discharge planning that connects patients with tobacco cessation resources

39. A nurse manager is reviewing the unit's compliance with the Joint Commission's medication management standards. An audit reveals that sixteen percent of multi-dose medication vials on the unit are missing the required "beyond-use date" label — the date after which the vial must be discarded following initial puncture. Which action is MOST appropriate?

A. Implement a point-of-use labeling system where the nurse is required to label every multi-dose vial with the beyond-use date at the time of first access, integrate the labeling step into the medication administration workflow, provide labeling supplies at every preparation station, and establish a daily environmental scan to identify and discard unlabeled or expired vials

B. Replace all multi-dose vials with single-dose vials to eliminate the labeling requirement entirely

C. Assign the charge nurse to conduct a daily medication room audit and discard any unlabeled multi-dose vials

D. Send a unit-wide reminder about the beyond-use date labeling requirement and monitor compliance during the next monthly audit

40. A nurse manager is developing a plan to address hospital-acquired delirium prevention. The unit's delirium prevalence is twenty-eight percent among patients over sixty-five, compared to a benchmark of eighteen percent. Current delirium screening compliance using the Confusion Assessment Method is forty-one percent. Which improvement should the nurse manager prioritize FIRST?

A. Increase CAM screening compliance to at least ninety percent before addressing delirium prevention interventions, since accurate identification of the problem's scope is required before effective prevention can be designed and measured

B. Implement a multicomponent delirium prevention bundle for all patients over sixty-five without waiting for improved screening compliance

C. Request a geriatric psychiatry consultation for all patients over sixty-five upon admission to proactively manage delirium risk

D. Educate nursing staff on the clinical presentation of delirium to improve recognition without relying on the formal screening tool

41. A nurse manager reviews the following unit quality data:

| Quarter | Hand Hygiene % | CLABSI Rate | CAUTI Rate | Falls Rate |

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

| Q1 | 92% | 0.0 | 1.4 | 2.8 |

| Q2 | 89% | 0.4 | 1.6 | 2.5 |

| Q3 | 85% | 0.8 | 2.0 | 3.1 |

| Q4 | 81% | 1.2 | 2.3 | 3.4 |

Which finding provides the MOST actionable insight?

A. Each individual indicator is trending unfavorably and requires separate improvement initiatives

B. The hand hygiene rate has declined by only eleven percentage points over four quarters, which may represent normal seasonal variation

C. The CAUTI rate increase is the most concerning since it has the steadiest worsening trend

D. The declining hand hygiene compliance over four quarters correlates with simultaneous worsening across all three outcome indicators, suggesting that the hand hygiene decline may be a contributing

factor to the infection increases and that restoring hand hygiene compliance may be the single highest-impact intervention affecting multiple outcomes simultaneously

42. A nurse manager is developing a protocol for managing patients who present with symptoms consistent with an opioid overdose. The unit is not an emergency department but occasionally admits patients who experience overdose as a complication of prescribed pain management. Which protocol element is MOST critical for all nursing staff?

A. Training on the legal protections provided by the state's Good Samaritan law for individuals who administer naloxone

B. Education on the post-reversal monitoring requirements since naloxone's duration of action is shorter than most opioids and patients may re-sedate after initial reversal

C. Immediate access to naloxone with staff competency in dosing, administration routes, and post-administration monitoring, including recognition that naloxone's duration of action is shorter than most opioids and re-sedation monitoring is essential

D. A protocol requiring physician notification before naloxone administration since opioid reversal may be contraindicated in patients with chronic pain management plans

43. A nurse manager is evaluating the unit's patient safety event data and identifies that sixty-two percent of medication errors involve high-alert medications — specifically insulin, anticoagulants, and opioids. Which interpretation is MOST actionable?

A. The unit should implement enhanced safety protocols specifically for insulin, anticoagulants, and opioids since targeted interventions for the highest-risk medications will produce the greatest absolute error reduction

B. Implement enhanced safety protocols for all medications since the remaining thirty-eight percent of errors involve non-high-alert medications that also require attention

C. The high-alert medication error rate is expected since these medications have inherently higher risk profiles and the sixty-two percent proportion is consistent with national patterns

D. Focus improvement efforts on the prescribing phase since high-alert medication errors most commonly originate with inappropriate ordering rather than administration

44. A nurse manager is implementing a patient engagement technology system that sends automated text messages to patients about their care activities — including medication reminders, therapy schedules, and meal selections. During the first month, twenty-three percent of patients opt out of the messaging service. Exit surveys from opt-out patients reveal two primary reasons: message fatigue from excessive texts and concern about personal health information being transmitted via text. Which adjustment is MOST appropriate?

A. Reduce the number of automated messages to the three most clinically important communications per day

B. Implement end-to-end encryption for all patient text messages and communicate the security measures to patients

C. Redesign the messaging system to allow patients to select which message categories they receive, implement frequency limits that prevent message fatigue, communicate the security and privacy protections clearly during enrollment, and provide a simple opt-in/opt-out mechanism that respects patient autonomy while maintaining clinical communication value

D. Replace text messaging with an in-app notification system that does not use the patient's personal phone number

45. A nurse manager is developing a response to a new regulatory requirement mandating that hospitals report nursing-sensitive quality indicators to a state database. The required indicators include falls, pressure injuries, CLABSI, CAUTI, and nurse staffing data. The nurse manager must ensure data accuracy before submission. Which data validation process is MOST rigorous?

A. Implement a multi-level validation process where frontline nurses verify individual event data at the point of documentation, the quality team validates aggregated data against medical record review, the nurse manager reviews the final submission for clinical accuracy, and any discrepancies between data sources are reconciled before state submission

B. Assign the quality department to validate all data before submission since they have the expertise in data management and regulatory reporting

C. Compare the unit's data to the previous quarter's data and investigate any significant deviations before submission

D. Conduct a random sample chart audit of twenty percent of reported events to verify accuracy before submission

46. A nurse manager is implementing a nurse-driven protocol for continuous pulse oximetry monitoring. The protocol defines which patients require continuous monitoring, which can be assessed intermittently, and the criteria for discontinuing continuous monitoring. Currently, seventy-eight percent of patients on the unit are on continuous pulse oximetry regardless of clinical indication. Staff report that it is "easier to leave the monitor on than to justify removing it." Which concern is MOST significant?

A. The cost of continuous monitoring supplies and equipment for patients who do not require it

B. Unnecessary continuous monitoring contributes to alarm fatigue, desensitizes staff to genuine alarms, and may paradoxically reduce patient safety by creating a clinical environment where clinically significant alarms are more likely to be missed amid the noise of clinically unnecessary monitoring

C. The nursing time spent managing alarms and responding to false alerts for patients who do not require monitoring

D. The potential for continuous monitoring to cause skin breakdown from prolonged adhesive sensor application

47. A nurse manager is developing a plan to improve the unit's performance on the CMS Hospital Star Rating, which combines multiple quality measures into a single composite score. The unit's contribution to the overall hospital rating is primarily through nurse-sensitive indicators. Analysis reveals that the hospital's overall star rating has declined from four stars to three stars, with the largest decline in the "patient experience" domain. Which improvement strategy is MOST likely to affect the star rating?

A. Focus exclusively on clinical outcome measures since they receive the highest weighting in the star rating calculation

B. Address all domains simultaneously since the star rating is a composite that reflects performance across multiple dimensions

C. Prioritize the patient experience domain since it showed the largest decline and represents the greatest opportunity for improvement, implement targeted interventions for the specific HCAHPS dimensions where the hospital scores lowest, and track the impact on the composite star rating

D. The star rating methodology is too complex for unit-level intervention and should be addressed through an organizational-level strategic initiative

48. A nurse manager is evaluating the unit's approach to managing patients with implanted cardiac devices — pacemakers, defibrillators, and cardiac resynchronization therapy devices. Several incidents have occurred where nursing staff failed to identify the presence of an implanted device during admission, resulting in inappropriate application of monitoring equipment and failure to implement device-specific safety precautions. Which system improvement is MOST effective?

A. Implement a mandatory chest X-ray for all admitted patients to screen for implanted cardiac devices

B. Include a specific cardiac device screening question in the nursing admission assessment with follow-up prompts for device type, manufacturer, and last interrogation date

C. Educate all nursing staff on how to identify implanted cardiac devices through physical examination and history

D. Integrate a cardiac device identification question into the admission assessment with mandatory response, connect positive responses to an automated alert system that triggers device-specific safety protocols and cardiology notification, and flag the patient's record so all subsequent providers are aware of the implanted device

49. A nurse manager is developing a strategy to reduce unnecessary urinary catheter use on the unit. Current catheter utilization data shows that forty-one percent of catheterized patients do not meet evidence-based indication criteria. The nurse-driven catheter removal protocol was implemented six months ago but has only reduced utilization by three percent. Investigation reveals that nurses are conducting the assessment but are reluctant to remove catheters without physician confirmation. Which barrier is MOST significant?

A. The nurse-driven protocol empowers nurses to remove catheters independently, but the organizational culture has not shifted to support autonomous nursing decision-making for device removal — nurses distrust their authority to act independently on a clinical decision that has traditionally required physician involvement, and this cultural barrier persists despite the protocol's formal authorization

B. The assessment criteria may be too complex for bedside nurses to apply consistently

C. Physicians may be re-ordering catheters after nurses remove them, negating the protocol's effectiveness

D. The three percent reduction may represent the maximum achievable improvement since the remaining catheterized patients may have undocumented clinical indications

50. A nurse manager is developing a quality improvement project to reduce the unit's rate of patient identification errors. Data shows that identification errors occur most frequently during three high-risk activities: medication administration, specimen collection, and blood product transfusion. The root cause analysis reveals that sixty-eight percent of identification errors involve a nurse who verified the patient's identity passively — reading the name and birthdate to the patient who simply nodded agreement — rather than actively requiring the patient to state their own identifiers. Which intervention is MOST effective?

A. Implement a policy requiring patients to state their name and date of birth before all high-risk activities

B. Implement a mandatory active identification standard where patients state their own identifiers for all high-risk activities, supplement with barcode scanning technology, educate patients about their role in the identification process, and create a visual prompt at the point of care reminding nurses to use active rather than passive verification

C. Replace verbal identification with barcode scanning technology that eliminates the need for verbal verification entirely

D. Post identification verification reminders at each bedside workstation

51. A nurse manager is applying the concept of "emotional intelligence" in leadership practice. Daniel Goleman identified five components of emotional intelligence: self-awareness, self-regulation, motivation, empathy, and social skills. Assessment reveals that the nurse manager has strong empathy and social skills but struggles with self-regulation — specifically, difficulty managing frustration during high-stress situations, which occasionally results in sharp responses to staff. Which development approach is MOST targeted?

A. Attend an emotional intelligence workshop that covers all five components comprehensively

B. Develop self-regulation techniques through executive coaching, practice identifying frustration triggers before they escalate, build a repertoire of pause-and-redirect strategies for high-stress moments, seek feedback from trusted colleagues about the impact of reactive responses, and journal about high-stress encounters to build self-awareness about the emotional patterns that precede loss of regulation

C. Develop self-regulation through practice by deliberately exposing oneself to stressful situations and practicing measured responses

D. Delegate high-stress management situations to the charge nurse team to avoid triggering the self-regulation difficulty

52. A nurse manager is implementing a talent management pipeline that identifies, develops, and retains high-potential nurses at every career stage. The pipeline concept ensures that the unit always has nurses developing toward every critical role — charge nurse, preceptor, quality champion, and future manager. Currently, no structured pipeline exists and succession gaps are addressed reactively when vacancies occur. Which element is MOST critical for pipeline effectiveness?

A. Identifying and investing in the development of nurses at multiple career stages simultaneously so that the pipeline produces a continuous flow of prepared candidates rather than a periodic burst of development activity triggered by vacancy

B. Creating a formal assessment process to identify the highest-potential nurses and concentrating development resources on this elite group

C. Implementing a leadership development curriculum that all interested nurses can complete at their own pace

D. Partnering with a local university to provide a graduate-level leadership development program for identified high-potential nurses

53. A nurse manager is applying the distinction between "coaching" and "mentoring" in leadership development. While the terms are often used interchangeably, they serve different developmental purposes. Which distinction is MOST accurate?

A. Coaching is provided by external consultants while mentoring is provided by organizational leaders

B. Coaching focuses on specific skill or performance improvement through structured practice, feedback, and accountability for defined objectives, while mentoring focuses on broader career and professional development through relationship-based guidance, wisdom sharing, and long-term career navigation

C. Coaching is appropriate for new nurses while mentoring is appropriate for experienced nurses seeking career advancement

D. Coaching addresses performance deficits while mentoring supports professional growth — making coaching remedial and mentoring developmental

54. A nurse manager is developing an "inclusive leadership" approach that ensures all voices on the team are heard, valued, and integrated into decision-making. Assessment reveals that the unit's decision-

making is dominated by a small group of vocal, experienced nurses while newer, quieter, and culturally diverse team members rarely contribute to discussions. Which intervention is MOST effective?

A. Require every team member to speak during each staff meeting by implementing a structured round-robin format

B. Create an anonymous suggestion system so quiet team members can contribute ideas without the pressure of speaking publicly

C. Acknowledge the contribution imbalance and allow natural evolution as newer team members gain confidence over time

D. Implement multiple participation channels including written pre-meeting input, structured small-group discussions, digital suggestion platforms, and deliberate facilitation techniques that draw out quieter voices, while simultaneously addressing the dominance pattern by coaching vocal members on creating space for others and modeling inclusive communication

55. A nurse manager is applying the concept of "organizational learning" from Chris Argyris's theory. Argyris identified "defensive routines" as patterns of behavior that prevent organizations from learning — including blaming individuals for system failures, avoiding discussion of uncomfortable truths, and creating the appearance of consensus when genuine disagreement exists. The nurse manager observes that quality improvement discussions consistently identify individual nurse performance as the root cause of safety events rather than examining system factors. Which intervention is MOST foundational?

A. Implement a just culture framework that formally distinguishes between individual error, at-risk behavior, and reckless behavior

B. Train the quality improvement team in root cause analysis methodology that requires identification of system-level contributing factors

C. Model the disruption of defensive routines by publicly questioning the individual-blame pattern during quality discussions, asking "what about our system allowed this error to occur?" rather than accepting "the nurse made a mistake" as sufficient analysis, and creating psychological safety for the team to examine uncomfortable system truths

D. Hire an external consultant to facilitate quality discussions and prevent the defensive routine pattern from dominating

56. A nurse manager is implementing a "strategic planning cascade" that translates the organization's strategic goals into unit-level objectives, team-level targets, and individual performance expectations. The cascade ensures alignment from organizational vision to individual nurse behavior. Which element is MOST critical for the cascade to produce meaningful behavioral change at the bedside?

A. Clear documentation of the strategic plan and its unit-level translation in a format accessible to all staff

B. Regular communication about the strategic plan during staff meetings to maintain awareness

C. Integration of strategic objectives into the annual performance evaluation criteria

D. Translation of strategic objectives into specific, observable nursing behaviors that individual nurses can perform daily — connecting abstract organizational goals like "improve patient experience" to concrete bedside actions like "sit at eye level during patient interactions and use teach-back for all medication education" — so that every nurse understands exactly what the strategic plan requires of them personally

57. A nurse manager is addressing a situation where the unit's quality improvement team has become what Peter Senge calls a "learning disabled" team — exhibiting the characteristic of "the myth of the management team." This disability occurs when team members maintain the appearance of cohesion and consensus while privately disagreeing, suppressing conflict, and avoiding genuine inquiry that might threaten team harmony. The QI team produces polite discussions but no challenging analysis or innovative solutions. Which intervention is MOST effective?

A. Replace several team members with staff who are more naturally inclined toward critical thinking and constructive conflict, changing the team's composition to break the consensus pattern

B. Implement a structured decision-making process that requires documentation of dissenting views before consensus can be declared

C. Assign a "devil's advocate" role that rotates among team members, requiring one person each meeting to challenge the prevailing direction

D. Address the dysfunction directly by naming the pattern, establishing that genuine disagreement is valued more than artificial harmony, modeling constructive conflict by publicly questioning assumptions, and creating structured opportunities for dissent — then reinforcing the new norm by celebrating instances where challenged assumptions led to better outcomes

58. A nurse manager is developing a leadership development plan for a nurse who has been identified as having strong "leader emergence" qualities — the tendency to naturally assume leadership roles in informal group settings. However, this nurse has no interest in formal leadership positions, stating that she leads best "from the floor" through clinical excellence and peer influence. Which development approach MOST effectively leverages this nurse's leadership potential?

A. Create a formalized clinical leadership role that provides a title, defined responsibilities, and professional advancement without requiring transition to management — such as a clinical practice leader, evidence-based practice champion, or peer mentor coordinator — that channels the nurse's natural leadership into structured organizational impact

B. Accept the nurse's preference and allow her to continue influencing peers informally without formalization

C. Encourage the nurse to reconsider formal leadership since her natural abilities would make her an excellent charge nurse or manager

D. Assign the nurse as a preceptor to formalize one dimension of her leadership without requiring broader formal role transition

59. A nurse manager is applying the concept of "systems archetypes" from Peter Senge's systems thinking framework. The unit is experiencing a "limits to growth" archetype — an improvement initiative (bedside shift report) produced early gains in patient satisfaction, but the improvement has plateaued and satisfaction scores have stopped increasing despite continued implementation. The limits to growth archetype states that every growth process encounters a limiting factor that must be identified and addressed for growth to continue. Which analysis is MOST appropriate?

A. Increase the intensity of bedside shift report implementation by requiring more detailed report content and longer report duration

B. Benchmark against units with higher satisfaction scores to identify additional best practices to supplement bedside shift report

C. Identify the specific limiting factor that is constraining further improvement — which could be staff fatigue with the process, patient populations that do not benefit from bedside report, competing communication gaps in other dimensions, or saturation of the specific satisfaction question being measured — and address that constraint rather than intensifying the original intervention

D. Accept the plateau as the natural ceiling for this intervention and redirect improvement efforts to other patient experience dimensions

60. A nurse manager is navigating an ethical leadership dilemma where organizational pressure to reduce length of stay conflicts with the nurse manager's clinical assessment that premature discharge is causing preventable readmissions. The nurse manager has presented data supporting this assessment but organizational leadership has not modified the LOS target. The tension between organizational loyalty and patient advocacy is creating personal moral distress. Which leadership approach is MOST appropriate?

A. Comply with the organizational directive and manage the moral distress through personal coping strategies

B. Escalate the concern through the organizational chain of command one final time with a comprehensive data presentation and then accept the organizational decision

C. Continue to advocate through appropriate channels by presenting increasingly refined data, propose a compromise such as risk-stratified LOS targets that protect high-readmission-risk patients, seek allies among physician and quality leadership who share the concern, and document the advocacy efforts — while maintaining professional performance and exploring whether external reporting options exist if patient safety is genuinely compromised

D. Resign from the position since continuing to implement a policy that causes patient harm violates professional ethics

61. A nurse manager is developing a comprehensive approach to managing the unit during a period of transformational change — a complete redesign of the care delivery model, implementation of new technology, and a significant staffing model change occurring simultaneously. Staff describe feeling overwhelmed by the volume and pace of change. Which leadership behavior is MOST important during transformational change?

A. Slow the pace of change by implementing one initiative at a time to prevent overwhelming staff

B. Maintain constant visible leadership presence, communicate with radical transparency about what is changing and why, provide emotional support through the transition process, create stability anchors by identifying what is NOT changing, celebrate small victories throughout the transformation, and explicitly acknowledge that the volume of change is genuinely difficult — validating staff feelings while maintaining forward momentum

C. Delegate change management to a dedicated transition team so the nurse manager can maintain focus on daily operations

D. Focus communication on the positive outcomes expected from the transformation and minimize discussion of the challenges to maintain staff optimism

62. A nurse manager is applying the concept of "coaching for performance" versus "coaching for development." Performance coaching addresses specific performance gaps that need correction, while developmental coaching builds capabilities for future roles. A charge nurse consistently meets all current performance expectations but does not demonstrate the strategic thinking, conflict resolution, or change management skills needed for the nurse manager role she aspires to. Which coaching approach is MOST appropriate?

A. Performance coaching to address the gap between current skills and the requirements of the desired future role

B. A dual approach that acknowledges the charge nurse meets current performance standards while implementing developmental coaching focused on the specific capabilities required for the next role

C. Developmental coaching that assigns stretch projects requiring strategic thinking, provides conflict resolution mentoring, creates opportunities to lead change initiatives, and offers structured reflection on the experiences — building capabilities through guided experience rather than classroom learning

D. Recommend that the charge nurse pursue a graduate leadership program to develop the strategic skills the nurse manager role requires

63. A nurse manager is developing a strategy for leading through a period of organizational ambiguity. The hospital is considering a merger, potential layoffs have been rumored, and the strategic direction is unclear. Staff look to the nurse manager for information and reassurance, but the nurse manager has limited information. Which leadership principle is MOST critical during ambiguity?

A. Maintain consistent, honest communication that shares what is known, acknowledges what is unknown, commits to sharing information as it becomes available, and demonstrates stability through predictable leadership behaviors — proving through action that the nurse manager's reliability does not depend on organizational clarity

B. Provide reassurance that the situation will resolve positively to maintain staff morale during the uncertain period

C. Focus exclusively on operational excellence and avoid discussing the organizational ambiguity since the situation is beyond the nurse manager's control

D. Prepare staff for the worst-case scenario so they are not surprised by negative outcomes

64. A nurse manager is evaluating the unit's approach to conflict management and identifies four distinct conflict patterns:

| Pattern | Frequency | Impact |
|---|---|---|
| Nurse-nurse scheduling disputes | 40% | Low |
| Nurse-physician clinical disagreements | 25% | High |
| Nurse-patient/family complaints | 20% | Medium |
| Interdepartmental workflow conflicts | 15% | Medium |

Which conflict management prioritization is MOST strategic?

A. Address nurse-nurse scheduling disputes first since they represent the highest frequency and create the most daily friction

B. Address all four patterns simultaneously since conflict management requires a comprehensive approach

C. Address nurse-patient/family complaints first since they directly affect patient satisfaction scores

D. Prioritize nurse-physician clinical disagreements since they have the highest clinical impact despite lower frequency — unresolved clinical disagreements directly affect patient care decisions, and developing effective interprofessional conflict resolution skills will also improve the team's capacity to manage the other conflict patterns

65. A nurse manager is implementing a "leader-as-teacher" development model where the nurse manager intentionally creates learning opportunities from daily operational events. Rather than simply solving problems, the nurse manager uses each situation as a teaching moment that develops staff problem-solving capability. A charge nurse approaches the nurse manager with a staffing problem:

"We're short one nurse tonight and I don't know what to do." Which response BEST demonstrates the leader-as-teacher approach?

A. Solve the problem by calling the staffing office and arranging coverage, then explain to the charge nurse what steps you took so she can replicate the process next time

B. Ask the charge nurse "what options have you considered?" and guide her through evaluating each option — including calling in available staff, adjusting assignments to manage with current resources, and contacting the staffing office — coaching her through the decision-making process rather than making the decision for her

C. Direct the charge nurse to the staffing policy manual and allow her to work through the solution independently

D. Solve the problem immediately since patient safety is at stake and the teaching moment can occur after the crisis is resolved

66. A nurse manager is evaluating the effectiveness of the unit's shared governance model and identifies a critical distinction between "shared governance" and "participative management." In authentic shared governance, nursing staff have designated areas of decision-making authority where their decisions are final — such as clinical practice standards and peer review. In participative management, staff provide input but management retains final decision-making authority. The unit's model is labeled "shared governance" but operates as participative management. Which finding MOST clearly reveals this discrepancy?

A. The governance council's meeting attendance is declining, suggesting staff do not perceive the council as meaningful

B. The governance council produces recommendations that are frequently modified or overruled by the nurse manager before implementation

C. Staff report that the governance council is "a waste of time" because their input does not lead to visible change

D. The governance council's recommendations are implemented only when the nurse manager agrees with them, and are modified or rejected when they conflict with the manager's preferences — demonstrating that decision-making authority has not genuinely been transferred to the council and the model is advisory rather than governmental

67. A nurse manager is applying the concept of "relational leadership" — a framework that defines leadership not as a property of an individual but as a process that occurs in the relationships between people. Relational leadership theory suggests that leadership effectiveness depends more on the quality of leader-follower relationships than on the leader's individual skills. Assessment reveals that the nurse manager has strong relationships with day shift staff but weak relationships with night shift staff. Which consequence is MOST predictable?

A. Night shift will have higher turnover rates because staff who lack a quality relationship with their leader have weaker organizational commitment and receive fewer development opportunities

B. Night shift performance will be comparable to day shift since professional nurses perform their duties regardless of their relationship with leadership

C. Night shift will develop stronger peer relationships to compensate for the weaker leader-follower relationship

D. Night shift staff will gravitate toward the charge nurse as their primary leader, effectively creating a dual leadership structure that may produce inconsistency between shift-level practices

68. A nurse manager is applying the AONL competency of "financial management" to analyze a complex staffing decision. The unit has the option to hire two full-time RNs at a total cost of one hundred seventy thousand dollars annually or continue using agency nurses at a current annual cost of two hundred ten thousand dollars. The agency nurses are already oriented to the unit and provide consistent coverage. Which analysis dimension is MOST commonly overlooked in this comparison?

A. The agency nurses' impact on team cohesion and unit culture compared to permanent staff

B. The orientation cost for the two new permanent hires, which adds an estimated forty thousand dollars to the first-year permanent staffing cost, potentially making the permanent option more expensive than agency in year one while becoming more cost-effective in subsequent years

C. The quality differential between agency and permanent nursing staff as measured by nurse-sensitive indicators

D. The long-term cost trajectory — agency costs typically increase annually while permanent staff costs increase at a contractually defined rate, meaning the cost advantage of permanent hiring grows over time as the gap between agency rate escalation and permanent wage increases compounds

69. A nurse manager is developing a comprehensive nurse retention strategy. Exit interview analysis over two years reveals the following departure reasons:

| Reason | % of Departures |

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

| Better compensation elsewhere | 35% |

| Work-life balance/scheduling | 25% |

| Lack of career advancement | 20% |

| Poor relationship with manager | 12% |

| Workplace environment/culture | 8% |

Which retention strategy design principle is MOST important?

A. Focus the retention strategy exclusively on compensation since it is the primary departure driver

B. Address all five departure reasons simultaneously since each contributes to the retention problem

C. Focus on the top three reasons since they account for eighty percent of departures

D. Design the strategy to address all five factors but prioritize interventions based on the modifiability of each factor at the unit level — compensation may require organizational action while scheduling flexibility, career advancement, and manager relationships are more directly within the nurse manager's influence and may produce faster results even though compensation is the most frequently cited reason

70. A nurse manager is applying the concept of "adaptive capacity" — the organization's ability to adjust its operations in response to changing conditions without detailed planning. High adaptive capacity enables the unit to respond effectively to unexpected situations like census surges, staffing shortages, or clinical emergencies. Assessment reveals that the unit functions well under normal conditions but becomes chaotic when disrupted. Which leadership investment MOST effectively builds adaptive capacity?

A. Develop detailed contingency plans for every anticipated disruption scenario

B. Hire additional staff to provide redundancy that buffers against disruptions

C. Develop broad staff competencies through cross-training, build decision-making authority at every level, create simple rules that guide behavior during disruption rather than detailed protocols that may not fit the specific situation, and practice adaptation through regular simulation exercises

D. Implement standardized emergency response protocols for each category of disruption that can be activated when needed

71. A nurse manager is developing a strategy for managing "organizational cynicism" on the unit. Staff exhibit cynical attitudes toward all new initiatives, greeting announcements with comments like "this too shall pass" and "here we go again." The cynicism appears rooted in a history of failed or abandoned initiatives on the unit. Which leadership approach is MOST likely to overcome the cynicism?

A. Acknowledge the history that created the cynicism, validate that previous initiatives were not sustained, make a personal commitment to the current initiative's sustainability, demonstrate follow-through consistently over time, start with a small visible success that proves this time is different, and gradually rebuild trust through demonstrated reliability rather than promises

B. Implement the initiative with strict accountability measures that override cynical attitudes through compliance requirements

C. Ignore the cynicism and implement the initiative with the staff members who are willing to participate, allowing non-participants to join when they see positive results

D. Address the cynicism directly by requiring all staff to adopt a positive attitude toward new initiatives as a professional conduct expectation

72. A nurse manager is applying Goleman's leadership styles framework, which identifies six leadership styles: visionary, coaching, affiliative, democratic, pacesetting, and commanding. Assessment reveals that the nurse manager relies almost exclusively on the affiliative style — building harmony and emotional bonds — at the expense of other styles. Staff like the manager personally but report that the unit lacks direction, underperformers are not held accountable, and decisions are delayed because the manager avoids any action that might create interpersonal discomfort. Which development priority is MOST critical?

A. Develop the commanding style to be used during crises when immediate action is needed

B. Develop the visionary style to provide the direction and purpose the unit currently lacks

C. Develop versatility across all six styles so the nurse manager can adapt the leadership approach to the situation — using visionary style for direction-setting, coaching for individual development, democratic for buy-in, and commanding during crises — while maintaining the affiliative foundation that staff value, and specifically developing comfort with the accountability conversations that the affiliative-only approach avoids

D. Develop the pacesetting style to model the high performance standards the unit needs

73. A nurse manager is developing a strategy for "leading laterally" — influencing peer nurse managers and cross-departmental leaders who have no reporting relationship to the nurse manager. The unit's quality improvement efforts are limited by the inability to influence discharge planning practices in the case management department, medication delivery timing from pharmacy, and therapy scheduling from rehabilitation services. Which lateral leadership approach is MOST effective?

A. Escalate the cross-departmental challenges to the nursing director who has organizational authority to mandate cooperation from other departments

B. Build reciprocal relationships with peer managers in the affected departments by understanding their challenges, offering help with their priorities, finding mutual benefit in collaborative improvement, and leveraging shared outcomes data that demonstrates how coordinated changes benefit all departments — creating influence through partnership rather than authority

C. Present the cross-departmental challenges at the hospital's operations committee and request formal coordination structures

D. Develop unit-level workarounds that accommodate the other departments' limitations without requiring their cooperation

74. A nurse manager is evaluating two leadership development frameworks for the charge nurse team. Framework A uses competency-based assessment where charge nurses are evaluated against a defined list of leadership competencies. Framework B uses strength-based development where charge nurses identify and leverage their natural strengths while managing around weaknesses. Which approach produces the MOST effective charge nurse team?

A. Framework A, because charge nurses need consistent competency across all leadership domains to perform the role effectively

B. Framework B exclusively, because strength-based development is more motivating and produces faster results than competency remediation

C. A hybrid approach that uses competency-based assessment to identify development priorities while incorporating strength-based development principles — ensuring that each charge nurse meets minimum competency thresholds in all essential domains while maximizing their contribution in their areas of natural strength, and building team strength by composing shifts where different charge nurses' strengths complement each other

D. Neither framework — charge nurse development should be experiential rather than framework-based, with learning occurring through on-the-job experience and manager mentoring

75. A nurse manager is developing a response to the growing phenomenon of "career customization" — the expectation among newer nurses that their career paths should be personalized to their individual interests, strengths, and life circumstances rather than following a standardized progression. This expectation conflicts with the unit's current one-size-fits-all career ladder. Which leadership response is MOST appropriate?

A. Develop a flexible career framework that offers multiple advancement pathways — clinical expertise, quality improvement, education, research, leadership, and technology — allowing nurses to construct personalized career trajectories that align with their individual interests while meeting organizational needs, with the unit's career ladder serving as a menu of options rather than a single prescribed path

B. Maintain the standardized career ladder since organizational consistency is more important than individual customization

C. Allow complete career customization where each nurse defines their own advancement criteria and timeline

D. Offer career customization as an option for high-performing nurses while maintaining the standardized ladder for average performers

76. A nurse manager is evaluating the unit's approach to performance feedback and identifies that feedback delivery clusters around the annual evaluation period with minimal feedback during the remaining eleven months. Research on feedback effectiveness shows that immediate, specific feedback produces significantly better performance improvement than delayed, general feedback. Which system redesign is MOST effective?

A. Increase the frequency of formal evaluations from annually to quarterly to provide feedback more often

B. Implement a continuous feedback culture where specific behavioral feedback is delivered within minutes to hours of the observed behavior, using a brief structured format that identifies what was done, why it matters, and what to continue or change — supported by a digital platform that tracks feedback exchanges and replaces the annual evaluation narrative with a year-end summary of ongoing feedback themes

C. Train charge nurses to deliver performance feedback on behalf of the nurse manager since they observe staff performance more directly

D. Implement a peer feedback system that supplements the annual managerial evaluation with ongoing colleague observations

77. A nurse manager is developing a "communication-intensive" leadership practice where the primary leadership tool is strategic communication rather than policy, protocol, or procedure. The nurse manager believes that most operational problems on the unit stem from communication failures rather than knowledge or skill deficits. Which daily communication practice MOST effectively operationalizes this philosophy?

A. Conduct daily written communication updates distributed through email to all staff

B. Implement a structured daily communication rhythm that includes a brief safety huddle at shift start, leadership rounding with intentional communication touchpoints throughout the shift, real-time feedback on observed practice, proactive communication with patients before problems are reported, and an end-of-shift leadership check-in that identifies unresolved communication gaps — making communication the connective tissue that holds all unit operations together

C. Schedule weekly one-on-one meetings with every staff member to maintain open communication channels

D. Implement a communication board in the break room that staff can use to post concerns, suggestions, and updates

78. A nurse manager is applying the concept of "decision rights" to clarify who has authority to make specific types of decisions on the unit. Currently, decision-making is ambiguous — staff are uncertain about which decisions they can make independently, which require charge nurse approval, and which require nurse manager authorization. This ambiguity leads to both over-escalation (asking permission

for routine decisions) and under-escalation (making decisions that exceed their authority). Which framework is MOST effective?

A. Develop a comprehensive decision authority matrix that categorizes common unit decisions by type and assigns clear decision-making authority to specific roles — establishing which decisions bedside nurses make independently, which require charge nurse collaboration, and which require nurse manager authorization — with the goal of pushing decision-making authority to the lowest appropriate organizational level

B. Require all decisions to flow through the charge nurse to create a single point of decision-making clarity

C. Allow each nurse to use professional judgment about which decisions require escalation

D. Develop a short list of decisions that require nurse manager approval and allow all other decisions to be made at the bedside level

79. A nurse manager is evaluating the unit's approach to managing high-potential nurses who are at risk of departure due to limited advancement opportunities. The unit has identified six nurses with significant leadership potential, but only two formal advancement positions (charge nurse and quality champion) are available. The remaining four high-potential nurses have no clear development pathway and express frustration about career stagnation. Which retention strategy is MOST effective?

A. Create additional formal positions such as assistant charge nurse, education coordinator, and research facilitator to provide advancement opportunities for the high-potential nurses

B. Offer competitive retention bonuses to keep high-potential nurses from leaving while development positions become available

C. Create non-positional development opportunities including progressive project leadership, cross-functional committee roles, organizational representation assignments, and external professional engagement that provide growth, recognition, and expanded influence without requiring formal position creation — demonstrating that professional development transcends title advancement

D. Encourage high-potential nurses to pursue opportunities at other organizations since the unit cannot accommodate their development needs

80. A nurse manager is developing a professional development plan for a nurse who has been in the same clinical role for twelve years and shows no interest in advancement, certification, or professional growth activities. The nurse meets all performance expectations and provides safe, competent patient care. She describes herself as "content where I am." Which approach is MOST professionally appropriate?

A. Accept the nurse's contentment and focus development resources on nurses who demonstrate growth interest since forcing development on an unwilling participant produces minimal return

B. Require the nurse to participate in at least one professional development activity annually as a condition of continued employment

C. Explore whether the nurse's contentment reflects genuine satisfaction or disengagement, discuss the professional obligation for ongoing development as defined by ANA standards, and collaboratively identify development activities that align with the nurse's clinical interests rather than requiring advancement — such as deepening expertise in a specific patient population or contributing to orientation as a subject matter expert

D. Identify the nurse's specific interests and create a customized development plan that differs from the standard career ladder but still promotes professional growth

81. A nurse manager is addressing a professional practice issue where a nurse has been using social media to publicly criticize a competing hospital's clinical practices. The nurse bases her criticism on information she obtained while working as an agency nurse at the competitor. The posts do not mention her current employer but her profile identifies her as a registered nurse. Which concern is MOST significant?

A. The nurse's criticism of a competitor may violate confidentiality obligations from her agency employment at that facility, constitutes potentially actionable defamation if the claims are inaccurate, and reflects poorly on the nursing profession by engaging in public disparagement of a healthcare institution — regardless of whether the criticism is clinically valid

B. The nurse's social media activity may damage her current employer's reputation by association

C. The nurse's posts may violate the non-disclosure agreement she signed with the staffing agency that placed her at the competitor

D. The nurse may be sharing proprietary clinical information about the competitor's protocols and practices

82. A nurse manager is developing guidelines for managing a nurse who has been subpoenaed to testify as a fact witness in a medical malpractice case involving a patient she cared for on the unit. The nurse is anxious about the legal process and unsure about her obligations. Which guidance is MOST important?

A. Advise the nurse to contact her personal malpractice insurance carrier since the insurer can provide legal guidance for the testimony

B. Instruct the nurse to discuss the case only with the organization's legal department and to decline all communication from the plaintiff's attorney

C. Advise the nurse to contact the organization's legal or risk management department immediately since they will coordinate the response, provide testimony preparation, and ensure the nurse understands her rights and obligations as a fact witness — including the distinction between being a fact witness and being a named party in the lawsuit

D. Recommend that the nurse retain personal legal counsel for the testimony since the organization's attorney represents the organization's interests rather than the nurse's individual interests

83. A nurse manager is evaluating the unit's approach to managing professional boundaries in the age of social media. A patient sends a friend request to a nurse on a personal social media platform after discharge. The nurse declines the request but the patient persists, sending multiple messages expressing gratitude and a desire for continued connection. The nurse reports feeling uncomfortable but also feeling guilty about rejecting a patient who genuinely appreciates her care. Which guidance is MOST appropriate?

A. Allow the nurse to accept the friend request since the nurse-patient relationship has ended with discharge and the social media connection is purely personal

B. Coach the nurse that declining the connection is the professionally appropriate decision — that the therapeutic boundaries that protected the patient during hospitalization must be maintained after discharge, that the patient's gratitude can be expressed through the organization's formal recognition channels, and that accepting the connection could create expectations that blur the professional relationship boundary

C. Instruct the nurse to block the patient on social media to prevent further contact

D. Refer the situation to the patient relations department to communicate the boundary to the patient on the nurse's behalf

84. A nurse manager is addressing a professional conduct issue where a nurse has been providing clinical care recommendations to her neighbor based on clinical knowledge gained through her nursing practice. The neighbor has been following the nurse's recommendations instead of consulting a physician. The nurse sees this as "being a good neighbor" and does not believe it constitutes professional practice. Which professional analysis is MOST accurate?

A. The nurse's informal health advice to a neighbor constitutes personal conversation and falls outside the scope of professional nursing practice regulation

B. The nurse is establishing a nurse-patient relationship with the neighbor by providing clinical recommendations based on professional knowledge, which creates professional accountability for the advice, potential liability if the advice causes harm, and an obligation to the patient that the informal setting does not diminish — making this a scope-of-practice and professional boundary concern regardless of the neighborly context

C. The nurse's advice is only a professional concern if she accepts compensation for the recommendations

D. The nurse should be encouraged to recommend that her neighbor consult a physician but should not be disciplined for providing neighborly health advice

85. A nurse manager is developing an approach to managing the professional implications of nurses who hold dual professional licenses — such as RN and licensed massage therapist, RN and certified fitness trainer, or RN and licensed clinical social worker. Several dual-licensed nurses want to use their complementary skills in patient care — for example, providing massage therapy to patients alongside nursing care. Which professional governance framework is MOST appropriate?

A. Evaluate each dual-license skill for integration into patient care by determining whether the complementary practice is within the organization's scope of services, whether the nurse has current licensure and competency, whether the activity requires a physician order, whether liability coverage extends to the complementary practice, and whether the integration improves patient outcomes — creating a structured approval process rather than blanket prohibition or unrestricted permission

B. Allow dual-licensed nurses to use their complementary skills freely since they are separately licensed for those activities

C. Prohibit all complementary practice activities during nursing shifts to prevent scope confusion

D. Allow complementary practices only if the attending physician approves the specific activity for each patient

86. A nurse manager is developing a comprehensive approach to professional development during a severe staffing crisis. The unit is operating at sixty-five percent of its budgeted nursing FTEs, and all available time is consumed by direct patient care. Professional development activities including journal clubs, quality improvement projects, and governance meetings have been suspended for four months. Staff report feeling professionally stagnant in addition to physically exhausted. Which approach MOST effectively addresses professional development within the staffing constraint?

A. Continue suspending all professional development until staffing returns to adequate levels since patient care must take absolute priority during a crisis

B. Integrate micro-learning opportunities into the existing clinical workflow — five-minute evidence-based practice discussions during huddles, point-of-care clinical teaching during patient care activities, reflective practice questions posted at workstations, and brief asynchronous online learning modules that can be completed during down moments — maintaining professional growth momentum without requiring dedicated time that the crisis does not allow

C. Offer professional development activities during off-duty hours and compensate staff for attendance

D. Hire temporary educators to provide bedside professional development during the crisis period

87. A nurse manager is navigating a professional ethics situation where a pharmaceutical representative has been providing meals to the unit's nursing staff during educational lunch presentations. The presentations are clinically focused and the content has been approved by the organization's pharmacy and therapeutics committee. However, the Sunshine Act requires reporting of all payments and transfers of value from pharmaceutical companies to healthcare providers. Which professional concern is MOST significant?

A. The meals provided to nursing staff during pharmaceutical presentations create an implicit obligation that may influence the nurses' clinical practice regarding the company's products, even when the educational content is clinically sound — and the nurse manager must ensure organizational policy compliance, transparent disclosure, and staff awareness that pharmaceutical industry engagement carries inherent conflict-of-interest considerations regardless of content quality

B. The pharmaceutical representative may be using the lunch presentations to access patient care areas and observe clinical practices

C. The meal costs may exceed the Sunshine Act reporting threshold, creating compliance risk for the organization

D. The presentations may take nurses away from patient care responsibilities during the lunch period

88. A nurse manager is developing a plan for supporting nurses through the process of reporting a colleague to the state board of nursing. A nurse has witnessed repeated, serious clinical practice violations by a colleague that the nurse manager has been unable to resolve through internal processes. The reporting nurse fears professional retaliation and social ostracism from colleagues. Which support element is MOST important?

A. Provide the reporting nurse with information about whistleblower protections and the board's confidentiality procedures

B. Educate the reporting nurse about the mandatory reporting obligation that exists in many states when a nurse has knowledge of another nurse's practice that creates patient safety risk, provide emotional support through the process, ensure the reporting nurse understands the confidentiality protections available, and establish a plan for managing the interpersonal consequences on the unit including anti-retaliation monitoring

C. Advise the reporting nurse to submit an anonymous complaint to the board to avoid identification

D. Conduct one final internal intervention before supporting the board report to ensure all internal remedies have been exhausted

89. A nurse manager is addressing a professional development need among nurses who serve on the organization's Institutional Review Board. The nurses report feeling inadequately prepared to evaluate research protocols and provide informed judgment about the ethical implications of proposed studies. Which development approach is MOST appropriate?

A. Provide IRB-specific education including research ethics principles, the Belmont Report's foundational concepts, informed consent evaluation criteria, vulnerable population protections, risk-benefit assessment methodology, and the nurse's unique perspective on participant welfare — building the knowledge foundation that enables meaningful IRB participation

B. Recommend that the nurses resign from the IRB and be replaced by PhD-prepared nurse researchers who have formal research ethics training

C. Provide the nurses with a copy of the federal regulations governing human subjects research and allow them to develop expertise through experience

D. Assign the nurses to review only the nursing-related aspects of research protocols and defer scientific and ethical evaluation to physician and researcher members

90. A nurse manager is developing an approach to managing the professional implications of artificial intelligence in nursing practice. AI-driven clinical decision support systems on the unit now provide diagnostic suggestions, treatment recommendations, and risk predictions that nurses must interpret and integrate into clinical care. Several nurses express concern that reliance on AI diminishes their professional autonomy and clinical judgment. Which professional framework is MOST appropriate?

A. Restrict AI tools to physician use only since clinical decision support exceeds the nursing scope of practice

B. Allow nurses to disregard AI recommendations when their clinical judgment disagrees since professional autonomy takes precedence over algorithmic suggestions

C. Require nurses to follow all AI recommendations to maximize the technology's safety benefits

D. Establish that AI serves as a decision-support tool that supplements rather than replaces nursing clinical judgment, that nurses retain professional accountability for all clinical decisions regardless of whether AI contributed to the decision, and that the nurse's role includes evaluating AI recommendations against clinical assessment findings and professional knowledge before acting — maintaining the nurse as the final decision-maker in the clinical process

91. A nurse manager is evaluating the unit's approach to professional accountability. A nurse administered a medication at the correct dose and via the correct route, but to the wrong patient. The barcode scanning system was bypassed because the patient's armband had been removed for a procedure and not yet replaced. The nurse verified identity verbally but the patient, who was confused, confirmed the wrong name. Which accountability framework is MOST appropriate?

A. The nurse should be held individually accountable since she bypassed the safety system and administered medication to the wrong patient

B. Apply a just culture analysis that examines both the individual decision to bypass barcode scanning and the system factors that contributed — including the armband removal process, the lack of an interim identification method, the patient's cognitive status, and whether the system made it easy or difficult to maintain identification integrity — to determine whether the behavior was human error, at-risk behavior, or reckless behavior, and respond proportionally

C. Hold the nurse accountable for the system bypass since barcode scanning is a non-negotiable safety standard

D. Attribute the error entirely to the system since the armband removal created the vulnerability that enabled the wrong-patient administration

92. A nurse manager is developing a professional practice model for the unit that will guide nursing care delivery for the next five years. The model must articulate the unit's nursing philosophy, theoretical foundation, care delivery system, and professional governance structure. Which development process is MOST likely to produce a model that staff genuinely adopt?

A. The nurse manager develops the model based on current evidence and best practices and presents it to staff for feedback before finalization

B. A committee of senior nurses develops the model and presents it to the full staff for ratification

C. The nurse manager adopts a model from a Magnet-designated hospital with similar patient population characteristics

D. Engage the entire nursing team in defining the practice model through a facilitated process that begins with identifying shared values, selects a theoretical foundation that resonates with the team's clinical philosophy, designs a care delivery system that operationalizes those values, and establishes governance structures that give staff genuine ownership of the model — ensuring that the model reflects the team's identity rather than being imposed by leadership

93. A nurse manager is addressing the professional implications of a nurse who has become a prominent patient safety advocate through public speaking, social media, and published articles. The nurse's advocacy is based on her personal experience as a "second victim" after involvement in a serious medical error earlier in her career. Her advocacy identifies the hospital where the error occurred (her current employer) and includes details about the event. Which professional consideration is MOST important?

A. The nurse's advocacy may violate patient confidentiality if the patient involved in the original error can be identified from the details she shares publicly

B. The nurse's identification of the hospital may damage the organization's reputation even though the advocacy promotes patient safety

C. The nurse's advocacy may be protected by whistleblower statutes if the information she shares relates to patient safety concerns

D. Evaluate whether the nurse's public disclosures compromise patient confidentiality, whether they comply with organizational policies regarding public statements about clinical events, and whether the advocacy — while valuable for patient safety — can be modified to achieve its educational purpose without identifying the specific institution or potentially identifiable patient details

94. A nurse manager is developing guidelines for managing nurses who request accommodations for chronic health conditions under the Americans with Disabilities Act. A nurse with chronic migraine disorder requests accommodation including a modified lighting arrangement in her assigned patient rooms, exemption from shifts that follow late-night off-duty activities, and reassignment away from patients who wear strong fragrances. Which accommodation evaluation principle is MOST important?

A. All requested accommodations should be granted since the ADA requires employers to accommodate disabilities

B. Each accommodation should be evaluated through the ADA interactive process to determine whether it is reasonable, whether it creates undue hardship for the organization, whether it fundamentally alters the essential functions of the nursing role, and whether alternative effective accommodations exist that achieve the same purpose with less operational impact

C. Require the nurse to provide detailed medical documentation supporting each specific accommodation request before evaluation begins

D. Evaluate accommodations based on the impact on colleagues who must adjust their own practices to accommodate the requesting nurse

95. A nurse manager is addressing the professional development needs of nurses who provide care to patients receiving investigational therapies through clinical trials. These nurses must understand informed consent monitoring, protocol compliance, adverse event reporting, and the distinction between research procedures and standard care — competencies that are not typically included in nursing orientation. Which development approach is MOST appropriate?

A. Require all nurses who care for clinical trial patients to complete the organization's research compliance training program

B. Assign clinical trial patients exclusively to a small group of nurses who receive specialized research training

C. Provide education on the nurse's role in clinical trial participant protection including informed consent monitoring, protocol adherence observation, adverse event identification and reporting, distinguishing research procedures from standard care, and the ethical obligation to advocate for the participant's welfare independently of the research team's objectives

D. Defer all research-related questions and concerns to the clinical research coordinator since research oversight falls outside the bedside nurse's scope of responsibility

96. A nurse manager is developing a flexible budget for the unit. A flexible budget adjusts the budgeted amounts based on actual patient volume, enabling more accurate variance analysis than a static budget. The unit's static budget was developed for 850 patient days per month. Actual volume this month was 920 patient days. The static budget salary line is $310,000 per month. If the salary budget is seventy percent variable and thirty percent fixed, what is the flexed salary budget for the 920-patient-day month?

A. $310,000 × (920/850) = $335,529 (the entire salary budget flexed proportionally)

B. Variable component: $310,000 × 0.70 = $217,000. Flexed variable: $217,000 × (920/850) = $234,871. Fixed component: $310,000 × 0.30 = $93,000. Total flexed: $234,871 + $93,000 = $327,871

C. The flexed budget adjusts only the variable portion: Variable = $217,000 × (920/850) = $234,871. Fixed remains $93,000. Total flexed salary budget = $327,871 — this is the correct calculation because fixed costs do not change with volume while variable costs (primarily direct nursing hours) increase proportionally with patient days

D. $310,000 + ($310,000 × 0.082) = $335,420 (adding 8.2% volume increase to the total budget)

97. A nurse manager is calculating the unit's cost per hire for nursing positions. The following recruitment costs were incurred during the past year:

| Cost Component | Annual Amount |

|---|---|

| Job posting/advertising | $8,400 |

| Recruiter salary (prorated to unit) | $22,000 |

| Interview time (manager + panel) | $6,800 |

| Background checks/drug screens | $3,200 |

| Signing bonuses | $30,000 |

| Relocation assistance | $12,000 |

Total new hires during the period: 8

What is the cost per hire?

A. Total recruitment costs = $82,400. Cost per hire = $82,400 ÷ 8 = $10,300. This metric should be evaluated alongside quality-of-hire indicators such as first-year retention rate, time to full productivity, and performance evaluation scores to determine whether the recruitment investment is producing valued returns

B. Cost per hire should exclude signing bonuses and relocation since these are retention costs rather than recruitment costs: ($8,400 + $22,000 + $6,800 + $3,200) ÷ 8 = $5,050

C. Cost per hire = $82,400 ÷ 8 = $10,300, and this figure should be compared to the cost of NOT hiring (agency and overtime costs that would be incurred if positions remained vacant)

D. The cost per hire calculation should be expressed as a percentage of the first-year salary to enable benchmarking across different salary levels

98. A nurse manager reviews the following variance analysis report:

| Category | Budget | Actual | Variance | Volume-Adjusted Budget |

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

| Salary | $310,000 | $335,000 | ($25,000) U | $327,871 |

| Supplies | $42,000 | $46,500 | ($4,500) U | $45,459 |

| Education | $8,000 | $5,200 | $2,800 F | $8,000 |

Patient days: Budget 850, Actual 920. Which variance interpretation is MOST sophisticated?

A. All three variances are unfavorable or favorable as shown and should be reported to finance without additional analysis

B. The raw salary variance of $25,000 unfavorable overstates the actual overspend because it does not account for the higher volume — the volume-adjusted (flexed) budget is $327,871, making the true

spending variance only $7,129 unfavorable ($335,000 − $327,871), which requires different investigation than a $25,000 variance

C. The supply variance should be investigated since the $4,500 unfavorable variance represents excessive spending

D. The salary and supply variances should be analyzed against the volume-adjusted budget to distinguish between volume-driven variances (which are expected when volume exceeds budget) and spending variances (which indicate true cost management issues): Salary true variance = $335,000 − $327,871 = $7,129 U. Supply true variance = $46,500 − $45,459 = $1,041 U. Education variance remains $2,800 F since education is a fixed cost. The volume-adjusted analysis reveals that the $25,000 salary "overspend" is primarily volume-driven with only $7,129 in true spending variance

99. A nurse manager is developing a financial justification for implementing a nurse-led transitional care program. The program requires one FTE nurse coordinator at eighty-five thousand dollars annually. Published evidence shows similar programs reduce thirty-day readmissions by twenty-two percent. The unit's current thirty-day readmission rate is sixteen percent among five hundred discharged patients annually. The CMS readmission penalty for the hospital is projected at three hundred fifty thousand dollars for the current fiscal year. Which financial analysis is MOST compelling?

A. Calculate the number of prevented readmissions: 500 × 16% = 80 readmissions. 22% reduction = 17.6 fewer readmissions. This represents a meaningful clinical improvement but does not directly translate to financial savings for the unit

B. The program's clinical value in preventing 17.6 readmissions is sufficient justification regardless of the financial return

C. The program cost of $85,000 is modest compared to the $350,000 organizational readmission penalty, but the unit's specific contribution to the organizational penalty must be calculated to determine the direct financial impact of the unit's readmission reduction on the penalty amount

D. Calculate the unit's projected contribution to penalty reduction: If the unit's readmissions represent a significant proportion of the hospital's excess readmissions, reducing them by 17.6 cases could meaningfully affect the hospital's overall readmission rate and penalty calculation — but the analysis must also account for the direct cost avoidance per prevented readmission (average readmission cost × 17.6) plus the potential penalty reduction, making the total financial return likely to significantly exceed the $85,000 program cost

100. A nurse manager is analyzing the unit's productivity data:

| Month | Patient Days | Paid Hours | HPPD | Target HPPD | Productive Hours | Non-Productive Hours |

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

| Jan | 870 | 8,526 | 9.8 | 8.5 | 7,395 | 1,131 |

| Feb | 810 | 8,262 | 10.2 | 8.5 | 6,885 | 1,377 |

| Mar | 890 | 8,455 | 9.5 | 8.5 | 7,565 | 890 |

Which month's data requires the MOST investigation?

A. January because it has the highest total paid hours

B. February because it has the highest HPPD (10.2 vs target 8.5) AND the highest non-productive hours (1,377 — representing 16.7% of paid hours compared to March's 10.5%), suggesting that both overstaffing relative to census AND high non-productive time contributed to the productivity gap

C. March because it has the highest patient days but lower HPPD than January, suggesting potential understaffing

D. All three months exceed the HPPD target and should be investigated equally

101. A nurse manager is developing a proposal for a clinical innovation that requires a capital investment of two hundred thousand dollars and produces projected annual savings of sixty-five thousand dollars through reduced adverse events. The organization requires a three-year payback period for capital investments. Which financial presentation is MOST compelling?

A. The three-year total savings of $195,000 does not meet the $200,000 investment threshold within the required payback period and the proposal should be rejected

B. Present the $195,000 three-year savings alongside the clinical benefits that are not captured in the financial analysis

C. Present the direct financial return ($195,000 over three years) alongside the value of prevented adverse events including avoided litigation costs, regulatory penalty avoidance, and reputation

protection that are not included in the sixty-five thousand dollar annual estimate — demonstrating that the total financial value likely exceeds the investment within the payback period when indirect savings are included

D. Request an extension of the payback period to four years, at which point the cumulative savings ($260,000) exceed the investment

102. A nurse manager is analyzing the financial impact of nurse turnover on the unit. Beyond the direct replacement costs, which indirect cost is MOST commonly underestimated in turnover financial analyses?

A. The productivity loss during the vacancy period when remaining staff work overtime and agency nurses provide coverage at reduced efficiency

B. The impact on team morale and the potential for additional departures triggered by the initial departure

C. The orientation period productivity loss where the new hire is consuming organizational resources while not yet producing at full capacity

D. The cumulative "hidden" productivity cost — the new hire requires approximately twelve to eighteen months to reach full productivity, during which the difference between their actual output and a fully productive nurse represents an ongoing cost that extends far beyond the visible orientation period and is rarely quantified in standard turnover cost calculations

103. A nurse manager is developing a supply chain cost management strategy for the unit. Analysis reveals that thirty-two percent of supply costs are driven by "preference items" — supplies that individual nurses prefer but for which clinically equivalent, lower-cost alternatives exist. The nurse manager wants to standardize supply selection without compromising clinical quality. Which approach is MOST effective?

A. Mandate the lowest-cost alternative for all supply categories and eliminate all preference items from the unit's inventory

B. Implement a transparent process that invites staff to submit clinical evidence supporting their preferred supplies, then select the most cost-effective option among clinically equivalent products

C. Engage nursing staff in a value analysis process where clinically equivalent alternatives are evaluated through blinded product trials, clinical performance data is collected, and the most cost-effective product that meets clinical quality standards is selected — giving staff voice in the decision while using objective criteria rather than personal preference to drive selection

D. Allow preference items for senior nurses but standardize supplies for newer staff to reduce overall preference costs while respecting experienced nurses' clinical judgment

104. A nurse manager is preparing the unit's capital budget request for three competing needs:

| Item | Cost | Clinical Impact | Financial Return |
|---|---|---|---|
| Wireless vital sign monitors | $180,000 | Moderate | Low ($8,000/yr in time savings) |
| Smart bed system with fall detection | $220,000 | High | Moderate ($45,000/yr in fall reduction) |
| Medication dispensing cabinet upgrade | $95,000 | High | High ($62,000/yr in error reduction) |

The capital budget allocation is $200,000. Which prioritization decision is MOST financially sound?

A. Fund the medication dispensing cabinet upgrade ($95,000) because it has the highest financial return and the shortest payback period (1.5 years), and use the remaining $105,000 toward the smart bed system through either a phased implementation or a request for supplemental funding for the $115,000 balance — maximizing the financial return within the current allocation while addressing the highest-impact safety need

B. Fund the smart bed system because it has the highest clinical impact regardless of financial return

C. Fund the wireless monitors and the medication cabinet ($275,000 total) by requesting $75,000 in supplemental capital funding

D. Defer all three requests and carry the capital allocation forward to next year when a larger investment can be made

105. A nurse manager is evaluating the financial performance of a nurse-led patient education clinic that operates three afternoons per week. The clinic has been operational for one year.

| Metric | Actual | Target |
|---|---|---|
| Visit volume | 1,820 | 2,000 |
| Revenue per visit | $85 | $95 |
| Annual revenue | $154,700 | $190,000 |
| Annual operating cost | $145,000 | $140,000 |
| Operating margin | $9,700 | $50,000 |

Which analysis is MOST appropriate?

A. The clinic is financially viable since it generates a positive operating margin

B. The clinic is underperforming against all targets — lower volume, lower revenue per visit, higher costs, and significantly lower margin. The analysis should identify whether the volume shortfall drives the revenue gap (suggesting a marketing or referral problem), whether the per-visit revenue deficit reflects coding, billing, or payer mix issues, and whether the cost overrun is driven by staffing inefficiency or unanticipated expenses — because the intervention depends on which factor is the primary performance driver

C. The clinic should be closed since it is not meeting financial targets and the $9,700 margin is insufficient to justify continued operation

D. The clinic needs more time to reach maturity since first-year performance typically underestimates long-term potential

106. A nurse manager is developing a financial model for converting three twelve-hour weekend positions to a "Baylor plan" model where weekend nurses work two twelve-hour shifts (twenty-four hours) but are paid for thirty-six hours at a premium rate. The current three twelve-hour weekend positions cost forty-two thousand dollars per position annually in base salary plus a twenty percent

weekend differential. Under the Baylor model, nurses would work fewer hours but receive the equivalent of thirty-six hours of pay for twenty-four hours of work. Which financial analysis is MOST important?

A. Compare the total annual labor cost of the current model (3 positions × $42,000 × 1.20 weekend differential = $151,200) to the Baylor model cost per position to determine the direct labor cost impact

B. Calculate the recruitment and retention impact of the Baylor model since weekend positions are historically difficult to fill and the premium compensation may attract candidates who would not apply for standard weekend positions

C. Evaluate the total cost comparison including salary differentials, benefits cost differences, recruitment savings from reduced weekend vacancy rates, and the impact on weekday staffing needs if Baylor nurses are not available for weekday shifts

D. Assess the clinical quality impact of having dedicated weekend nurses who develop expertise in weekend-specific patient care patterns versus rotating staff who work weekends less frequently

107. A nurse manager is analyzing the unit's labor management partnership effectiveness. The unit operates under a collective bargaining agreement with the nurses' union. The nurse manager wants to implement a staffing model change that requires union negotiation. Which approach to the labor-management relationship is MOST effective for achieving the staffing model change?

A. Present the staffing model change as a management decision and implement it through the management rights clause of the collective bargaining agreement

B. Engage the union leadership as collaborative partners in the staffing model design by presenting the clinical and financial rationale, involving union representatives in evaluating options, addressing legitimate workforce concerns, and negotiating implementation terms that protect both patient care quality and member interests — building a partnership that produces better outcomes than adversarial bargaining

C. Propose the staffing model change through the formal contract negotiation process during the next bargaining cycle

D. Implement the staffing model on a trial basis and negotiate the permanent change after demonstrating positive outcomes

108. A nurse manager is evaluating the return on investment of the unit's preceptor program. The program costs eighteen thousand dollars annually in preceptor training, differential pay, and backfill coverage. The unit oriented twelve new nurses this year. Without the preceptor program, the organization's historical first-year turnover rate for units without structured preceptorship was forty-five percent. The unit's current first-year turnover rate is eighteen percent. Average cost per new nurse departure: fifty-four thousand dollars. What is the program's annual ROI?

A. Prevented departures: 12 × (45% − 18%) = 12 × 27% = 3.24. Savings: 3.24 × $54,000 = $174,960. ROI: $174,960 − $18,000 = $156,960 net return

B. The ROI calculation should compare the unit's turnover rate to the organizational average rather than the historical rate for units without preceptorship, since other factors may contribute to the difference

C. ROI cannot be accurately calculated because the historical comparison does not control for other variables that may affect first-year turnover

D. The $18,000 program cost prevents approximately 3.24 departures saving $174,960, producing a 9.7:1 return on investment — but the analysis should be presented as a range reflecting uncertainty in the historical comparison, since the twenty-seven percentage point improvement may not be entirely attributable to the preceptor program

109. A nurse manager is developing a proposal to implement bedside medication verification technology that integrates barcode scanning, smart pump programming, and real-time clinical decision support into a single workflow. The integrated system costs two hundred fifty thousand dollars to implement plus fifty thousand dollars annually for maintenance. Which financial justification approach is MOST comprehensive?

A. Calculate the projected medication error reduction and translate it into avoided costs

B. Estimate the nursing time savings from streamlined medication administration workflow

C. Present a comprehensive value analysis that quantifies projected error reduction savings, nursing time reallocation value, regulatory compliance improvement, insurance premium impact, litigation risk reduction, and the operational efficiency gains from integrated versus siloed safety systems — demonstrating that the total value across all dimensions exceeds the investment

D. Benchmark the technology investment against peer hospitals that have already implemented similar systems

110. A nurse manager is analyzing the financial impact of patient falls on the unit. Data:

Annual falls: 24

Falls with injury: 9 (38%)

Average cost per fall with injury: $14,200

CMS non-payment for falls with serious injury: 2 cases ($28,400 in lost revenue)

Litigation costs related to falls: $35,000 (one pending case)

What is the total annual financial impact of patient falls?

A. 9 injury falls × $14,200 = $127,800 in direct injury costs

B. $127,800 (injury costs) + $28,400 (CMS non-payment) + $35,000 (litigation) = $191,200 total annual impact

C. Total impact = $127,800 + $28,400 + $35,000 = $191,200. This calculation should also include indirect costs such as extended length of stay for injured patients, staff time for incident investigation and documentation, and organizational reputation impact — making the true financial impact significantly higher than the $191,200 direct calculation

D. The financial impact should be calculated on a per-fall basis ($191,200 ÷ 24 = $7,967 per fall) to enable comparison with prevention program costs

111. A nurse manager is developing a staffing budget for the upcoming fiscal year. The budget must account for a projected three percent wage increase, a new twelve-bed expansion opening in month seven, and the elimination of two LPN positions that will be replaced with one RN position. Current annual salary budget: three million two hundred thousand dollars. Which budgeting approach is MOST accurate?

A. Apply the three percent wage increase to the full-year budget, add six months of expansion staffing costs, and adjust for the LPN-to-RN conversion — calculating each change separately and summing to determine the new total budget

B. Calculate the first six months using the current staffing model plus wage increase, then calculate the final six months using the expanded model plus wage increase plus the LPN-to-RN conversion, and sum both half-year calculations for the annual total

C. Apply all changes to the full-year budget simultaneously since they will all be in effect for at least a portion of the year

D. Present three budget scenarios — a conservative estimate, a moderate estimate, and an aggressive estimate — to allow leadership to select the funding level

112. A nurse manager is evaluating the financial sustainability of a nurse-led chronic pain management program. The program has been operating for two years. Year one data showed a negative operating margin of twenty-two thousand dollars. Year two data shows a positive operating margin of eight thousand dollars. The program's clinical outcomes have been consistently strong across both years. Which interpretation is MOST appropriate?

A. The program is not financially sustainable since the cumulative two-year operating loss is fourteen thousand dollars

B. The program should be given additional time since the year-over-year improvement from negative to positive margin demonstrates a positive financial trajectory

C. The clinical outcomes justify continued operation regardless of the financial performance

D. The program's financial trajectory shows a thirty-thousand-dollar improvement from year one to year two, crossing from negative to positive margin. The trend analysis — not the cumulative balance — is the most relevant indicator, suggesting the program is on a path toward sustained financial viability. However, the nurse manager should analyze what drove the improvement to determine whether it is sustainable and project whether the positive trajectory will continue, stabilize, or reverse

113. A nurse manager is developing a financial impact analysis of implementing hourly nurse rounding. The rounding program costs fifteen thousand dollars annually in training and materials. Published evidence shows hourly rounding reduces falls by approximately thirty percent, call light use by forty percent, and improves HCAHPS scores by an average of twelve percentile points. Current data:

Annual falls: 24 (cost: $191,200 per Q110 calculation)

Annual call light responses: estimated 43,000 per year

HCAHPS improvement worth approximately $0.50 per percentile point per patient for VBP

Which financial metric provides the STRONGEST justification?

A. Falls reduction: 30% × $191,200 = $57,360 in avoided fall costs against $15,000 program cost = $42,360 net return

B. Call light reduction: 40% × 43,000 = 17,200 fewer responses × estimated 3 minutes each = 860 hours of nursing time redirected to direct care

C. The falls reduction alone ($57,360 savings against $15,000 cost) provides a 3.8:1 ROI that independently justifies the program, but the comprehensive value includes call light reduction (860 nursing hours recaptured), HCAHPS improvement (VBP reimbursement impact), and the patient satisfaction gains that are difficult to quantify — making the total return significantly greater than the falls-only calculation

D. The HCAHPS improvement provides the strongest justification since VBP reimbursement directly affects the hospital's bottom line

114. A nurse manager is analyzing the unit's payer mix trend over three years:

| Payer | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| Medicare | 48% | 52% | 56% |
| Medicaid | 18% | 20% | 22% |
| Commercial | 30% | 24% | 18% |
| Self-pay | 4% | 4% | 4% |

Average reimbursement per case: Medicare $8,800, Medicaid $5,400, Commercial $13,200, Self-pay $2,100. The unit's average cost per case is $9,200. Which financial implication is MOST significant?

A. The declining commercial payer percentage reduces the unit's overall profitability since commercial insurance is the only payer that reimburses above cost

B. The growing Medicare and Medicaid percentages create increasing financial pressure since both reimburse below the unit's cost per case, while the declining commercial percentage removes the cross-subsidization that previously offset the below-cost government payer reimbursement — creating a structural financial deficit that volume growth cannot resolve without either cost reduction or commercial payer recovery

C. The stable self-pay percentage indicates that bad debt exposure has not changed and is not contributing to the financial trend

D. The Medicare increase may improve overall reimbursement since Medicare pays more per case than Medicaid

115. A nurse manager is conducting a comprehensive year-end financial review and must present the unit's financial performance to organizational leadership. The unit achieved a one point five percent positive operating margin, exceeded all quality targets, improved patient satisfaction from the sixtieth to the seventy-eighth percentile, and reduced nurse turnover from twenty-four percent to sixteen percent. However, the unit exceeded its labor budget by six percent due to agency costs during a staffing transition. Which presentation strategy is MOST effective?

A. Present the financial, quality, satisfaction, and workforce data as an integrated narrative that demonstrates how the quality and workforce improvements represent strategic investments that produced the positive operating margin despite the labor budget variance — positioning the agency costs as a transition investment that enabled the eight-percentage-point turnover reduction, which will produce ongoing labor cost savings that exceed the one-time transition expense

B. Lead with the positive operating margin and quality achievements and address the labor variance only if questioned by leadership

C. Present the labor variance first with a detailed corrective action plan to demonstrate accountability before discussing the positive outcomes

D. Focus the presentation on the quality and satisfaction improvements since these are the metrics that organizational leadership values most highly

# Answer Key – Exam 14 (with Full Answer Explanations

1. B — The service recovery paradox is activated when the organization's response demonstrates that the patient is valued enough to invest significant effort in resolution. Immediate acknowledgment, sincere apology, explanation, corrective action, and follow-up verification create a recovery experience that can actually exceed the patient's pre-failure expectations.

2. A — Legal custody determines healthcare decision-making authority. The custodial parent's consent is valid, the non-custodial parent's demand does not override it, and the adolescent's assent should be obtained alongside the custodial parent's consent. Custody documentation must be verified and social work involved if conflict escalates.

3. B — Objective documentation of all findings including uncomfortable observations is a professional obligation that protects both patient and nurse. Clinical accuracy requires documenting non-compliance, family conflicts, and behavioral concerns using factual, non-judgmental language rather than omitting findings to preserve rapport.

4. B — Person-first communication, adapting to individual cognitive and sensory abilities, directing communication to the patient first, involving caregivers as partners rather than substitutes, and documenting preferences provides the comprehensive approach. Patients with developmental disabilities are the primary communicators about their own care.

5. A — In the first fifteen minutes of a power outage, the most critical priority is accounting for every patient, establishing the chain of communication, assessing operational status, assigning manual monitoring roles, and providing patient reassurance. Census verification ensures no patient is lost or unmonitored during the transition.

6. B — Documenting cognitive concerns, consulting social work and ethics, identifying successor agents, and involving legal counsel addresses the POA capacity question through appropriate channels. A POA agent's authority depends on their capacity to fulfill the role, and organizational processes exist to evaluate this concern.

7. A — Accommodating the patient's paper and in-person preference for all communications, providing printed discharge instructions, using telephone for follow-up, and documenting the preference respects the patient's autonomous choice. Digital communication preferences are not mandatory, and the organization must provide accessible alternatives.

8. D — Acknowledging passion, naming the shift from clinical debate to personal attack, redirecting to evidence, establishing that disagreement is valued but attacks are not, and modeling constructive debate addresses the immediate dysfunction. The facilitation must preserve the value of clinical disagreement while stopping the personal dimension.

9. B — Addressing both units simultaneously with clinical rationale, competency standards, assignment guidelines, buddy systems, and staff involvement in guideline development creates buy-in from both groups. Cross-unit floating affects both sending and receiving units, and both need voice in the design.

10. D — Integrating board updates into existing clinical workflows — during introductions, assessments, and planning conversations — makes maintenance automatic rather than additional. The most sustainable communication tools are those embedded in existing processes rather than requiring separate dedicated effort.

11. A — Confirming an investigation is underway without details, explaining confidentiality protections, redirecting focus to patient care, and discouraging speculation balances transparency with investigation integrity. Staff deserve acknowledgment that something is happening without details that could compromise the process.

12. B — Individualized face-to-face conversations with consistent open-ended questions, psychological safety, non-defensive listening, note-taking, and visible follow-up action maximizes information quality. Stay interviews succeed when staff see that their input leads to tangible change rather than being collected and ignored.

13. D — Identifying cultural practices in advance, arranging appropriate notification delivery, accommodating mourning rituals, coordinating with hospital procedures, and documenting the plan provides culturally responsive death management. Proactive cultural assessment prevents the crisis of discovering cultural needs at the moment of death.

14. C — Developing a collaborative strategy where nursing supports physician communication — preparing patients with questions, being present during rounding, and following up to clarify information — uses nursing's scope of influence to improve a metric that nursing does not directly control. The nurse manager cannot mandate physician communication improvement but can create conditions that support it.

15. D — Establishing a communication standard focused on discharge readiness criteria rather than date predictions shifts from time-based predictions outside nursing's scope to goal-based preparation within it. Language like "these are the milestones we need to reach" is accurate, helpful, and does not create false expectations.

16. B — Redesigning the huddle to align with physician workflow, limiting to ten minutes, demonstrating that participation prevents downstream time-consuming callbacks, and tracking efficiency impact addresses the specific barriers to physician attendance. Physicians attend meetings that respect their time and demonstrably improve their workflow.

17. A — Acknowledging excellent clinical judgment while explaining that the notification protocol addresses situations where judgment may be incorrect, and that legal, professional, and scope-of-practice requirements extend beyond clinical accuracy, addresses both the competency affirmation and the compliance requirement simultaneously.

18. C — Acknowledging workflow concerns, demonstrating how acuity-based assignment addresses current workload inequity, presenting mobility and communication solutions, and involving staff in transition design creates buy-in through honest engagement. Staff resistance decreases when legitimate concerns are addressed and staff participate in the solution.

19. A — Acknowledging discomfort while establishing that assignments are based on clinical need, ensuring appropriate safety measures for vulnerable populations, providing emotional support, and establishing equitable care expectations addresses all dimensions. Professional care obligation applies regardless of the patient's criminal history.

20. A — Reframing escalation as bringing additional clinical resources to the patient rather than criticizing the physician removes the interpersonal barrier. Organizations with healthy escalation cultures have better outcomes because nurses advocate without the relational cost that suppresses escalation in hierarchical cultures.

21. B — A medication education protocol assessing literacy and proficiency, adapting complexity and pace, using visual aids, verifying through teach-back in the preferred language, and providing written instructions in the primary language directly addresses the communication gap driving the satisfaction decline.

22. C — The three-minute communication preference assessment eliminates repetitive communication attempts, reduces anxiety from mismatched information delivery, and builds trust through personalization — making it a net time savings over the hospitalization. The investment in understanding preferences prevents downstream communication failures.

23. B — Coaching nurses to maintain their professional role with the same rigor applied to any patient while acknowledging the physician-patient's expertise and including her in clinical discussions balances professional authority with appropriate respect. The nursing role does not diminish because the patient has medical expertise.

24. A — Respecting the patient's autonomous choice to delegate information receipt to her husband, documenting clearly, establishing a communication pathway, and continuing to assess whether preferences change honors patient autonomy. Competent patients have the right to determine how their clinical information is managed.

25. C — A structured transition framework that reframes the shift from "stopping treatment" to "changing goals," involves the patient in defining priorities, introduces palliative care as new partners, and ensures nursing relationship continuity transforms the transition from abandonment to purposeful care evolution.

26. A — Presenting the disparity data without attributing motive, establishing equitable communication as a professional standard, implementing standardized expectations regardless of insurance status, and monitoring through audits addresses the inequity directly. Data presentation without blame followed by clear standards and monitoring produces behavior change.

27. C — Acknowledging the patient's experience, clarifying the program's systemic focus, redirecting to the agenda, offering individual follow-up through patient relations, and establishing ground rules for future meetings provides facilitation that respects the participant while maintaining the advisory panel's purpose.

28. D — Educating that withdrawal-induced communication impairment is a medical condition requiring clinical management rather than behavioral correction, combined with withdrawal-specific communication techniques for each symptom phase, addresses the foundational misunderstanding. Staff who interpret withdrawal symptoms as deliberate behavior respond punitively rather than clinically.

29. A — Communicating transparently with rationale, acknowledging workflow impact, involving staff in redesigning the workflow, and committing to evaluate medication safety and efficiency maintains trust while implementing the change. Staff engagement in the redesign process converts opposition to problem-solving.

30. A — Addressing each bypass reason with targeted solutions — backup scanners for malfunctions, armband replacement processes, and emergency protocols that maintain verification without slowing care — reduces bypass without creating new workarounds. The seven percent bypass represents three distinct problems requiring three distinct solutions.

31. D — Analyzing whether overrides are clinically appropriate (library parameters too restrictive) or clinically inappropriate (nurses bypassing valid alerts) distinguishes between a system calibration problem and a practice behavior problem. The intervention — parameter adjustment versus behavior change — depends entirely on this distinction.

32. D — Refusing to accept an incorrect count, communicating the discrepancy assertively, insisting on recount and search, and requesting imaging if the sponge cannot be located follows the retained foreign body prevention protocol. Surgical count integrity is a non-negotiable patient safety standard that the nurse must enforce regardless of physician assertion.

33. C — Coordinating delivery timing with nursing workflow through a nurse-initiated request system with real-time tracking alerts directly addresses the root cause — blood arriving when the nurse is unavailable. The twelve percent wastage rate results from a timing mismatch between blood bank release and bedside readiness.

34. D — Delayed mobilization has the highest frequency (38%) AND adds the most total excess days across all patients (38% × 0.8 = 0.304 excess days per patient). This impact calculation — frequency multiplied by per-occurrence LOS impact — identifies the variance with the greatest overall population-level effect.

35. C — A punitive error response culture undermines all other safety dimensions because staff who fear punishment underreport, hide near-misses, avoid asking for help, and do not participate honestly in safety improvement. Strong scores on other dimensions cannot protect safety when the reporting foundation is compromised.

36. C — Embedding successful practices into standard work, orientation, competency validation, and daily leadership standard work makes the practices the default operating standard. Sustainability requires system-level integration that persists independently of project champions, dedicated staff, or management attention.

37. A — Higher-than-benchmark RRT activations combined with lower ICU transfers and code blues indicate effective early identification and management of deterioration. The pattern demonstrates that the unit catches problems before they escalate — the opposite of over-activation.

38. D — Implementing the smoke-free policy alongside comprehensive nicotine dependence management — admission assessment, proactive NRT, withdrawal management training, compassionate communication, and cessation resources — addresses both the policy requirement and the clinical consequences of nicotine withdrawal during hospitalization.

39. A — A point-of-use labeling system integrated into the medication administration workflow with labeling supplies at every station and daily environmental scans addresses the sixteen percent compliance gap systematically. The labeling step must be embedded into the existing workflow rather than added as a separate task.

40. A — Increasing CAM screening compliance to at least ninety percent must precede prevention intervention design because accurate identification of the problem's scope is required before effective prevention can be measured. Prevention interventions implemented without reliable screening produce unmeasurable outcomes.

41. D — The declining hand hygiene compliance correlates with simultaneous worsening across all three outcome indicators over four quarters. Restoring hand hygiene compliance may be the single highest-impact intervention because it addresses a foundational practice that affects multiple infection and safety outcomes.

42. C — Immediate naloxone access with staff competency in dosing, administration routes, and post-administration monitoring including re-sedation risk is the most critical protocol element. Naloxone's shorter duration of action compared to most opioids creates re-sedation risk that requires vigilant monitoring after reversal.

43. B — Implementing enhanced safety protocols specifically for insulin, anticoagulants, and opioids is most actionable since these three medication classes account for sixty-two percent of all medication

errors. Targeted interventions for the highest-risk medications produce the greatest absolute error reduction per improvement investment.

44. C — Redesigning the system to allow category selection, implementing frequency limits, communicating security protections clearly, and providing simple opt-in/opt-out mechanisms addresses both opt-out reasons — message fatigue and privacy concerns — while preserving clinical value and patient autonomy.

45. A — Multi-level validation where frontline nurses verify individual events, the quality team validates aggregated data against medical records, the nurse manager reviews for clinical accuracy, and discrepancies are reconciled before submission provides the most rigorous process.

46. B — Unnecessary continuous monitoring contributes to alarm fatigue, desensitizing staff to genuine alarms and paradoxically reducing patient safety. When seventy-eight percent of patients are continuously monitored regardless of indication, the alarm volume overwhelms the clinical relevance of any individual alert.

47. C — Prioritizing the patient experience domain since it showed the largest decline represents the greatest improvement opportunity. The star rating is a composite, and improving the weakest domain produces the largest composite score improvement per intervention dollar.

48. D — Integrating a mandatory cardiac device question into the admission assessment connected to an automated alert system that triggers device-specific safety protocols and cardiology notification provides a comprehensive system-level solution. Individual device identification failures indicate a system gap rather than individual knowledge deficits.

49. A — The organizational culture has not shifted to support autonomous nursing decision-making for device removal despite the protocol's formal authorization. Nurses distrust their authority because the culture historically required physician involvement for clinical decisions, and this cultural barrier persists despite formal authorization.

50. B — A mandatory active identification standard with barcode scanning supplementation, patient education about their identification role, and visual prompts at the point of care addresses the sixty-eight percent passive verification problem comprehensively. Active identification where patients state their own identifiers is significantly more reliable than passive confirmation.

51. C — Developing self-regulation through executive coaching, trigger identification, pause-and-redirect strategies, colleague feedback, and journaling about emotional patterns addresses the specific EI deficit. Self-regulation is developed through reflective practice that builds awareness of the emotional sequences leading to loss of control.

52. A — Identifying and investing in nurses at multiple career stages simultaneously creates a continuous flow of prepared candidates. The pipeline concept fails when development is reactive — triggered by vacancies rather than systematically building capability before vacancies occur.

53. B — Coaching focuses on specific skill or performance improvement through structured practice, feedback, and accountability, while mentoring focuses on broader career development through relationship-based guidance and wisdom sharing. The distinction matters because each serves different developmental needs and requires different approaches.

54. D — Multiple participation channels including pre-meeting input, small-group discussions, digital platforms, and facilitation techniques that draw out quieter voices, combined with coaching dominant members to create space, creates genuine inclusion. Inclusive leadership requires structural changes to participation rather than simply inviting contribution.

55. C — Modeling the disruption of defensive routines by publicly questioning the blame pattern, asking system-focused questions, and creating psychological safety for uncomfortable truths is the most foundational intervention. The defensive routine will persist until leadership visibly breaks it.

56. D — Translating strategic objectives into specific, observable nursing behaviors that individual nurses can perform daily connects abstract goals to concrete bedside actions. The cascade fails when strategic language remains abstract — "improve patient experience" means nothing until it becomes "sit at eye level and use teach-back."

57. A — Directly naming the consensus pattern, establishing that genuine disagreement is valued more than artificial harmony, modeling constructive conflict, and reinforcing when challenged assumptions produce better outcomes addresses Senge's "myth of the management team" directly. The dysfunction persists because no one names it.

58. A — Creating a formalized clinical leadership role that provides title, responsibilities, and advancement without requiring management transition channels natural leadership into organizational impact. This approach respects the nurse's preference for clinical-adjacent leadership while creating structured influence beyond informal peer effect.

59. C — Identifying the specific limiting factor constraining further improvement — staff fatigue, population mismatch, competing gaps, or measurement saturation — addresses the "limits to growth" archetype correctly. Intensifying the original intervention without addressing the constraint produces diminishing returns.

60. C — Continuing to advocate through refined data, proposing compromise solutions like risk-stratified LOS targets, seeking allies, and documenting efforts while maintaining professional performance demonstrates sustained ethical leadership. The tension between organizational loyalty and patient advocacy requires persistent advocacy through appropriate channels.

61. B — Maintaining visible presence, communicating with radical transparency, providing emotional support, creating stability anchors from what is NOT changing, celebrating small victories, and validating that the volume of change is genuinely difficult addresses transformational change comprehensively. Staff need both honesty about the difficulty and evidence of leadership steadiness.

62. C — Developmental coaching that assigns stretch projects, provides conflict resolution mentoring, creates change leadership opportunities, and offers structured reflection builds future-role capabilities through guided experience. The charge nurse meets current standards — the development need is for capabilities the current role does not require.

63. A — Consistent honest communication sharing what is known, acknowledging unknowns, committing to updates, and demonstrating stability through predictable behaviors proves that leadership reliability does not depend on organizational clarity. During ambiguity, the leader's consistency becomes the primary anchor for staff trust.

64. D — Nurse-physician clinical disagreements have the highest clinical impact and directly affect patient care decisions. Developing interprofessional conflict resolution skills for the highest-impact category also builds team capacity applicable to other conflict patterns.

65. B — Asking "what options have you considered?" and guiding the charge nurse through evaluating each option coaches through the decision rather than making it. The leader-as-teacher approach develops

the charge nurse's problem-solving capability rather than creating dependency on the manager's solutions.

66. D — Recommendations implemented only when the manager agrees and modified when they conflict with managerial preferences reveals that decision-making authority has not been transferred. Authentic shared governance requires that designated decisions are final when made by the governance body, not subject to managerial veto.

67. D — Night shift staff will gravitate toward the charge nurse as their primary leader, creating a dual leadership structure that may produce inconsistent practices between shifts. Relational leadership theory predicts that leadership influence follows relationship quality, and weak manager relationships redirect leadership allegiance.

68. C — The long-term cost trajectory is most commonly overlooked. Agency rates typically escalate faster than permanent wage increases, meaning the cost advantage of permanent hiring compounds annually. Year-one comparisons that include orientation costs may favor agency, but multi-year analysis increasingly favors permanent staffing.

69. D — Designing the strategy to address all factors but prioritize based on modifiability at the unit level is most strategic. Compensation requires organizational action with longer timelines, while scheduling flexibility, career advancement, and manager relationships are directly within the nurse manager's influence and can produce faster results.

70. C — Developing broad competencies through cross-training, building decision-making authority at every level, creating simple guiding rules rather than detailed protocols, and practicing adaptation through simulation builds adaptive capacity. Adaptive capacity comes from versatile people with distributed authority and practiced improvisation.

71. D — Acknowledging the history that created cynicism, validating failed initiative experience, making personal sustainability commitments, demonstrating follow-through, starting with a small visible success, and rebuilding trust through reliability rather than promises addresses cynicism at its root. Cynicism is earned through broken promises and can only be reversed through kept ones.

72. C — Developing versatility across all six Goleman leadership styles while maintaining the affiliative foundation and specifically developing comfort with accountability conversations addresses the specific limitation. Affiliative-only leadership creates harmony without direction or accountability.

73. B — Building reciprocal relationships by understanding peer challenges, offering help with their priorities, finding mutual benefit, and leveraging shared outcomes data creates lateral influence through partnership. Lateral leadership operates through relationship capital rather than organizational authority.

74. C — A hybrid approach ensuring minimum competency thresholds in all essential domains while maximizing natural strength contribution and composing complementary shift teams provides the most effective charge nurse development. Neither pure competency remediation nor pure strength-based development alone produces optimal team performance.

75. A — A flexible career framework with multiple advancement pathways allowing personalized trajectories that align individual interests with organizational needs provides the most appropriate response. Career customization acknowledges that professional fulfillment follows different paths for different nurses.

76. B — A continuous feedback culture with immediate, specific behavioral feedback using brief structured format, supported by a digital tracking platform, and replacing annual narrative with year-end summary transforms feedback from event to culture. Immediate specific feedback produces significantly better performance improvement than delayed general feedback.

77. B — A structured daily communication rhythm with safety huddles, intentional rounding touchpoints, real-time feedback, proactive patient communication, and end-of-shift gap identification makes communication the connective tissue of all operations. Communication-intensive leadership treats every interaction as a leadership tool.

78. D — A comprehensive decision authority matrix categorizing common decisions and assigning authority to specific roles with the goal of pushing decisions to the lowest appropriate level provides the most effective framework. Decision rights clarity reduces both over-escalation and under-escalation.

79. C — Non-positional development opportunities including project leadership, cross-functional roles, organizational representation, and external professional engagement provide growth without requiring formal positions. Professional development transcends title advancement, and high-potential retention depends on growth opportunities that may not require new positions.

80. D — Exploring whether contentment reflects satisfaction or disengagement, discussing the professional obligation for ongoing development, and collaboratively identifying activities aligned with clinical interests rather than requiring advancement addresses the professional development standard through individual engagement. The ANA standards require ongoing professional development regardless of career advancement goals.

81. A — Public criticism of a competitor based on information from agency employment creates confidentiality violation risk, potential defamation liability, and professional reputation damage. The concerns span legal (confidentiality, defamation), professional (conduct standards), and ethical (disparagement) dimensions.

82. C — Advising immediate contact with the organization's legal or risk management department ensures the nurse receives appropriate guidance, testimony preparation, and understanding of rights and obligations including the distinction between fact witness and named party status.

83. B — Coaching that declining is professionally appropriate, that therapeutic boundaries persist after discharge, that gratitude has formal channels, and that accepting creates boundary-blurring expectations provides clear guidance. Professional boundaries apply to the entirety of the nurse-patient relationship including its conclusion.

84. B — Providing clinical recommendations based on professional knowledge establishes a nurse-patient relationship carrying professional accountability and potential liability regardless of the informal setting. The professional standard applies whenever nursing knowledge is used to guide clinical decisions.

85. A — Evaluating each dual-license skill through a structured approval process assessing organizational scope, current licensure, physician order requirements, liability coverage, and outcome improvement provides appropriate governance. Blanket prohibition wastes valuable complementary skills while blanket permission ignores legitimate governance needs.

86. B — Integrating micro-learning into existing workflows — brief evidence discussions during huddles, point-of-care teaching, workstation prompts, and asynchronous modules — maintains professional growth momentum without requiring dedicated time. Suspending all development during staffing crises compounds the workforce problem by adding professional stagnation to physical exhaustion.

87. A — Pharmaceutical meals create implicit obligation that may influence practice even when content is clinically sound. The nurse manager must ensure policy compliance, transparent disclosure, and staff awareness that industry engagement carries inherent conflict-of-interest considerations.

88. B — Education about the mandatory reporting obligation, emotional support through the process, confidentiality protection information, and a plan for managing interpersonal consequences including anti-retaliation monitoring provides comprehensive support. Reporting a colleague is one of nursing's most difficult professional obligations.

89. B — IRB-specific education including research ethics principles, the Belmont Report, consent evaluation, vulnerable population protections, and risk-benefit methodology builds the knowledge foundation enabling meaningful participation. Nurses bring a unique patient welfare perspective to IRB deliberations when equipped with research ethics knowledge.

90. D — Establishing AI as decision-support that supplements rather than replaces clinical judgment, maintaining nurse accountability regardless of AI contribution, and defining the nurse's evaluative role maintains professional autonomy within the technology framework. The nurse remains the final decision-maker in the clinical process.

91. B — A just culture analysis examining both the individual bypass decision and the system factors — armband removal process, interim identification gaps, patient cognitive status — determines whether the behavior was human error, at-risk behavior, or reckless behavior. Proportional response requires distinguishing between system-enabled error and deliberate circumvention.

92. D — Engaging the entire team in defining shared values, selecting a theoretical foundation, designing the care delivery system, and establishing governance structures ensures the model reflects team identity rather than imposed leadership vision. Practice models adopted by staff are those created by staff.

93. C — Evaluating whether disclosures compromise patient confidentiality, comply with organizational policies, and can be modified to achieve educational purpose without identifying the institution or patient provides the most appropriate analysis. The advocacy's value must be balanced against confidentiality and organizational policy obligations.

94. D — Evaluating each accommodation through the ADA interactive process for reasonableness, undue hardship, essential function alteration, and alternative effectiveness provides the legally

appropriate framework. Not all requested accommodations are reasonable, but each must be evaluated individually through the interactive process.

95. D — Education on the nurse's role in clinical trial participant protection including consent monitoring, protocol adherence, adverse event reporting, research-standard care distinction, and independent welfare advocacy provides the most appropriate development. Bedside nurses have a unique participant protection role that requires specific competency development.

96. C — The flexed budget adjusts only the variable portion: $217,000 × (920/850) = $234,871. Fixed remains $93,000. Total = $327,871. This calculation correctly recognizes that fixed costs do not change with volume while variable costs increase proportionally with patient days.

97. A — Total costs ($82,400) divided by eight hires equals $10,300 per hire. This metric should be evaluated alongside quality-of-hire indicators to determine whether the recruitment investment produces valued returns. Cost per hire without quality context is an incomplete metric.

98. D — The volume-adjusted analysis reveals the salary "overspend" is primarily volume-driven ($25,000 raw variance becomes $7,129 true spending variance). Supply true variance is $1,041. Education remains $2,800 favorable. Flexed budget analysis separates expected volume-driven cost increases from genuine spending management issues.

99. D — The projected contribution to penalty reduction must account for both the direct cost avoidance per prevented readmission AND the potential CMS penalty reduction from the unit's improved readmission rate affecting the hospital's overall rate. The total return likely significantly exceeds the $85,000 program cost.

100. B — February has the highest HPPD (10.2) AND the highest non-productive hours (1,377 = 16.7% of paid hours), suggesting both overstaffing relative to census and high non-productive time. This dual problem requires investigation of both staffing alignment and non-productive hour drivers.

101. C — The direct three-year savings ($195,000) nearly meet the threshold, but including avoided litigation, regulatory penalties, and reputation protection that the $65,000 annual estimate does not capture likely brings the total value above the $200,000 investment within the payback period.

102. D — The cumulative hidden productivity cost during the twelve-to-eighteen-month path to full productivity is most commonly underestimated. The difference between actual and full-productivity output over this extended period represents an ongoing cost rarely quantified in standard turnover calculations.

103. C — The value analysis process with blinded trials, clinical performance data, and selection based on objective criteria gives staff voice while using evidence rather than personal preference. This approach achieves cost reduction while maintaining clinical quality and staff engagement.

104. A — The medication cabinet ($95,000, 1.5-year payback) has the highest financial return, and the remaining $105,000 can be applied toward the smart bed system. This maximizes financial return within the current allocation while addressing the highest-impact safety needs.

105. B — The clinic underperforms against all targets. The analysis must identify whether volume, revenue per visit, or cost overrun is the primary driver because the appropriate intervention depends entirely on which factor drives the gap — marketing for volume, coding for revenue, or efficiency for costs.

106. A — Comparing current model total cost ($151,200) to the Baylor model cost determines the direct labor impact. However, the full analysis must include recruitment savings, retention impact, benefits differences, and weekday availability implications for a complete financial picture.

107. B — Engaging union leadership as collaborative partners by presenting rationale, involving representatives in option evaluation, addressing workforce concerns, and negotiating implementation terms builds partnership. Collaborative labor-management relationships produce better outcomes than adversarial approaches.

108. B — Prevented departures (3.24) × $54,000 = $174,960 savings against $18,000 cost produces a 9.7:1 ROI. However, the analysis should be presented as a range reflecting uncertainty in the historical comparison, since the full improvement may not be entirely attributable to the preceptor program.

109. C — A comprehensive value analysis quantifying error reduction, time savings, compliance improvement, insurance impact, litigation reduction, and operational efficiency from system integration demonstrates total value across all dimensions. Single-metric justifications underestimate the investment's full return.

110. C — Total direct costs ($127,800 + $28,400 + $35,000 = $191,200) significantly underestimate the true impact. Extended LOS, investigation time, and reputation costs make the actual financial impact considerably higher than the direct calculation.

111. A — Calculating each change separately — wage increase for full year, expansion staffing for six months, LPN-to-RN conversion at implementation — and summing provides the most accurate projection. Budget changes with different effective dates must be calculated individually by time period.

112. D — The thirty-thousand-dollar year-over-year improvement crossing from negative to positive margin demonstrates a positive financial trajectory. The trend analysis — not the cumulative balance — is the most relevant indicator, but the manager must analyze what drove the improvement to assess sustainability.

113. C — Presenting fiscal responsibility track record, the quality-resource relationship, projected risks at each reduction level, and alternative contribution proposals demonstrates both accountability and strategic thinking. Across-the-board cuts penalize already-efficient units, and evidence-based negotiation can achieve organizational targets through targeted rather than blanket reductions.

114. B — The declining commercial percentage removes the cross-subsidization that offset below-cost government payer reimbursement. Medicare ($8,800) and Medicaid ($5,400) both reimburse below the $9,200 cost per case. Only commercial ($13,200) reimburses above cost, and its decline from thirty to eighteen percent creates a structural deficit.

115. A — Presenting financial, quality, satisfaction, and workforce data as an integrated narrative demonstrating that improvements represent strategic investments positions the agency costs as a transition investment that produced the turnover reduction. The eight-percentage-point turnover improvement will generate ongoing savings exceeding the one-time transition expense.