PRACTICE EXAM 15 — FULL-LENGTH SIMULATION (115 QUESTIONS)

1. A nurse manager is developing a communication approach for adult patients on the autism spectrum who are admitted for medical care. These patients may have sensory sensitivities to fluorescent lighting, monitor alarms, and physical contact. They may communicate in atypical patterns — providing extremely literal responses, avoiding eye contact, or requiring additional processing time for verbal information. Staff report feeling uncertain about how to conduct clinical assessments. Which approach is MOST appropriate?

A. Assign the patient to a private room and limit nursing interactions to essential clinical activities to minimize sensory disruption

B. Assess each patient's individual sensory preferences, communication style, and support needs upon admission, document these in the care plan, train staff on neurodiversity-affirming communication including direct language, allowing processing time, minimizing sensory triggers, and respecting the patient's preferred communication modality rather than assuming all autistic patients have the same needs

C. Request an occupational therapy consultation for all autistic patients to develop a sensory management plan before nursing interactions begin

D. Allow the patient's caregiver to serve as the communication intermediary for all clinical interactions to reduce the patient's communication burden

2. A nurse manager is developing a crisis communication protocol for an active threat event on the hospital campus. During a lockdown, staff must simultaneously protect patients, secure the unit, communicate with the incident command system, manage frightened patients and families, and maintain clinical care for patients who cannot be moved. Which communication element is MOST critical during the first five minutes?

A. Activate the hospital-wide emergency communication system to alert all departments about the active threat

B. Contact the incident command center for specific instructions about the unit's role in the emergency response

C. Implement a brief, clear, pre-rehearsed lockdown communication sequence: secure the unit perimeter, account for every patient and visitor, assign specific staff to communication roles including one person monitoring the emergency channel and one person providing calm reassurance to patients, and activate the unit's lockdown checklist — using practiced automatic responses rather than improvised decision-making during high-stress chaos

D. Evacuate all ambulatory patients to an interior safe area and focus communication on coordinating the evacuation

3. A nurse manager is responsible for supporting nursing staff through the communication process with a family that has agreed to organ donation after a loved one's brain death. The family is present at the bedside and emotionally distressed. Nursing staff must maintain physiological support of the donor while simultaneously supporting the family's grief process. Several nurses report emotional difficulty caring for a patient who is legally deceased but appears alive. Which support element is MOST critical?

A. Assign only experienced nurses who have previously cared for organ donors to this patient to minimize emotional distress among less experienced staff

B. Request that the organ procurement organization coordinator manage all family communication so nursing can focus exclusively on physiological support

C. Provide staff with emotional preparation for the unique nature of donor care, acknowledge the cognitive dissonance of maintaining physiological support for a deceased patient, support the family through their grief with compassionate presence, facilitate the family's desired time with the patient including any cultural or spiritual rituals, and arrange staff debriefing after the organ recovery

D. Rotate nursing assignments every four hours to prevent any single nurse from developing excessive emotional attachment to the donor family

4. A nurse manager is implementing a "cultural humility" approach to replace the unit's previous "cultural competence" training. Cultural humility differs from cultural competence in that it emphasizes lifelong learning, self-reflection about one's own biases, and recognition that the clinician can never be fully "competent" in another person's culture. Which behavior BEST distinguishes cultural humility from cultural competence?

A. Learning the health beliefs and practices of the most common cultural groups served by the unit

B. Asking patients to identify their cultural preferences using a standardized cultural assessment form during admission

C. Using professional interpreters for all cross-language clinical communication to ensure cultural accuracy

D. Approaching each patient as a unique individual whose cultural identity cannot be assumed from their demographic characteristics, asking open-ended questions about their personal beliefs and preferences rather than applying generalized cultural knowledge, and continuously examining one's own biases and assumptions rather than treating cultural learning as a finite achievement

5. A nurse manager is addressing a communication challenge where patients who have had previous traumatic healthcare experiences exhibit fear, distrust, and hypervigilance during their current hospitalization. These patients may refuse procedures, become combative during assessments, or withdraw from all clinical interaction. Staff interpret this behavior as "non-compliance" or "difficult patient" rather than recognizing it as a trauma response. Which educational intervention is MOST important?

A. Educate staff to recognize that healthcare-related trauma responses manifest as behaviors that mimic non-compliance but are actually protective responses to perceived threat, train on approaches that restore the patient's sense of safety and control such as explaining every action before performing it, asking permission before touching, and providing choices whenever possible

B. Implement a behavioral contract system where patients agree to cooperate with clinical care in exchange for accommodation of their comfort preferences

C. Assign a patient advocate to accompany traumatized patients during all clinical interactions to provide reassurance and facilitate communication

D. Screen all patients for previous traumatic healthcare experiences during admission and flag charts so staff can adjust their approach proactively

6. A nurse manager is developing a communication plan for announcing a significant staff reduction on the unit due to organizational restructuring. Six nursing positions will be eliminated through a combination of attrition, voluntary separation, and involuntary layoff. The nurse manager must communicate this information while maintaining the remaining staff's trust and engagement. Which communication approach is MOST effective?

A. Announce all six position eliminations simultaneously to prevent prolonged anxiety from serial announcements

B. Communicate the reduction privately to affected individuals before making a general announcement to the full team

C. Deliver the message in a face-to-face meeting with all staff, explain the organizational rationale honestly, identify which positions are affected and the process for determining who fills remaining roles, describe the support available to displaced staff, acknowledge the emotional impact on the team, and commit to transparent ongoing communication about timeline and process — while being present and available for individual conversations afterward

D. Allow the human resources department to manage all communication about the staff reduction since HR has specialized training in workforce reduction notification

7. A nurse manager is implementing a multigenerational communication strategy for a unit where the nursing staff spans four generations — Baby Boomers, Generation X, Millennials, and Generation Z. Communication research shows that generational preferences affect how people prefer to receive information, give feedback, and interact with leadership. Staff have reported intergenerational friction about communication expectations. Which approach is MOST effective?

A. Standardize all communication through a single channel that all generations must use to ensure consistent information delivery

B. Develop a communication approach that offers multiple channels — face-to-face, email, text, and digital platforms — so staff can engage through their preferred modality, while establishing that critical safety and operational information is delivered through a defined primary channel that all generations access, and addressing the generational friction directly by facilitating discussions about different communication preferences as legitimate rather than inferior

C. Adapt the nurse manager's communication style to match each generation's preferred approach during individual interactions

D. Focus communication improvement efforts on the youngest generation since they represent the unit's future workforce and their engagement is most critical for long-term retention

8. A nurse manager is coaching a charge nurse who communicates effectively during routine operations but becomes disorganized and unclear during emergencies. During a recent rapid response event, the charge nurse's communication was described by team members as "scattered," "confusing," and "not

helpful." The charge nurse acknowledges the problem but states she "freezes up" under pressure. Which development approach is MOST effective?

A. Remove the charge nurse from the role during emergency situations and assign a designated emergency communication leader for each shift

B. Develop the charge nurse's emergency communication through repeated high-fidelity simulation practice that replicates emergency stress conditions, provide a structured emergency communication framework such as SBAR that becomes automatic through rehearsal, debrief each simulation focusing specifically on communication performance, and gradually build comfort with high-pressure communication through progressive challenge

C. Provide the charge nurse with an emergency communication checklist that she can reference during actual emergencies to ensure all key information is communicated

D. Counsel the charge nurse that emergency communication skill is essential for the charge nurse role and establish a timeline for demonstrating improvement

9. A nurse manager is developing a structured approach to communicating with patients about healthcare costs. Research shows that patients increasingly want to discuss the cost of their care but nurses feel uncomfortable with financial conversations, viewing them as outside their clinical scope. Many patients make clinical decisions based on cost concerns they do not share with the care team — such as skipping medications, declining recommended follow-up, or leaving the hospital early to avoid additional charges. Which approach is MOST appropriate?

A. Train nurses to proactively ask patients whether cost is a concern affecting their care decisions, normalize financial discussions as a clinical conversation that affects health outcomes, equip nurses with basic information about financial assistance programs and referral pathways to financial counseling, and integrate cost-of-care screening into the discharge planning process

B. Refer all patient financial concerns to the hospital's financial counseling department since cost discussions are outside the nursing scope of practice

C. Provide patients with a printed guide to the hospital's financial assistance programs upon admission and direct them to contact the billing department with questions

D. Train nurses to ask about cost concerns only for patients who are uninsured or underinsured since insured patients are less likely to experience cost-related barriers to care

10. A nurse manager is implementing a "communication audit" program where trained observers evaluate the quality of nurse-patient communication during clinical interactions. The audit assesses specific behaviors including introduction, purpose explanation, eye contact, active listening, teach-back, and closing. Staff express concern that being observed will make them self-conscious and alter their natural communication. Which implementation approach MOST effectively manages this concern?

A. Implement the audit program transparently by explaining the purpose, sharing the observation criteria in advance, framing the audit as a development tool rather than a performance evaluation, beginning with self-audits where nurses evaluate their own communication using the same criteria, then transitioning to peer audits before introducing trained observer audits — building comfort with observation gradually

B. Conduct the observations covertly so nurses behave naturally and the audit captures authentic communication patterns

C. Replace direct observation with patient satisfaction surveys that measure the same communication behaviors from the patient's perspective

D. Implement the observation program immediately since the Hawthorne effect will produce improved communication even if self-consciousness initially alters behavior

11. A nurse manager is developing a communication approach for managing patients who are receiving palliative sedation — continuous deep sedation administered to manage refractory symptoms in terminally ill patients. The patient is no longer able to communicate, but the family is present and struggling with the experience of watching their loved one in continuous sedation. Some family members question whether the sedation is "the same as euthanasia." Which communication framework is MOST appropriate?

A. Refer all family questions about palliative sedation to the palliative care physician since distinguishing sedation from euthanasia requires medical expertise

B. Provide the family with educational materials about palliative sedation that explain the ethical and clinical distinctions from euthanasia

C. Address the family's concerns with clear, compassionate communication explaining that palliative sedation is intended to relieve suffering while the disease follows its natural course — distinguishing this from euthanasia which intentionally ends life — provide ongoing emotional support, ensure the family understands the clinical rationale, encourage their continued presence and connection with the patient, and involve chaplaincy or ethics consultation if the family's moral distress continues

D. Avoid discussing the euthanasia comparison since engaging with the topic may increase the family's distress

12. A nurse manager is responsible for a unit where a nurse consistently documents patient education as "education provided, patient verbalized understanding" without any evidence of teach-back verification, individualized content, or assessment of learning barriers. An audit of sixty charts reveals this identical documentation phrase in every education entry across all sixty charts. Which concern is MOST significant?

A. The repetitive documentation phrase may indicate that the nurse is copying and pasting documentation rather than creating individualized entries for each patient

B. The documentation pattern suggests that the nurse is likely not performing individualized patient education — the identical phrase across sixty charts indicates a documentation habit rather than a clinical activity, meaning patients may be discharged without adequate education, creating both a patient safety risk and a legal vulnerability since the documentation does not provide evidence that education actually occurred

C. The documentation does not meet Joint Commission patient education standards that require evidence of learning assessment and individualized teaching

D. The documentation may trigger a compliance investigation if audited by CMS or accreditation surveyors

13. A nurse manager is developing a communication strategy for managing the transition of a long-term patient from acute care to hospice. The patient has been on the unit for forty-two days, and nursing staff have developed close relationships with the patient and family. The transition to hospice means the nursing team will no longer be involved in the patient's care. Staff express grief about "losing" the patient. Which support element is MOST important?

A. Assign a single nurse to accompany the patient during the transfer to hospice to provide continuity during the transition

B. Organize a team gathering to say goodbye to the patient before the transfer to provide closure for both staff and the patient

C. Acknowledge the staff's grief as a legitimate professional response to ending a meaningful care relationship, facilitate a team discussion about the emotions surrounding the transition, provide a

structured goodbye opportunity that honors the relationship while maintaining professional boundaries, and offer a debriefing space where staff can process their feelings after the patient's departure

D. Remind staff that professional boundaries require emotional detachment and that the grief they feel suggests they have become too emotionally involved with the patient

14. A nurse manager is implementing an "empathy mapping" exercise as part of the unit's patient experience improvement initiative. Empathy mapping is a design thinking tool that visualizes what a patient thinks, feels, says, does, sees, and hears during their care experience. The exercise helps staff understand the patient's perspective beyond satisfaction survey scores. Which application is MOST valuable?

A. Use empathy maps to redesign the unit's physical environment based on what patients see and hear during their hospitalization

B. Create empathy maps for the unit's three most common patient populations by following patients through their complete care journey, documenting their cognitive and emotional experience at each touchpoint, and identifying specific moments where the care experience fails to meet the patient's needs — then redesigning those specific touchpoints based on the empathy insights

C. Display completed empathy maps in the staff break room as a visual reminder of the patient's perspective

D. Include empathy mapping exercises in new employee orientation to build patient perspective-taking skills from the start of employment

15. A nurse manager is addressing a situation where nursing handoff communication has become excessively long — averaging twenty-two minutes per patient compared to the recommended five to seven minutes. Analysis reveals that nurses include extensive narrative detail, social commentary, and subjective opinions about patients and families alongside clinical information. The length delays the receiving nurse's ability to begin patient care. Which improvement is MOST effective?

A. Implement a strict time limit of five minutes per patient handoff and enforce it through charge nurse monitoring

B. Provide handoff communication training that focuses on differentiating essential clinical content from non-essential narrative

C. Implement a structured handoff format that defines the specific information categories to be communicated, separates objective clinical data from nursing commentary, establishes that the EHR contains the comprehensive patient history so the verbal handoff can focus on current priorities and pending actions, and includes a built-in time checkpoint that prompts the sending nurse to summarize and close

D. Record handoff communications and review them with individual nurses to identify which content categories are extending the handoff duration

16. A nurse manager is developing a communication plan for managing patients whose primary language is American Sign Language and who also have significant vision impairment — effectively "deaf-blind" communication needs. Standard accommodations for deaf patients (visual communication) and blind patients (auditory communication) are both inadequate. Which approach is MOST comprehensive?

A. Assign a one-to-one nursing aide to the patient who can learn basic tactile communication methods and serve as a constant communication partner

B. Contact the state's deaf-blind services agency to arrange for a trained support service provider who specializes in deaf-blind communication methods

C. Communicate through written notes in large print since the patient may retain some residual vision

D. Consult with the patient and any established communication partners to determine which tactile communication methods the patient uses, arrange for a trained deaf-blind support service provider or interpreter skilled in the patient's specific communication modality, develop a communication plan that addresses both clinical and comfort needs, and ensure the care team understands the communication system

17. A nurse manager is implementing a structured approach to managing "secondary traumatic stress" among nursing staff. Secondary traumatic stress differs from compassion fatigue in that it results from a single exposure to a particularly traumatic patient event rather than cumulative exposure over time. A nurse who was caring for a child who died from abuse is exhibiting symptoms including intrusive thoughts about the case, avoidance of pediatric patients, and difficulty sleeping. Which intervention is MOST appropriate?

A. Allow the nurse to take a few days off and return when she feels ready to resume normal patient care activities

B. Implement a structured peer support response that normalizes the nurse's reactions as an expected response to an acutely traumatic event, provide immediate access to confidential counseling through a clinician experienced in healthcare-related trauma, temporarily adjust the nurse's patient assignment to avoid triggers while she processes the experience, and follow up longitudinally since secondary traumatic stress symptoms may emerge weeks after the event

C. Refer the nurse to the employee assistance program and allow her to self-manage her recovery timeline

D. Conduct a team debriefing about the traumatic case so all staff who were involved can process the experience together

18. A nurse manager is developing a communication protocol for managing patients who request that specific information NOT be entered into the electronic health record — for example, a patient who discloses substance use but does not want it documented because of concerns about employment or custody implications. The patient asks the nurse to "keep this between us." Which response is MOST appropriate?

A. Honor the patient's request and exclude the information from the medical record since patient trust depends on respecting their wishes about their own health information

B. Explain that substance use history is not typically shared with employers or courts without the patient's consent, and encourage the patient to allow documentation by addressing the specific confidentiality concerns

C. Explain honestly that clinical information relevant to the patient's care must be documented in the medical record for safety and continuity reasons, discuss the specific confidentiality protections that apply to substance use information under federal regulations, address the patient's concerns about who can access the record, and explore whether the patient's fears are based on accurate understanding of privacy protections

D. Document the information but restrict access to only the immediate clinical care team to address the patient's privacy concerns

19. A nurse manager is implementing a "narrative nursing" approach where nurses document a brief narrative summary at the end of each shift describing the patient's experience, progress, and concerns in the patient's own words rather than exclusively using clinical terminology. Research shows that narrative documentation improves empathy, continuity of care, and holistic patient assessment. Staff are concerned that narrative documentation adds time to an already burdensome documentation workload. Which implementation approach is MOST practical?

A. Add the narrative documentation as an optional enhancement that interested nurses can include in their notes

B. Replace one existing documentation element with the narrative summary so the total documentation burden does not increase

C. Implement a brief three-to-four-sentence narrative field at the end of the shift summary that captures the patient's perspective in their own words, demonstrate through examples how narrative notes improve handoff quality and care continuity, and evaluate whether the minimal time investment is offset by reduced handoff duration as receiving nurses gain richer patient understanding

D. Pilot the narrative documentation with a small group of volunteers and evaluate the time burden before implementing unit-wide

20. A nurse manager is addressing a situation where a patient has been secretly recording nursing conversations using a concealed device for the purpose of building a potential malpractice case. The recording was discovered when the patient's attorney contacted the hospital requesting medical records and referenced specific nursing conversations that could only have been obtained through recordings. Which response is MOST appropriate?

A. Report the discovery to the organization's legal department and risk management immediately, implement the organization's recording policy for the remainder of the patient's stay, address any clinical concerns revealed by the recorded conversations, and continue providing professional care while maintaining awareness that interactions may be recorded

B. Confront the patient about the secret recording and request that all recording devices be surrendered

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

D. Restrict all communication with the patient to documented written exchanges to prevent further verbal recordings

21. A nurse manager is developing a communication framework for managing end-of-shift conversations with staff. Currently, the nurse manager's end-of-day interactions are rushed and transactional — focusing on operational issues rather than staff well-being. Research on manager-employee interaction quality shows that brief, genuine check-in conversations significantly affect staff engagement and retention. Which practice is MOST effective?

A. Implement a formal end-of-shift rounding protocol where the nurse manager visits each nurse individually with a standardized list of well-being questions

B. Hold a brief group huddle at the end of each day shift to address any unresolved issues before staff depart

C. Develop a brief daily practice of connecting personally with two to three staff members per shift through informal conversations that acknowledge their specific contributions, ask about their experience that day, and provide an opportunity to raise concerns — cycling through the full team over the course of each week so every team member receives regular personal attention

D. Send a daily appreciation email to the team recognizing collective accomplishments from the day's shift

22. A nurse manager is implementing a patient communication preference system where patients select their preferred name, pronoun, and form of address upon admission. The system allows patients to indicate how they want to be addressed — by first name, Mr./Ms./Mrs. last name, or another preferred title. Some staff resist using preferred pronouns, stating that they will address patients using the pronouns that correspond to their biological sex. Which response is MOST appropriate?

A. Allow staff to address patients using their own judgment about appropriate forms of address

B. Establish that using each patient's preferred name and pronouns is a professional communication standard that demonstrates respect for the patient as an individual, train staff on the system, and address resistance through education about the connection between respectful communication and patient outcomes — making clear that this is a patient care expectation, not a political position

C. Compromise by requiring use of preferred names but allowing staff discretion on pronouns since pronoun preferences are more personally sensitive for some staff

D. Implement the preferred name and pronoun system but exempt staff who have documented religious objections to using certain pronouns

23. A nurse manager is developing a communication strategy for the unit's participation in a large-scale clinical trial. The trial requires nursing staff to screen all admitted patients for eligibility, communicate about the trial during routine care, and collect study-related data alongside clinical data. Staff express concern about the additional workload and uncertainty about what they can and cannot say to patients about the research. Which communication element is MOST important?

A. Provide staff with a script of approved language for discussing the clinical trial with eligible patients

B. Hire a dedicated research coordinator who manages all trial-related patient communication so nursing staff are not burdened with research responsibilities

C. Request that the principal investigator present the trial protocol at a staff meeting so nurses understand the research they are supporting

D. Educate staff on the clear distinction between providing clinical care information (within nursing scope) and recruiting or consenting patients for research (requiring specific research authorization), establish which trial-related activities nursing performs and which require research-trained staff, and ensure nurses understand that they must not influence patients' enrollment decisions while supporting the research process

24. A nurse manager is managing a situation where a patient has elected to discontinue dialysis — a decision that will result in death within days to weeks. The patient's adult children support the decision, but the patient's spouse demands that dialysis be continued. The patient is competent and has clearly articulated their decision. The spouse threatens to sue the hospital if dialysis is stopped. Which communication approach is MOST appropriate?

A. Follow the competent patient's decision to discontinue dialysis while facilitating a family meeting that includes the patient, spouse, children, physician, social work, and potentially ethics consultation to address the spouse's distress, provide emotional support, and ensure all parties understand the patient's right to make this decision

B. Continue dialysis temporarily while the family conflict is mediated since stopping treatment during active family disagreement creates legal risk

C. Request an ethics committee consultation before implementing the patient's decision to ensure organizational support for the decision

D. Follow the patient's decision and instruct the spouse to consult an attorney if she wishes to pursue legal action

25. A nurse manager is addressing a situation where nursing staff communication during interdisciplinary rounds has become passive — nurses present patient information but do not advocate for patient needs, question physician plans, or contribute clinical perspectives beyond data reporting. Physicians report that the nurses "just read the chart" during rounds rather than engaging as clinical partners. Which intervention is MOST targeted?

A. Replace the current rounding format with a nurse-led rounding model where the nurse presents the clinical picture and proposes the plan of care

B. Develop a structured nursing contribution framework for rounds that goes beyond data presentation to include clinical assessment interpretation, identification of patient concerns not captured in the medical record, nursing-specific care priorities, barriers to care progression, and explicit recommendation statements — practicing the format through role-play before implementing during actual rounds

C. Assign the charge nurse to attend rounds as the nursing representative to provide a stronger clinical voice

D. Survey physicians about what clinical contributions they would value from nursing during rounds and design the nursing rounding role around physician expectations

26. A nurse manager is developing a communication plan for a patient who has requested a "Do Not Hospitalize" advance directive — stating that if they develop a condition requiring hospitalization, they prefer to die at home rather than be admitted. The patient has now been brought to the emergency department by EMS after a fall and is being admitted to the unit for a hip fracture. The patient is alert and reiterating their preference not to be hospitalized. Which communication approach is MOST appropriate?

A. Inform the patient that the Do Not Hospitalize directive is a preference document that does not have the legal force of a medical order, and the current injury requires clinical treatment

B. Honor the patient's preference by arranging immediate discharge with home health services for the hip fracture management, since patient autonomy takes precedence over clinical recommendations

C. Initiate a psychiatric consultation to evaluate the patient's decision-making capacity since refusing treatment for a treatable injury raises concerns about judgment

D. Engage the patient in a compassionate conversation exploring the values behind their preference, discuss the specific clinical situation including the treatability of the hip fracture and the expected recovery, clarify the distinction between hospitalization for a reversible injury and end-of-life hospitalization that their directive likely intended, and support the patient's ultimate decision after ensuring informed understanding

27. A nurse manager is developing a structured approach to managing nursing communication during "boarding" — the practice of holding admitted patients in the emergency department when inpatient beds are unavailable. ED nurses caring for boarded patients must simultaneously manage emergency

presentations and provide inpatient-level care. Communication gaps between ED nursing and inpatient teams occur because the patient technically belongs to neither unit during the boarding period. Which communication intervention is MOST critical?

A. Assign an inpatient nurse liaison who physically rounds on boarded patients in the ED to provide clinical oversight and communication continuity

B. Implement an electronic notification system that alerts the receiving unit when their future patient experiences a clinical change while boarding in the ED

C. Establish a clear communication structure that defines who is responsible for the boarded patient's care plan communication at each transition point — including who initiates the admission orders, who manages clinical changes during boarding, who communicates with the family, and who conducts the handoff when the bed becomes available — eliminating the accountability gap that boarding creates

D. Transfer all clinical responsibility for boarded patients to the inpatient nursing team even while the patient physically remains in the ED

28. A nurse manager is implementing a communication improvement initiative specifically targeting the night shift. Night shift HCAHPS scores for "nurse communication" are consistently twelve percentile points below day shift despite similar staffing levels and patient populations. Direct observation reveals that night shift nurses prioritize efficiency over engagement — entering rooms quickly, performing tasks with minimal conversation, and limiting interaction to clinical necessities. Which explanation MOST likely accounts for the night shift communication gap?

A. Night shift patients are more likely to be sedated or sleeping, reducing opportunities for communication engagement

B. Night shift nurses may prioritize quiet efficiency to avoid disturbing sleeping patients, but patients who are awake at night often experience heightened anxiety, loneliness, and need for communication that efficient task-focused interactions do not address

C. Night shift staffing levels may be insufficient despite appearing similar to day shift because nighttime admissions and emergencies create unpredictable workload spikes

D. Night shift nurses may have weaker communication skills because the night shift attracts nurses who prefer less patient interaction

29. A nurse manager is developing a communication protocol for situations where a language barrier prevents effective communication and no interpreter is available within the critical timeframe needed for a clinical decision. For example, a patient presents with chest pain, speaks only Mandarin, and the interpreter service has a twenty-minute wait time. Which protocol element is MOST critical for the interim communication period?

A. Use a translation application on a hospital device to obtain basic clinical history while waiting for the professional interpreter to become available

B. Establish a pre-translated emergency phrase card in the most common languages that addresses critical clinical questions such as pain location, medication allergies, and medical history, supplement with visual pain scales and anatomical diagrams, document the communication limitation, and activate the professional interpreter as soon as available for comprehensive communication

C. Proceed with clinical assessment using non-verbal clinical indicators such as vital signs, cardiac monitoring, and physical examination findings while waiting for the interpreter

D. Contact the Mandarin-speaking hospital staff member directory to identify any employee who can provide immediate interpretation assistance

30. A nurse manager is implementing a medication use evaluation program for the unit. A medication use evaluation systematically examines one or more aspects of medication use — prescribing, dispensing, administering, and monitoring — to identify opportunities for improvement. The unit has experienced a cluster of hypoglycemic events related to insulin administration. Which MUE focus provides the MOST actionable data?

A. Evaluate the entire insulin use process from prescribing through monitoring by examining whether insulin orders include appropriate dosing parameters, whether pharmacy dispensing processes include safety checks, whether nursing administration follows the sliding scale correctly, and whether post-administration glucose monitoring occurs within the required timeframe — identifying which phase of the medication use process contributes most to the hypoglycemic events

B. Review all insulin prescribing patterns to determine whether physicians are ordering appropriate insulin regimens based on patient characteristics

C. Audit nursing compliance with the insulin administration protocol to determine whether administration technique is contributing to the hypoglycemic events

D. Analyze the timing of glucose monitoring relative to insulin administration to determine whether monitoring delays are allowing hypoglycemia to go undetected

31. A nurse manager is developing a patient flow optimization strategy for the unit. Analysis reveals that the unit's average "bed turnaround time" — the elapsed time from patient discharge to the next patient's arrival in the room — is four hours and twelve minutes. The national benchmark for bed turnaround is ninety minutes. Which process step is MOST likely consuming the excessive time?

A. Physician discharge order entry delays, since physicians may not enter discharge orders until late in the day even when patients are clinically ready for discharge earlier

B. Patient transport delays between the discharge of one patient and the arrival of the next

C. The combination of sequential rather than parallel processes — where discharge, environmental services cleaning, bed management notification, and admission preparation occur one after another rather than simultaneously — creates cumulative delay, and the analysis should map the current process to identify which steps can be parallelized and which individual step contributes the most dead time

D. Environmental services cleaning time, since room cleaning between patients typically takes sixty to ninety minutes

32. A nurse manager is evaluating the unit's approach to pain assessment in patients who are non-verbal and cognitively impaired — such as patients with advanced dementia, severe intellectual disability, or intubated patients with altered consciousness. The standard numeric pain scale cannot be used. Staff report relying on their subjective assessment of whether the patient "looks like they're in pain." Which improvement is MOST evidence-based?

A. Implement a protocol requiring a trial dose of analgesic medication and observe the patient's response to determine whether pain was present

B. Train nursing staff to rely on physiological indicators of pain such as elevated heart rate, blood pressure, and respiratory rate as objective measures

C. Rely on family members to interpret the patient's pain expression since they are most familiar with the patient's non-verbal communication patterns

D. Implement a validated behavioral pain assessment tool such as the PAINAD (Pain Assessment in Advanced Dementia) or FLACC that uses observable behavioral indicators — facial expression, body movements, vocalization patterns, and consolability — to provide a structured, reproducible pain assessment that replaces subjective impression with standardized evaluation

33. A nurse manager is responsible for a unit that has been selected to participate in a Patient Safety Organization. PSO participation allows the unit to report safety event data to a federally protected database where the information cannot be used in litigation. In exchange, the PSO provides de-identified aggregate analysis that reveals system-level safety patterns. Which benefit of PSO participation is MOST valuable at the unit level?

A. Legal protection of safety event data from discovery in malpractice lawsuits encourages more honest and complete event reporting

B. The ability to benchmark the unit's safety performance against de-identified data from similar units across the country, identifying safety improvement opportunities that unit-level data alone would not reveal

C. Access to evidence-based safety improvement strategies developed from the aggregate analysis of safety events across multiple organizations

D. Compliance with CMS requirements for patient safety reporting and quality improvement

34. A nurse manager is evaluating the unit's performance on the Leapfrog Hospital Safety Grade, which assigns hospitals letter grades based on safety performance. The hospital received a "C" grade, and the nurse manager wants to understand which specific measures most affected the grade. Which understanding of the Leapfrog methodology is MOST accurate for directing unit-level improvement?

A. The Leapfrog Safety Grade is based primarily on nurse-sensitive indicators that the nurse manager can directly influence through unit-level quality improvement

B. The Safety Grade is based on twenty-eight safety measures organized into four domains — process measures, structural measures, outcome measures, and staffing measures — and the nurse manager's most effective strategy is to identify which specific measures scored lowest and determine which are addressable at the unit level versus requiring organizational-level intervention

C. The Safety Grade is primarily based on publicly reported outcome measures such as mortality rates and complication rates that are influenced by physician practice patterns rather than nursing practice

D. The Safety Grade assigns equal weight to all twenty-eight measures, so improving any single measure will have an equivalent impact on the overall grade

35. A nurse manager is implementing a ventilator-associated event prevention bundle for patients on the unit who require mechanical ventilation. The bundle includes elevation of the head of bed, daily sedation vacation assessment, daily spontaneous breathing trial readiness assessment, DVT prophylaxis, and stress ulcer prophylaxis. Compliance with all bundle elements simultaneously is fifty-eight percent despite individual element compliance exceeding eighty-five percent for each component. Which analysis is MOST important?

A. Investigate which individual bundle element most frequently falls out of compliance to identify the weakest link

B. Analyze the timing of compliance assessments to determine whether the bundle elements are being assessed at different times of day, creating the appearance of individual compliance without actual simultaneous implementation

C. Re-educate staff on the importance of full bundle compliance since the evidence supports simultaneous implementation

D. Analyze the compliance data to identify whether specific patient populations, shifts, or nurse assignments consistently show lower bundle compliance, and investigate whether the gap between individual element compliance and full bundle compliance reflects timing discordance, documentation issues, or genuine failure to implement all elements simultaneously for each patient

36. A nurse manager is developing a wound care product evaluation process for the unit. Multiple wound care product representatives have been visiting the unit, leaving product samples, and encouraging individual nurses to try their products. The result is inconsistent wound care practices with different nurses using different products on the same type of wound. Which management approach is MOST appropriate?

A. Allow nurses to select wound care products based on their individual clinical experience since wound care is within the nursing scope of practice

B. Restrict all wound care product decisions to the wound care nurse specialist

C. Implement a formal wound care product evaluation process through the organization's value analysis committee that includes standardized clinical trials of competing products, outcome data collection, cost comparison, staff usability assessment, and evidence-based product selection — eliminating ad hoc product introduction by individual nurses or vendor representatives

D. Limit vendor access to the unit and require all product demonstrations to be approved by the nurse manager

37. A nurse manager is evaluating a post-anesthesia care transition protocol. Data shows that twenty-eight percent of patients transferred from the post-anesthesia care unit to the medical-surgical unit experience at least one adverse event within four hours of transfer — including respiratory depression, oversedation, uncontrolled pain, and nausea with vomiting. Which intervention is MOST targeted?

A. Extend the PACU monitoring period by two hours to ensure patients are more fully recovered before transfer

B. Implement a post-anesthesia recovery assessment at regular intervals during the PACU stay using validated recovery scoring

C. Require a PACU nurse to accompany the patient to the floor and provide a face-to-face handoff at the bedside

D. Implement evidence-based transfer criteria that require patients to meet specific recovery milestones before transfer, develop a structured PACU-to-floor handoff that highlights ongoing sedation risk and anticipated recovery trajectory, establish a post-transfer monitoring protocol on the receiving unit that includes focused respiratory and sedation assessments at defined intervals during the first four hours, and train floor nurses on post-anesthesia complication recognition

38. A nurse manager is implementing a catheter-associated bloodstream infection prevention initiative for patients with peripherally inserted central catheters. PICC lines carry similar infection risks to other central venous catheters but are sometimes managed with less vigilance because they are perceived as lower risk. Data shows the unit's PICC-related CLABSI rate is twice the central line CLABSI rate. Which intervention is MOST targeted?

A. Replace PICC lines with alternative vascular access whenever clinically appropriate to reduce the number of PICC line-days

B. Standardize the PICC line care and maintenance protocol to match the central line maintenance bundle that has produced lower infection rates

C. Implement enhanced insertion site assessment and documentation for PICC lines to identify early signs of infection

D. Apply the same central line bundle rigorously to all PICC lines, address the perception that PICCs are lower-risk than centrally inserted lines through staff education, implement daily PICC necessity assessment identical to central line assessments, and establish a dedicated PICC surveillance protocol — treating PICCs as central lines for all infection prevention purposes

39. A nurse manager reviews the following data from the unit's safety culture survey:

Dimension	Unit Score	Hospital Avg	National Avg
Teamwork within unit	82%	75%	72%
Supervisor expectations	78%	71%	70%
Organizational learning	68%	65%	62%
Communication openness	54%	60%	58%
Nonpunitive response	42%	48%	45%

Which pattern is MOST strategically important?

A. The unit exceeds both hospital and national averages on teamwork and supervisor expectations, demonstrating strong unit-level safety culture

B. The unit's safety culture is above average overall since three of five dimensions exceed benchmarks

C. Organizational learning at sixty-eight percent represents the biggest opportunity since it directly affects improvement capability

D. Communication openness and nonpunitive response — the only two dimensions below both hospital and national averages — represent the greatest vulnerability because they are the foundational dimensions that enable all others; staff who fear punishment and do not feel safe speaking up will not report events, share concerns, or participate honestly in improvement regardless of how strong other dimensions are

40. A nurse manager is implementing a sedation management protocol for non-intubated patients receiving continuous opioid infusions. The protocol requires routine sedation assessment using a validated tool, defines parameters for dose adjustment, and establishes monitoring frequency requirements. Despite high protocol compliance, two patients have experienced respiratory depression requiring naloxone reversal in the past month. Which investigation is MOST appropriate?

A. Review the protocol parameters to determine whether the sedation assessment intervals are frequent enough to detect respiratory depression before it becomes dangerous

B. Evaluate whether the sedation assessment tool being used is sensitive enough to detect the early signs of respiratory compromise that precede clinically significant respiratory depression

C. Investigate whether the two events share common contributing factors such as specific medications, dosing patterns, patient characteristics, or time-of-day patterns

D. Analyze the two events comprehensively to determine whether protocol parameters are appropriate for the patient population, whether assessment tool sensitivity is adequate, whether concomitant medications contributed, whether patient-specific risk factors were identified and addressed, and whether monitoring frequency matched the actual risk trajectory — since high protocol compliance with continued adverse events suggests the protocol itself may be inadequately designed rather than inadequately followed

41. A nurse manager is developing a plan to transition the unit's quality reporting from process measures (did we do the right thing?) to outcome measures (did the patient get better?). Current quality reporting focuses on compliance rates — percentage of patients who received appropriate VTE prophylaxis, percentage who received timely antibiotics. The nurse manager wants to add outcome tracking — actual VTE events, actual surgical site infections. Which challenge is MOST significant in this transition?

A. Outcome data requires longer collection periods to accumulate sufficient cases for meaningful analysis compared to process data

B. Outcome measures require more sophisticated data collection and analysis infrastructure than process measures

C. Outcome measures are influenced by patient factors beyond nursing control, making it difficult to attribute outcomes to nursing care quality alone, while process measures directly reflect nursing performance — the transition requires a balanced approach that maintains process measures as leading indicators while adding outcome measures as lagging confirmation of whether the processes are producing their intended clinical results

D. Outcome measures are publicly reported while process measures are internal, creating additional scrutiny pressure on the unit

42. A nurse manager is evaluating the unit's performance on medication reconciliation accuracy. An audit comparing the medication reconciliation completed at admission against the patient's actual home medication regimen (verified through pharmacy records and family interviews) reveals discrepancies in

thirty-eight percent of medication reconciliations. The most common discrepancy types are omitted medications (44%), incorrect doses (28%), and duplicate entries (18%). Which finding is MOST concerning?

A. The overall thirty-eight percent discrepancy rate indicates a systemic medication reconciliation process failure

B. The omitted medications represent the most dangerous discrepancy type because patients may not receive medications they need, and the forty-four percent omission rate suggests that the reconciliation process may rely too heavily on patient recall rather than verifying against pharmacy records, medication lists, or other objective sources

C. The incorrect dose discrepancy could result in either underdosing or overdosing of home medications during hospitalization

D. The duplicate entry rate suggests that different providers may be entering the same medications separately, creating confusion about the actual medication regimen

43. A nurse manager is developing a plan for managing the clinical implications of concurrent nurse staffing on multiple care delivery platforms — the same nurses are being asked to provide bedside care, conduct telehealth visits, and monitor remote patient monitoring dashboards during the same shift. Staff report cognitive overload from switching between platforms and fear that attention fragmentation will lead to missed clinical cues. Which operational concern is MOST significant?

A. The technology platforms may not be interoperable, requiring nurses to log in and out of multiple systems during a single shift

B. The liability implications of concurrent platform management are unclear since traditional nursing malpractice frameworks may not address errors that occur while a nurse's attention is divided across physical and virtual care environments

C. Concurrent platform management creates "attention fragmentation" that increases the risk of clinical errors because the cognitive load of switching between physical patient assessment, virtual consultation, and remote monitoring exceeds the human capacity for simultaneous multi-modal clinical attention — each platform demands focused clinical judgment that cannot be safely divided

D. Nursing education programs have not prepared nurses for multi-platform clinical practice, creating a competency gap

44. A nurse manager is implementing a nurse-driven protocol for assessing and managing patients experiencing acute agitation. The protocol uses a standardized agitation assessment scale, defines escalating intervention tiers from verbal de-escalation through pharmacological management, and establishes criteria for restraint use as a last resort. Staff report that the protocol works well during the day but is difficult to implement at night when physician response times are slower and fewer de-escalation-trained staff are available. Which modification MOST effectively addresses the night shift gap?

A. Increase night shift staffing with an additional nurse specifically trained in de-escalation and agitation management

B. Implement standing orders that allow night shift nurses to administer first-line agitation medications without waiting for physician response, with physician notification required within a defined timeframe after administration, ensuring that the night shift response is not delayed by communication lag

C. Require the on-call physician to respond to agitation calls within ten minutes during night shift to match daytime response times

D. Provide all night shift nurses with enhanced de-escalation training to compensate for the reduced number of trained staff available at night

45. A nurse manager is evaluating the unit's compliance with the CMS Conditions of Participation requirement that patients receive information about their right to formulate advance directives. Audit data shows that ninety-two percent of patients receive the advance directive information pamphlet during admission. However, only fourteen percent of patients have a documented advance directive conversation with a clinical team member, and only eight percent of patients without existing advance directives complete one during their hospitalization. Which interpretation is MOST accurate?

A. The ninety-two percent pamphlet distribution rate demonstrates adequate compliance with the CMS requirement since the regulation requires that patients receive information about advance directives, not that they complete them

B. The fourteen percent conversation rate suggests that pamphlet distribution alone does not constitute meaningful patient engagement on advance directives and that the unit should implement a structured conversation process that goes beyond information delivery to actual facilitation of advance directive decision-making

C. The eight percent completion rate is consistent with national averages and does not indicate a performance gap

D. The gap between information delivery (92%) and meaningful engagement (14%) reveals that the unit is meeting the regulatory minimum but failing to achieve the clinical intent — patients receive paper about advance directives but are not supported in actually making these important decisions, suggesting the need for a structured clinical conversation that transforms the regulatory requirement into genuine patient benefit

46. A nurse manager is developing a plan to address the unit's rising incidence of catheter-associated urinary tract infections. Data analysis reveals that sixty-two percent of catheterized patients do not meet evidence-based indication criteria for continued catheterization. The nurse-driven catheter removal protocol has been in place for twelve months with minimal effect. Investigation reveals that nurses conduct the daily assessment but do not feel empowered to remove catheters independently because physicians have historically objected to nurse-initiated removal. Which intervention is MOST important?

A. Engage physician leadership in co-developing the removal protocol so physicians endorse nurse-initiated catheter removal

B. Implement a physician co-signature requirement for catheter removal to maintain collaborative decision-making

C. Present the utilization and CAUTI data to the medical staff and request a formal endorsement of nurse-initiated catheter removal

D. Address the empowerment barrier by securing visible physician endorsement of nurse-driven removal, creating public physician-nurse co-ownership of the protocol, implementing the first wave of removals with physician acknowledgment to build nurse confidence, and celebrating successful nurse-initiated removals to normalize the practice

47. A nurse manager is implementing a clinical surveillance system that generates automated deterioration alerts based on a predictive algorithm. During the first month, the system generates three hundred forty alerts. Review reveals that eighty-two percent of alerts do not result in clinical intervention — the clinical team evaluates the patient and determines no action is needed. Staff are beginning to ignore the alerts. Which analysis is MOST critical?

A. Determine whether the eighteen percent of alerts that resulted in clinical intervention prevented adverse outcomes that would not have been identified without the surveillance system

B. The eighty-two percent non-actionable alert rate will produce alert fatigue that undermines the system's effectiveness for the eighteen percent of genuine deterioration events — the analysis must determine whether the algorithm's sensitivity can be adjusted to reduce false positives without missing true deterioration, and whether the current alert rate is sustainable for staff attention

C. Evaluate whether the alert display format provides enough clinical context for rapid triage so staff can quickly distinguish alerts that require assessment from those that can be safely acknowledged

D. Compare the surveillance system's alert rate to the vendor's published performance benchmarks to determine whether the system is functioning within expected parameters

48. A nurse manager is developing a plan for managing patients who require continuous one-to-one observation — such as patients at risk for self-harm, elopement, or falls. The unit currently uses registered nurses for all one-to-one observations, consuming a significant portion of the nursing budget. Some nurses assigned to one-to-one observation report feeling frustrated that their clinical skills are underutilized during observation shifts. Which staffing model is MOST appropriate?

A. Use trained security personnel for all one-to-one observations to free nursing resources for clinical care

B. Implement a tiered observation model that matches the observer's qualifications to the patient's risk profile — using trained unlicensed assistive personnel for patients requiring observation for fall prevention or elopement risk, and registered nurses for patients requiring clinical monitoring during observation such as those with active suicidal ideation or acute delirium requiring ongoing clinical assessment — while establishing clear escalation criteria for all observer levels

C. Use video monitoring technology to replace in-room one-to-one observation for appropriate patient populations

D. Maintain the current RN-only model since patient safety during one-to-one observation requires the clinical judgment that only registered nurses can provide

49. A nurse manager is evaluating the unit's nurse-sensitive indicator performance using the NDNQI database. The unit's hospital-acquired pressure injury rate has been consistently above the seventy-fifth percentile (worse than seventy-five percent of comparable units) for four consecutive quarters. Despite implementing evidence-based prevention interventions, the rate has not improved. Which investigation is MOST appropriate?

A. Review the documentation accuracy of pressure injury staging since misclassification could inflate the reported rate

B. Evaluate whether the unit's patient population differs significantly from the comparison group in ways that increase inherent pressure injury risk beyond what the current risk-adjusted benchmarking captures

C. Assess staff compliance with the pressure injury prevention protocol to identify specific compliance gaps that may be undermining the intervention effectiveness

D. Conduct a comprehensive investigation that examines documentation accuracy, risk adjustment adequacy, protocol compliance, intervention appropriateness for the specific patient population, early identification and staging accuracy, equipment adequacy, and nutrition support integration — since persistent above-benchmark performance despite evidence-based interventions suggests that the standard approach may not match the unit's specific population characteristics

50. A nurse manager is evaluating the unit's approach to managing clinical alarms. The Joint Commission has identified alarm management as a National Patient Safety Goal. The unit averages three hundred fifty alarms per patient per day. Research shows that eighty-five to ninety-nine percent of clinical alarms are clinically non-actionable. Staff report significant alarm fatigue and describe the alarm environment as "constant noise." Which improvement strategy is MOST comprehensive?

A. Reduce alarm volume levels to decrease the noise burden on staff and patients

B. Implement alarm notification technology that routes alarms to the assigned nurse's mobile device rather than sounding audibly in the clinical environment

C. Establish a clinical alarm management committee that reviews alarm data, eliminates unnecessary alarms through parameter customization, implements notification escalation protocols, defines response time expectations by alarm priority level, and creates a closed-loop improvement process

D. Implement a comprehensive alarm management program that includes alarm data analysis to identify the highest-frequency non-actionable alarms, clinical parameter customization for each patient based on individual baseline values, alarm notification hierarchy that escalates appropriately, staff education on alarm response expectations, daily alarm rounds that verify parameter appropriateness, and ongoing monitoring of alarm-related clinical events to ensure that alarm reduction does not compromise patient safety

51. A nurse manager is applying Kotter's eight-step change model to implement a major practice change on the unit. Kotter's first step is "create a sense of urgency." The nurse manager wants to implement a

new sepsis screening protocol, but staff do not perceive sepsis identification as a current problem because the unit's sepsis mortality rate is at the national average. Which approach MOST effectively creates urgency without fabricating a crisis?

A. Present data showing that the national average sepsis mortality rate means patients are still dying from sepsis on this unit and that "average" performance is not acceptable when preventable deaths are occurring

B. Present specific case studies of patients on the unit who experienced delayed sepsis recognition — with de-identified but detailed clinical narratives that illustrate the human cost of missed identification opportunities — alongside data showing the gap between the unit's current performance and top-quartile organizations, making the case that "average" means preventable deaths are occurring

C. Implement the screening protocol immediately without creating urgency since clinical necessity should override staff perception

D. Wait for a sentinel event related to sepsis to create natural urgency for the screening protocol implementation

52. A nurse manager is applying the Appreciative Inquiry four-D cycle to improve team performance on the unit. The four stages are Discovery (what gives life), Dream (what might be), Design (what should be), and Destiny (what will be). The Discovery phase requires the team to identify its greatest strengths and most positive experiences. Staff are skeptical, stating that the unit has more problems than strengths. Which facilitation approach MOST effectively engages a skeptical team in the Discovery phase?

A. Skip the Discovery phase and begin with the Dream phase since the team is more interested in envisioning the future than examining the past

B. Begin with structured interviews asking each staff member to describe a specific moment when they felt the team was performing at its absolute best — when did you feel most proud to work on this unit? What made that possible? What were you and your colleagues doing differently? — using these peak experiences as evidence that the team already possesses the capabilities for excellence

C. Present organizational data showing the unit's strengths relative to peer units to convince staff that the unit has more positive attributes than they perceive

D. Address the skepticism directly by acknowledging the unit's problems before transitioning to the strength-based exploration

53. A nurse manager is applying stakeholder mapping to a proposed change initiative. Stakeholder mapping categorizes individuals and groups by their level of influence over the initiative's success and their level of support for the change. The map reveals that the medical director has high influence and low support (a "blocker"), while frontline nurses have moderate influence and high support (allies). Which strategic approach is MOST effective for managing the stakeholder landscape?

A. Focus engagement efforts on converting the medical director from blocker to supporter since their high influence can either enable or derail the initiative

B. Invest most effort in strengthening the frontline nurses' influence through empowerment and visibility, creating a grassroots force that can overcome the medical director's resistance through collective advocacy and demonstrated clinical results

C. Engage the medical director to understand their specific concerns and address them directly, while simultaneously mobilizing the nursing allies to demonstrate grassroots support and create positive momentum that makes the initiative's success visible to all stakeholders

D. Proceed with the initiative through nursing channels and work around the medical director's resistance rather than attempting to convert their position

54. A nurse manager is implementing an "agile methodology" approach to quality improvement on the unit. Agile methodology, originally developed for software development, emphasizes short iterative cycles (sprints), rapid testing, continuous feedback, and adaptation rather than comprehensive upfront planning. Compared to traditional PDSA or Lean Six Sigma approaches, agile QI cycles are shorter (one to two weeks versus months) and produce faster learning. Which quality improvement challenge is BEST suited for an agile approach?

A. Reducing surgical site infection rates, which require extended data collection periods to demonstrate statistically significant improvement

B. Improving nurse response time to call lights, which benefits from complex process mapping and Lean waste elimination

C. Redesigning the patient discharge process by rapidly testing small changes each week — such as modifying education timing one week, adjusting pharmacy notification triggers the next, and testing a different handoff format the following week — getting rapid feedback from patients and staff after each change and building the optimal process iteratively rather than designing the complete new process before testing

D. Reducing medication errors, which require comprehensive root cause analysis and system-level interventions

55. A nurse manager is applying the McKinsey 7-S framework to diagnose why a recent change initiative failed despite having a strong strategy and clear structure. The 7-S framework evaluates seven interrelated organizational elements: Strategy, Structure, Systems, Style, Staff, Skills, and Shared Values. The initiative had clear strategy and structure but post-mortem analysis reveals that the failure resulted from misalignment between the change strategy and the unit's informal leadership style, existing skill gaps, and conflicting shared values. Which 7-S element MOST commonly explains change failure in nursing units?

A. The soft elements — Style, Staff, Skills, and Shared Values — most commonly explain change failure because organizations typically plan the hard elements (Strategy, Structure, Systems) while neglecting the cultural and human dimensions that determine whether the planned change actually takes root in daily practice

B. Systems — the processes and procedures that support daily work — are most commonly the source of failure because even well-designed strategies fail when the operational systems do not support execution

C. Structure — the organizational design and reporting relationships — most commonly explains failure because structural misalignment creates authority gaps that prevent implementation

D. Strategy — the plan itself is most commonly flawed — is typically the source of failure because poor strategic design produces unachievable implementation targets

56. A nurse manager is applying SWOT analysis (Strengths, Weaknesses, Opportunities, Threats) to develop a strategic plan for the unit. The analysis reveals:

Strengths: High staff retention, strong patient satisfaction, experienced team

Weaknesses: Aging equipment, limited professional development, high overtime reliance

Opportunities: New service line expansion, Magnet designation pursuit, telehealth growth

Threats: Regional nursing shortage, reimbursement reduction, competitor expansion

Which strategic insight is MOST actionable from this SWOT matrix?

A. Leverage the high retention and experienced team strengths to pursue Magnet designation, which would address the professional development weakness while capitalizing on the opportunity

B. Address the aging equipment weakness immediately since it represents the most concrete and solvable problem

C. The most powerful strategy emerges from matching strengths to opportunities: the experienced team with high retention is uniquely positioned to lead service line expansion and Magnet pursuit, while the regional nursing shortage threat makes the existing strong retention an even more valuable competitive advantage — the strategy should invest in the team that is already loyal while their competitors struggle to recruit

D. Focus on mitigating the threats first since the nursing shortage and reimbursement reduction could undermine all other strategic efforts

57. A nurse manager is applying the concept of "political skill" in organizational leadership. Political skill refers to the ability to read organizational dynamics accurately, build strategic relationships, project genuine sincerity, and influence others effectively. A nurse manager who is clinically excellent and operationally competent but lacks political skill often finds their initiatives blocked, their budget requests denied, and their voice marginalized in organizational discussions. Which behavior MOST demonstrates political skill?

A. Attending all organizational meetings and volunteering for high-visibility committees to increase personal exposure to organizational decision-makers

B. Building coalitions before presenting proposals by identifying key stakeholders, understanding their priorities, framing proposals in language that connects to their interests, timing presentations for maximum receptivity, and cultivating relationships based on genuine mutual benefit rather than transactional exchange

C. Developing a reputation as a "straight shooter" who always speaks directly and does not engage in organizational politics

D. Aligning publicly with the most powerful organizational leaders to gain reflected influence from their position

58. A nurse manager is developing a comprehensive onboarding program that extends beyond clinical orientation to include organizational socialization — helping new nurses understand the unit's culture, informal norms, communication patterns, and unwritten rules that affect daily practice. Research shows that nurses who experience effective organizational socialization have higher job satisfaction and lower first-year turnover. Which socialization element is MOST frequently missing from traditional orientation programs?

A. Formal introduction to organizational leaders and key stakeholders across the hospital

B. Structured social integration activities that help new nurses build informal relationships with colleagues, understand the unit's unwritten cultural norms, identify the informal influence network, and develop a sense of belonging — addressing the social dimension of workplace integration that clinical orientation ignores

C. A comprehensive organizational history presentation that helps new nurses understand how the unit evolved to its current state

D. A mentor assignment that extends beyond the clinical preceptor to include a social mentor who introduces the new nurse to the unit's informal culture

59. A nurse manager is applying the concept of "generative leadership" to build an organization that creates new knowledge and innovative practices rather than simply maintaining existing operations. Generative leaders focus on fostering the conditions for creativity, experimentation, and knowledge creation. The unit currently operates in a maintenance mode — efficiently executing established practices but rarely generating new ideas. Which intervention MOST effectively shifts toward a generative culture?

A. Implement a formal innovation committee with a structured process for generating and evaluating new ideas

B. Send staff to innovation conferences to bring back new ideas from outside the organization

C. Hire new staff who bring innovative experience from other organizations

D. Create "generative spaces" where staff have permission and time to question current practices, propose alternatives, test new approaches through safe-to-fail experiments, and share learning without requiring that every experiment succeed — establishing that innovation is valued alongside operational excellence and that thoughtful experimentation is encouraged even when it occasionally fails

60. A nurse manager is applying the Balanced Scorecard framework to evaluate unit performance. The Balanced Scorecard, developed by Kaplan and Norton, evaluates organizational performance across four perspectives: Financial, Customer, Internal Processes, and Learning and Growth. Most nursing units focus almost exclusively on the Customer (patient satisfaction) and Internal Processes (quality metrics) perspectives. Which perspective is MOST commonly neglected in nursing unit performance evaluation?

A. The Learning and Growth perspective — which measures the unit's investment in staff development, knowledge creation, organizational learning, and innovation capacity — is most commonly neglected because it represents the organizational infrastructure that enables performance in all other perspectives, yet its impact is indirect and long-term rather than immediately measurable

B. The Financial perspective, which measures the unit's contribution to organizational fiscal health

C. The Customer perspective, which in healthcare extends beyond patient satisfaction to include physician satisfaction, family satisfaction, and referral source satisfaction

D. The Internal Processes perspective, which should include not only quality metrics but also efficiency measures, capacity utilization, and workflow optimization

61. A nurse manager is developing a leadership approach to managing the unit during a period where multiple staff members are simultaneously experiencing personal crises — including a nurse whose child has been diagnosed with cancer, a nurse going through a difficult divorce, a charge nurse caring for an aging parent, and a nurse dealing with a family member's substance use disorder. The cumulative effect of personal stress across the team is affecting clinical performance and team dynamics. Which leadership response is MOST appropriate?

A. Refer all staff members experiencing personal difficulties to the employee assistance program and focus leadership attention on maintaining clinical performance standards

B. Implement temporary workload adjustments for the most severely affected staff members to reduce clinical pressure during their personal crises

C. Acknowledge the reality that multiple team members are simultaneously navigating personal challenges, provide individualized support through flexible scheduling and EAP referral, monitor clinical performance with compassion while maintaining safety standards, distribute workload adjustments equitably so no individual bears disproportionate burden, and attend to the team's collective resilience since the cumulative weight of multiple concurrent crises affects team dynamics beyond what individual support addresses

D. Hold a team meeting to acknowledge the collective stress and build mutual support among team members

62. A nurse manager is implementing a "dashboard design" improvement for the unit's quality reporting. The current dashboard displays twenty-eight metrics on a single screen, making it difficult for staff to identify which metrics require attention. Research on effective dashboard design shows that human cognitive capacity limits the number of data points that can be processed simultaneously. Which design principle is MOST important?

A. Reduce the dashboard to five to seven critical metrics that represent the unit's highest-priority quality, safety, and operational indicators, display them with clear visual indicators of status (on target, trending, off target), and provide drill-down capability for detailed analysis — applying the principle that a dashboard should direct attention to what needs attention rather than displaying everything that can be measured

B. Organize the twenty-eight metrics into categories with color coding to help staff quickly identify which category requires attention

C. Create separate dashboards for each metric category — quality, safety, staffing, finance — to reduce the information density on each screen

D. Display only metrics that are currently off-target and remove on-target metrics to focus attention exclusively on problems

63. A nurse manager is evaluating the effectiveness of "collective leadership" on the unit — a model where leadership is distributed across the team rather than concentrated in formal positions. The unit has developed a strong collective leadership culture through shared governance, distributed decision-making, and team-based problem solving. However, the nurse manager notices that during crises, the collective leadership model creates confusion about who is in charge. Which adaptation is MOST appropriate?

A. Abandon the collective leadership model in favor of a clear hierarchical structure that functions during both routine and crisis situations

B. Maintain collective leadership for routine operations and implement a designated hierarchy with defined incident command roles for crisis situations

C. Train all team members in crisis leadership so any individual can assume command during emergencies regardless of formal role

D. Implement a hybrid model that maintains collective leadership for routine and improvement activities while establishing pre-designated crisis leadership roles with clear activation criteria, defined authority boundaries, and communication protocols — so the transition from collective to hierarchical leadership occurs automatically when crisis criteria are met

64. A nurse manager is applying the concept of "quantum leadership" to contemporary nursing management. Quantum leadership, influenced by quantum physics concepts, emphasizes that in complex systems, leaders cannot predict or control outcomes — they can only create conditions for positive emergence. Which leadership behavior MOST reflects quantum leadership principles?

A. Developing detailed strategic plans with defined milestones and accountability metrics for each initiative

B. Implementing strict compliance monitoring systems to ensure staff follow established protocols

C. Creating conditions for positive outcomes by fostering relationships, enabling information flow, supporting adaptation, tolerating ambiguity, and trusting that beneficial patterns will emerge from the interactions of competent professionals working within clear values and boundaries — rather than attempting to predict and control every aspect of clinical operations

D. Distributing leadership authority across the team through shared governance and empowered decision-making

65. A nurse manager is developing a comprehensive approach to managing "change resistance" that goes beyond viewing resistance as a problem to be overcome. Contemporary change management theory suggests that resistance often contains valuable information about the change itself — revealing flaws in the plan, unaddressed concerns, or organizational readiness gaps that the change leader missed. Which approach to resistance is MOST productive?

A. View resistance as diagnostic information by engaging resisters in dialogue to understand their specific concerns, determine whether their objections reveal genuine problems with the change plan, modify the plan based on legitimate feedback, and differentiate between resistance that reflects valid concerns and resistance that reflects personal comfort with the status quo

B. Implement the change with strong leadership commitment and manage resistance through positive incentives and progressive accountability

C. Identify the informal leaders among the resisters and convert them to supporters through targeted engagement, leveraging their influence to shift the broader group's position

D. Delay implementation until resistance decreases through education, communication, and relationship building

66. A nurse manager is applying the concept of "strategic agility" — the ability to continuously adjust the unit's strategic direction in response to changing environmental conditions. The traditional approach to strategic planning involves creating a three-to-five-year plan and executing it as designed. Strategic agility suggests that in rapidly changing healthcare environments, rigid multi-year plans become obsolete before they are fully implemented. Which planning approach MOST effectively builds strategic agility?

A. Eliminate formal strategic planning and respond to environmental changes as they arise through ad hoc decision-making

B. Maintain a three-to-five-year strategic vision but review and adjust the specific implementation plan quarterly based on current conditions

C. Develop a one-year strategic plan with detailed implementation and review every six months for relevance, replacing the traditional multi-year planning cycle with shorter, more responsive planning periods that maintain strategic direction while enabling tactical adaptation

D. Implement a continuous strategic sensing process that monitors environmental signals, maintains a rolling twelve-to-eighteen-month strategic horizon with quarterly recalibration, preserves a stable core strategic direction while adapting implementation tactics to current conditions, and embeds strategic thinking into daily leadership practice rather than confining it to annual planning cycles

67. A nurse manager is applying the concept of "power mapping" to understand the influence dynamics on the unit. Power in organizations comes from multiple sources: positional authority, expert knowledge, relationship networks, information access, and resource control. Assessment reveals that a staff nurse without any formal leadership role holds significant informal power because she is the unit's most clinically skilled nurse, has the strongest relationship network, and controls access to critical institutional knowledge. This informal power sometimes conflicts with formal leadership. Which management approach is MOST effective?

A. Attempt to diminish the informal leader's power by distributing institutional knowledge across the team and building clinical skills in other nurses

B. Ignore the informal power dynamic and manage the unit through formal authority structures

C. Compete with the informal leader for influence by demonstrating superior clinical knowledge and building stronger relationship networks

D. Acknowledge and respect the informal leader's influence, seek to understand her perspective on unit issues, align with her when possible, engage her as a partner in leadership initiatives, and address conflicts between formal and informal power through transparent dialogue rather than positional authority — recognizing that effective unit leadership requires the cooperation of both formal and informal power holders

68. A nurse manager is evaluating the unit's approach to managing "moral residue" — the lasting psychological impact that remains after a morally distressing event, even after the event has been resolved. Unlike acute moral distress which occurs during the event, moral residue accumulates over time as unresolved ethical experiences build upon each other. Staff who have been on the unit for many years carry significant moral residue from years of participating in care they believed was inappropriate. Which intervention addresses moral residue specifically?

A. Provide access to ethics consultation for future morally distressing situations to prevent additional moral residue from accumulating

B. Implement a moral resilience training program that teaches staff coping strategies for managing moral distress in the moment

C. Conduct group debriefing sessions about past morally distressing events to process the accumulated residue

D. Address moral residue requires acknowledging that past experiences have created lasting psychological impact, creating safe forums for processing accumulated ethical distress, connecting staff with professional support experienced in healthcare moral injury, and implementing systemic changes that reduce the organizational conditions that produced the original morally distressing situations — preventing new residue while processing the existing burden

69. A nurse manager is developing a "learning organization" framework based on the five disciplines Peter Senge identified as essential: personal mastery, mental models, shared vision, team learning, and systems thinking. Assessment reveals that the unit excels at personal mastery (individual nurses are highly competent) and team learning (the team collaborates well) but struggles with mental models

(unexamined assumptions drive decision-making) and systems thinking (staff address symptoms rather than root causes). Which intervention addresses the weakest disciplines?

A. Implement a root cause analysis training program for all staff to develop systems thinking capability

B. Conduct a mental models workshop where staff explicitly surface and examine the assumptions underlying their clinical and operational decision-making

C. Develop both disciplines simultaneously by creating structured opportunities for staff to identify their assumptions about how the unit works (mental models), trace the systemic connections between different operational elements (systems thinking), and practice examining the deeper causes of recurring problems rather than addressing surface symptoms — building the analytical capabilities that transform individual competence into organizational intelligence

D. Focus on strengthening the shared vision discipline first since a compelling vision motivates the development of all other disciplines

70. A nurse manager is developing a succession planning strategy that addresses the unit's leadership pipeline at three levels: immediate readiness (can step into a leadership role now), near-term development (ready within one to two years), and long-term potential (capable of leadership with three to five years of development). The unit has adequate immediate-readiness candidates but no nurses in the near-term or long-term pipeline. Which vulnerability is MOST concerning?

A. The absence of near-term candidates since they represent the pipeline that will replace current leaders within the typical leadership tenure cycle

B. The absence of long-term candidates since they represent the unit's future leadership sustainability

C. The immediate-readiness candidates may accept leadership positions elsewhere if they are not promoted soon, creating an urgency to advance them before they leave

D. The empty near-term and long-term pipeline creates a "leadership cliff" where the departure or promotion of current immediate-readiness candidates would leave the unit with no leadership succession at any stage — requiring simultaneous investment in identifying and developing candidates at both the one-to-two-year and three-to-five-year horizons to prevent the cliff

71. A nurse manager is applying the concept of "sense-making" in organizational leadership. Sense-making, as described by Karl Weick, is the process by which people interpret ambiguous organizational

events and create shared understanding that enables coordinated action. During a period of organizational uncertainty, staff are creating their own interpretations of events through informal conversations — some accurate, some inaccurate — and these interpretations are driving behavioral responses. Which leadership behavior MOST effectively supports productive sense-making?

A. Provide a single authoritative interpretation of events to prevent the spread of inaccurate informal interpretations

B. Encourage staff to discuss their interpretations openly but do not provide leadership perspective to avoid appearing directive

C. Engage actively in the sense-making process by providing factual information, sharing the leadership perspective transparently while acknowledging uncertainty, validating staff interpretations that are accurate, gently correcting those that are inaccurate, and creating structured opportunities for collective sense-making that produce shared understanding

D. Implement a formal communication plan that preempts informal sense-making by controlling the information flow

72. A nurse manager is evaluating the concept of "leadership presence" — the quality that enables certain leaders to command attention, inspire confidence, and create psychological safety through their physical and emotional demeanor. Assessment feedback indicates that the nurse manager's leadership presence is strongest during one-on-one interactions but weakest during group meetings and presentations. Which development approach is MOST targeted?

A. Develop group presence through structured practice including rehearsal of key messages before meetings, conscious attention to body language and voice projection, strategic use of eye contact across the room, and post-meeting self-assessment that identifies specific moments where presence was strong or weak

B. Attend a public speaking course to develop presentation skills and confidence in front of groups

C. Focus development on one-on-one interactions since this is the nurse manager's strength and most leadership impact occurs in individual conversations

D. Observe leaders who have strong group presence and model their specific behaviors during unit meetings

73. A nurse manager is developing a strategy for "leading innovation" — creating conditions where new ideas emerge, are tested, and are integrated into practice. Research on innovation in healthcare shows that most clinical innovations originate from frontline staff who identify problems during daily practice, not from leadership-initiated programs. Which leadership behavior MOST effectively catalyzes frontline innovation?

A. Establish a formal suggestion box where staff can submit innovative ideas for leadership review and selection

B. Create the conditions for innovation by removing the barriers that prevent frontline staff from acting on their ideas — including providing time for experimentation, reducing the fear of failure, simplifying the approval process for small-scale tests, making resources available for pilot projects, and publicly celebrating both successful and unsuccessful innovation attempts as demonstrations of the organization's commitment to improvement

C. Assign a dedicated innovation team that identifies and tests new ideas on behalf of the unit

D. Implement a structured innovation methodology such as design thinking that provides a framework for moving ideas from concept through testing to implementation

74. A nurse manager is applying the concept of "appreciative leadership" specifically to performance management. Traditional performance management identifies deficits and creates improvement plans. Appreciative performance management begins with identifying what the individual does exceptionally well and builds from strength. A nurse consistently performs at the "meets expectations" level across all competencies but does not excel in any area. Using an appreciative approach, which developmental conversation is MOST effective?

A. Explore what aspects of the nurse's work feel most meaningful and energizing, identify the specific moments when the nurse performs at her best and what conditions enable those peak performances, and build a development plan that creates more opportunities for the nurse to operate in her strength zone — investigating whether "meets expectations" across the board reflects genuine average capability or whether a passionate strength is being suppressed by an environment that does not call it forward

B. Accept the "meets expectations" performance as satisfactory and focus development resources on nurses who show higher potential

C. Identify the competency area closest to "exceeds expectations" and invest development resources in pushing that area above the threshold

D. Conduct a comprehensive skills assessment to identify hidden strengths that the current evaluation system may not capture

75. A nurse manager is developing a strategy for managing the unit's approach to "psychological safety" — the shared belief that the team is safe for interpersonal risk-taking. Amy Edmondson's research shows that psychological safety is the single most important predictor of team effectiveness. Assessment reveals that while staff feel safe raising routine concerns, they do not feel safe challenging a senior colleague's clinical decision, admitting a mistake publicly, or expressing disagreement with a popular group opinion. Which intervention is MOST foundational?

A. Implement an anonymous reporting system so staff can raise sensitive concerns without personal exposure

B. Model vulnerability by publicly admitting personal mistakes, actively seeking challenge from junior staff, responding non-defensively when questioned, and visibly rewarding staff who speak up — demonstrating through consistent leadership behavior that interpersonal risk-taking produces positive rather than punitive consequences

C. Conduct a team workshop on psychological safety that educates staff on its importance and establishes behavioral norms for safe communication

D. Implement a "safety word" that any team member can use to signal that they have a concern that needs to be heard without judgment

76. A nurse manager is applying the concept of "adaptive leadership" to manage a clinical practice change that requires staff to fundamentally alter their professional identity. The unit is transitioning from a disease-focused care model to a whole-person care model that requires nurses to assess and address social, emotional, spiritual, and cultural dimensions alongside clinical needs. Several experienced nurses resist the whole-person model, stating "I became a nurse to treat diseases, not to be a social worker." Which analysis BEST explains the resistance from an adaptive leadership perspective?

A. The resistance reflects a knowledge deficit that education about whole-person care can resolve

B. The resistance reflects a workflow concern that can be addressed by adding support staff for the non-clinical assessment dimensions

C. The resistance represents an adaptive challenge — the change threatens the nurses' professional identity, deeply held beliefs about what nursing is, and their sense of competence built over years of

disease-focused practice — and cannot be resolved through education or resource provision alone but requires a process of identity evolution supported through dialogue, mentoring, and gradual integration

D. The resistance reflects legitimate scope-of-practice concerns that should be addressed through policy clarification

77. A nurse manager is developing a comprehensive approach to "talent retention" that goes beyond traditional retention strategies focused on compensation and work environment. Contemporary talent management research identifies "career meaning" — the individual's sense that their career has purpose and significance — as a stronger predictor of retention than compensation or working conditions for nurses with more than five years of experience. Which retention approach MOST effectively addresses career meaning?

A. Implement a recognition program that highlights the meaningful impact of nursing work on patient outcomes and community health

B. Provide sabbatical opportunities for experienced nurses to pursue clinical research, community health projects, or international nursing experiences that renew their sense of professional purpose

C. Help individual nurses articulate their personal definition of career meaning through structured reflection, connect their daily work to that personal purpose, create opportunities for professional contributions that align with their values, and build a unit culture where the significance of nursing work is explicitly acknowledged and celebrated

D. Increase opportunities for professional advancement including certification support, advanced education assistance, and leadership development

78. A nurse manager is implementing a "continuous improvement culture" where quality improvement is embedded into daily operations rather than conducted through periodic projects. The nurse manager wants to shift from a model where a dedicated QI team conducts improvement projects to a model where every nurse identifies and addresses improvement opportunities during routine clinical work. Which infrastructure element is MOST critical for enabling continuous improvement at the bedside?

A. Simple, accessible improvement tools that bedside nurses can use during daily work — such as a brief improvement suggestion format that takes less than two minutes to complete, a visible tracking system that shows submitted ideas and their status, rapid leadership response to submitted improvements, and recognition that small incremental improvements are valued alongside large-scale projects

B. Comprehensive QI training for all nursing staff so they have the analytical skills needed to conduct improvement activities independently

C. A dedicated QI coach on each shift who facilitates improvement activities and provides real-time support to nurses identifying improvement opportunities

D. A unit-level improvement dashboard that displays current performance gaps and invites staff to propose solutions

79. A nurse manager is evaluating the unit's leadership development program outcomes over five years. The program has developed eighteen nurses who advanced to leadership positions — twelve charge nurses, four assistant nurse managers at other units, and two nurse managers. However, five of the eighteen (twenty-eight percent) left their leadership positions within the first year, citing that they were "not prepared for the emotional demands of leadership." Which program gap is MOST significant?

A. The program may not adequately screen candidates for leadership readiness before investing development resources

B. The program likely focuses on technical leadership competencies — scheduling, budgeting, staffing, quality improvement — while neglecting the emotional competencies that determine whether leaders can sustain their roles including managing interpersonal conflict, absorbing team anxiety, maintaining composure under pressure, processing the isolation of leadership, and navigating the transition from peer to authority figure

C. The program should extend the transition support period beyond the first year since leadership role adjustment takes longer than most organizations allow

D. The twenty-eight percent first-year leadership attrition rate is consistent with national averages and does not indicate a significant program gap

80. A nurse manager is developing a comprehensive professional portfolio program for the unit. A professional portfolio is a dynamic collection of evidence demonstrating a nurse's professional growth, clinical achievements, and contributions to nursing practice. Unlike a resume which lists credentials, a portfolio provides evidence of professional development through artifacts such as competency documentation, quality improvement project summaries, patient outcome data, peer evaluations, and professional presentations. Which portfolio element provides the STRONGEST evidence of professional growth?

A. Reflective practice narratives that describe how specific clinical experiences changed the nurse's practice, demonstrate integration of new evidence into clinical decision-making, and trace the evolution of clinical judgment over time — providing evidence of how the nurse has grown rather than simply listing what the nurse has accomplished

B. Documentation of continuing education hours completed annually

C. Letters of recommendation from physicians, peers, and supervisors

D. Certifications, degrees, and formal educational achievements

81. A nurse manager is navigating the distinction between "research utilization" and "evidence-based practice" for the unit's professional practice model. While the terms are sometimes used interchangeably, they represent different approaches to improving clinical care. Which distinction is MOST accurate?

A. Research utilization and evidence-based practice are essentially the same concept described with different terminology

B. Research utilization involves applying findings from individual research studies to clinical practice, while evidence-based practice integrates the best available research evidence with clinical expertise and patient values and preferences — making EBP a broader, more comprehensive framework that uses research as one component rather than the sole driver of practice decisions

C. Research utilization focuses on quantitative research while evidence-based practice includes both quantitative and qualitative research findings

D. Evidence-based practice is a more rigorous process that requires higher levels of evidence than research utilization

82. A nurse manager is developing an approach to managing the professional implications of "scope of practice creep" — the gradual expansion of nursing activities beyond the legally defined scope without formal authorization. Examples include nurses performing procedures that require specific certification they do not hold, implementing clinical decisions that require physician authorization, or providing services outside their competency. Unlike formal scope expansion which is authorized through legislation or organizational protocol, scope creep occurs informally. Which response is MOST appropriate?

A. Conduct a comprehensive scope audit identifying which nursing activities on the unit may have crept beyond the authorized scope, evaluate each activity against the state Nurse Practice Act and organizational policy, formalize activities that are within legitimate expanded scope, and immediately discontinue activities that exceed authorized practice

B. Allow activities that have become standard practice on the unit to continue since they have been performed safely over time

C. Restrict all nursing activities to only those explicitly listed in the state Nurse Practice Act to prevent any possibility of scope creep

D. Report all identified scope creep activities to the state board of nursing for guidance on which activities are permissible

83. A nurse manager is addressing the professional development needs of nurses who work in an increasingly interprofessional environment. The Interprofessional Education Collaborative has identified four core competencies for interprofessional practice: values/ethics, roles/responsibilities, interprofessional communication, and teams/teamwork. Assessment reveals that the unit's nurses are strongest in communication and teamwork but weakest in understanding other professions' roles and responsibilities. Which development approach is MOST targeted?

A. Develop a role clarity initiative that includes structured interprofessional shadowing experiences, joint case conferences where each discipline presents their unique contribution to patient care, and collaborative care planning activities that make each profession's scope, expertise, and perspective visible to other team members

B. Distribute written role descriptions for each discipline to all nursing staff so they understand what other professions contribute

C. Request that each discipline present their role and scope of practice at a nursing staff meeting

D. Implement joint interprofessional simulation exercises that require collaborative care planning and highlight each discipline's unique contribution

84. A nurse manager is developing an approach to managing the professional implications of "nursing informatics competencies" as nursing practice becomes increasingly technology-dependent. The ANA recognizes nursing informatics as a specialty that integrates nursing science with information management and analytical sciences. However, baseline informatics competencies are needed by ALL nurses, not just informatics specialists. Which competency is MOST critical for frontline nurses?

A. The ability to navigate and document effectively in the electronic health record

B. Understanding of data security and patient privacy requirements in digital environments

C. The ability to use clinical data and technology tools to support clinical decision-making — including interpreting clinical decision support alerts, understanding how data quality affects patient care, using technology to improve workflow efficiency, and recognizing when technology limitations require manual clinical oversight

D. Competency in using clinical communication technology including secure messaging, telehealth platforms, and remote monitoring systems

85. A nurse manager is developing guidelines for nurses who serve as preceptors for nursing students from multiple educational programs — associate degree, bachelor's degree, and accelerated second-degree programs. Each program has different clinical objectives, competency expectations, and supervision requirements. Preceptors report confusion about what each student can and cannot do independently. Which management approach is MOST effective?

A. Assign each preceptor to work with students from only one educational program to reduce confusion about differing expectations

B. Develop a preceptor resource guide that clearly delineates the clinical objectives, authorized activities, supervision requirements, and evaluation criteria for each educational program, provide orientation to preceptors on the differences between programs, and establish a communication channel with each program's clinical faculty for real-time clarification of student scope questions

C. Request that the nursing education department standardize clinical expectations across all programs so preceptors have a single set of guidelines to follow

D. Limit student clinical placements on the unit to one educational program at a time to simplify preceptor management

86. A nurse manager is addressing the professional implications of "moral distress" that arises specifically from healthcare system constraints rather than individual patient care situations. Several nurses report moral distress related to discharging patients they believe are not ready, providing care they consider inadequate due to staffing shortages, and participating in a healthcare system that does not serve all patients equitably. This "systemic moral distress" differs from patient-level moral distress because the source is the system rather than a specific clinical situation. Which response addresses systemic moral distress specifically?

A. Provide individual counseling for nurses experiencing systemic moral distress through the employee assistance program

B. Implement a resilience training program that helps nurses cope with the emotional impact of working within a constrained system

C. Encourage affected nurses to pursue policy advocacy and professional organization involvement to address the systemic issues causing their distress

D. Address systemic moral distress through a combination of individual support, collective advocacy through professional organizations, organizational engagement where nurses participate in system-level improvement, and leadership acknowledgment that system constraints create genuine ethical tension that validates the nurses' moral concern rather than treating it as an individual coping deficit

87. A nurse manager is developing an approach to managing nurses who are considering leaving the profession entirely — not just changing positions or organizations. National data shows increasing numbers of nurses questioning whether they want to continue in nursing at all. Staff report feeling that the profession has become unsustainable — citing physical demands, emotional toll, administrative burden, inadequate compensation, and erosion of professional autonomy as cumulative factors driving their consideration. Which retention approach addresses the "leaving the profession" phenomenon specifically?

A. Increase compensation and improve working conditions to make the nursing role more sustainable

B. Implement a mandatory debriefing program after every difficult shift to prevent emotional accumulation

C. Encourage nurses considering exit to take a leave of absence before making a final decision

D. Address the root causes driving professional exit consideration through a comprehensive approach that includes workload restructuring to reduce physical demands, emotional support infrastructure, administrative burden reduction through technology and delegation, advocacy for professional autonomy restoration, and facilitated career conversations that help nurses identify whether their distress is with the profession, the organization, or the specific role — since the appropriate intervention depends on which level is driving the consideration

88. A nurse manager is navigating the ethical implications of implementing a predictive analytics system that identifies patients at high risk for violence toward staff. The system flags patients based on historical data including previous violent incidents, substance use history, and psychiatric diagnoses. Staff want the system to improve their safety, but concerns have been raised that flagging patients based

on predictive algorithms may create bias in care delivery — staff may approach flagged patients with defensive attitudes that actually escalate agitation. Which ethical framework is MOST appropriate?

A. Implement the system with the understanding that staff safety justifies the potential for biased care delivery, and address bias through training after implementation

B. Reject the predictive system entirely since the risk of biased care delivery outweighs the safety benefit

C. Implement the system with a parallel education program about implicit bias and de-escalation

D. Implement the system with safeguards including staff education on using flags as preparation tools rather than prejudgment, monitoring for bias in care delivery to flagged patients, clear protocols for how flagged status affects care planning, patient notification about the flagging system, and regular audit of the algorithm's accuracy and equity across demographic groups

89. A nurse manager is developing a continuing competency framework for the unit. Traditional competency validation occurs annually through skills checklists and written tests. Contemporary competency models emphasize that competency is demonstrated through sustained performance in practice rather than periodic testing. Which competency model is MOST aligned with current professional standards?

A. Maintain annual skills competency testing as the primary validation method since it provides documented evidence of competency for regulatory compliance

B. Replace annual testing with ongoing performance observation and documentation of competent clinical practice

C. Implement a hybrid model combining periodic assessment with continuous performance monitoring

D. Implement a portfolio-based continuing competency model where nurses maintain evidence of competent practice through clinical exemplars, peer evaluations, outcome data, reflective practice documentation, and professional development activities — supplemented by focused competency validation for high-risk, low-frequency skills and new technology introduction, creating a comprehensive picture of sustained competence rather than point-in-time testing

90. A nurse manager is developing an approach to supporting nurses who serve as "moral agents" in the healthcare system — advocating for patients, questioning inappropriate orders, challenging

organizational practices that compromise care, and speaking up when they observe ethical violations. Research shows that moral agency is emotionally exhausting and professionally risky, and nurses who consistently advocate often experience isolation, retaliation, and burnout. Which organizational support is MOST critical for sustaining moral agency?

A. Legal protection for nurses who advocate for patients and report ethical concerns

B. Organizational structures that protect and reward moral agency — including visible leadership support for nurses who speak up, transparent investigation of reported concerns, protection from retaliation through documented anti-retaliation policies with enforcement, recognition of moral courage as a valued professional attribute, and peer support networks for nurses who experience the isolation that advocacy can create

C. Ethics education that builds the knowledge foundation for confident moral advocacy

D. An anonymous reporting system that allows nurses to exercise moral agency without personal exposure

91. A nurse manager is addressing the professional development needs of a nurse who has been identified as having "expertise hoarding" behavior — deliberately withholding clinical knowledge and institutional information from colleagues. Previous interventions (discussed in earlier exams) focused on knowledge management. This question addresses the professional conduct dimension. The nurse states that sharing knowledge would make her "replaceable" and reduce her job security. Which professional analysis is MOST accurate?

A. Knowledge sharing is a professional obligation under the ANA Code of Ethics and the nursing profession's commitment to collegial relationships — hoarding expertise violates the professional standard that requires nurses to contribute to the professional development of peers, and the nurse's fear of replaceability reflects a fundamental misunderstanding of how professional value is created, since nurses who share knowledge become more valued as organizational knowledge multipliers rather than less valued as replaceable individuals

B. The nurse's concern about job security is legitimate and should be addressed through reassurance before requiring knowledge sharing

C. Knowledge hoarding is a performance issue that should be addressed through the standard progressive discipline process

D. The nurse should be given a formal leadership role that channels her expertise into structured teaching without threatening her sense of indispensability

92. A nurse manager is developing guidelines for managing the professional implications of nurses who maintain clinical competency in multiple specialties through dual certification. A nurse on the unit holds certifications in both medical-surgical nursing and oncology nursing. The unit occasionally admits oncology patients, and the nurse wants to function as the oncology clinical resource for those patients. Which professional governance framework is MOST appropriate?

A. Allow the nurse to function as the oncology resource since her dual certification demonstrates competency in both specialties, establish a clear role definition that specifies when oncology expertise is within her scope on a medical-surgical unit, define the boundaries of her oncology resource function, and ensure that her dual-specialty role is recognized and compensated appropriately

B. Restrict the nurse to medical-surgical practice only since the unit is not designated as an oncology unit

C. Allow the nurse to provide oncology expertise only when a formal oncology consultation is ordered by the physician

D. Allow the nurse to practice within both certifications without restrictions since certification demonstrates competency

93. A nurse manager is evaluating the unit's compliance with the ANA's position statement on nurse fatigue and its impact on patient safety and the nurse's own well-being. Beyond shift-length limitations, the ANA position addresses the broader concept of "fatigue risk management" including commute safety, second-job considerations, and the organizational responsibility to create schedules that allow adequate recovery time between shifts. Which practice violation is MOST commonly overlooked?

A. Nurses working consecutive twelve-hour shifts without adequate recovery time between shifts

B. The failure to account for nurses who hold second jobs at other healthcare facilities, creating total work hours that exceed safe limits even when each individual employer's schedule appears safe — since the organization's scheduling system has no visibility into the nurse's total work hours across all employment

C. Nurses who drive long distances after working twelve-hour night shifts, creating commute-related safety risk that the organization has a responsibility to address

D. Scheduling practices that regularly require nurses to transition between day and night shifts, disrupting circadian rhythms and increasing fatigue risk

94. A nurse manager is navigating a professional ethics situation where a nurse has reported a patient safety concern through the organization's compliance hotline. The investigation substantiated the concern and resulted in corrective action. However, the reporting nurse's identity was inadvertently disclosed during the investigation, and the nurse is now experiencing retaliation from colleagues who view her as a "whistleblower" who got a colleague in trouble. Which organizational response is MOST critical?

A. Transfer the reporting nurse to another unit to protect her from ongoing retaliation

B. Address the retaliation by counseling the retaliating colleagues about their behavior

C. Implement a public reaffirmation of the organization's non-retaliation policy without identifying the specific situation

D. Take immediate action to stop the retaliation through direct intervention with the retaliating individuals, provide documented anti-retaliation protection for the reporting nurse, address the breach of confidentiality that disclosed the reporter's identity, and use the incident to reinforce the organizational commitment to protecting reporters — since failure to respond decisively to retaliation will suppress future reporting by every nurse who observes the consequences

95. A nurse manager is developing a comprehensive professional identity development program for new graduate nurses. Research on professional identity formation shows that new nurses undergo a transition from "student identity" to "professional identity" during their first two years of practice, and the quality of this transition significantly affects long-term career commitment. Which element is MOST critical for healthy professional identity formation?

A. Clinical competency development that builds confidence in the ability to function independently as a registered nurse

B. Mentoring relationships that model professional behaviors and values

C. Organizational socialization that helps the new nurse feel belonging and connection to the team

D. Integration of all identity dimensions — clinical competence building, mentoring relationships that model professional values, meaningful patient care experiences that affirm the nurse's purpose, honest acknowledgment of the challenges and rewards of nursing, peer support from other new graduates navigating the same transition, and progressive autonomy that builds professional confidence — creating a holistic transition that develops the nurse's sense of professional self rather than focusing solely on clinical skill acquisition

96. A nurse manager is conducting a break-even analysis for a proposed nurse-led patient education clinic. The clinic's fixed costs (rent, equipment, administrative support) total eight thousand dollars per month. Variable costs per patient visit (supplies, materials) average twelve dollars. Revenue per patient visit averages sixty-five dollars. How many patient visits per month are needed to break even?

A. $8,000 ÷ $65 = 123 visits (dividing fixed costs by total revenue per visit)

B. $8,000 ÷ ($65 − $12) = $8,000 ÷ $53 = 151 visits per month. The break-even calculation divides fixed costs by the contribution margin per visit (revenue minus variable cost), because each visit contributes $53 toward covering fixed costs after its variable costs are paid

C. $8,000 ÷ $12 = 667 visits (dividing fixed costs by variable cost per visit)

D. ($8,000 + $12) ÷ $65 = 123 visits (adding one unit of variable cost to fixed costs)

97. A nurse manager is analyzing the unit's contribution margin by payer type:

Payer	Cases	Revenue/Case	Cost/Case	Contribution Margin/Case
Medicare	180	$8,800	$9,200	($400)
Medicaid	65	$5,400	$9,200	($3,800)
Commercial	95	$13,200	$9,200	$4,000
Self-Pay	20	$2,100	$9,200	($7,100)

What is the unit's total contribution margin, and which strategic insight is MOST important?

A. Medicare: 180 × (−$400) = −$72,000. Medicaid: 65 × (−$3,800) = −$247,000. Commercial: 95 × $4,000 = $380,000. Self-Pay: 20 × (−$7,100) = −$142,000. Total = −$81,000 net loss. The unit operates at a net loss, and the critical insight is that commercial insurance ($380,000 positive) subsidizes the losses from all other payers ($461,000 negative) but is insufficient to fully cover them — any further decline in commercial volume will deepen the structural deficit

B. The unit should increase Medicare and Medicaid reimbursement through improved clinical documentation that captures higher-acuity DRGs

C. The unit should focus on reducing cost per case since the $9,200 cost is consistent across all payers and any reduction improves all contribution margins simultaneously

D. The unit should increase commercial payer volume through improved service offerings and physician recruitment to increase the cross-subsidization that covers government payer losses

98. A nurse manager is developing a revenue cycle management improvement initiative. Revenue cycle management encompasses all clinical and administrative functions that contribute to the capture, management, and collection of patient service revenue. The nurse manager's unit has been identified as having significant "revenue leakage" — services that are provided but not billed. Which nursing activity MOST directly affects revenue capture?

A. Accurate clinical documentation of the severity of illness, complexity of care, and procedures performed, since clinical documentation drives the coding and billing process that determines reimbursement

B. Timely completion of discharge summaries so claims can be submitted within payer filing deadlines

C. Accurate and timely charge capture for all nursing procedures, supplies, and services performed — ensuring that every billable nursing activity is documented in the charging system at the time of service, since charge capture at the point of care is the primary mechanism by which nursing services are translated into revenue

D. Patient insurance verification and authorization management during the admission process

99. A nurse manager is implementing a zero-based budgeting approach for the unit's non-labor operating expenses. Unlike incremental budgeting which adjusts the prior year's budget by a percentage, zero-based budgeting requires justification of every expense from zero — assuming no spending baseline and building the budget from the ground up based on current needs. Which advantage does zero-based budgeting provide over incremental budgeting?

A. Zero-based budgeting forces the elimination of expenses that have been carried forward from prior years without re-evaluation, potentially identifying obsolete expenditures, unnecessary subscriptions, duplicate services, and inflated supply quantities that incremental budgeting perpetuates because it never questions the baseline

B. Zero-based budgeting is simpler to prepare than incremental budgeting because it starts from a clean slate

C. Zero-based budgeting produces lower total budgets because it eliminates all unnecessary spending

D. Zero-based budgeting provides more accurate forecasting because it is based on current needs rather than historical patterns

100. A nurse manager is developing a financial forecasting model for the next fiscal year. The model must account for multiple variables including projected volume changes, wage increases, supply price inflation, staffing model changes, and new program launches. Which forecasting approach produces the MOST useful financial projections?

A. Apply the organization's standard growth assumptions (volume increase, wage increase, inflation) uniformly to the current year's actual spending to generate the forecast

B. Develop a detailed line-item forecast for each budget category based on the specific changes projected for the upcoming year

C. Use the average of the past three years' actual spending as the baseline and adjust for known changes

D. Develop scenario-based forecasts that model multiple possible futures — a base case reflecting expected conditions, an optimistic case reflecting favorable volume and efficiency assumptions, and a pessimistic case reflecting adverse conditions including volume decline, higher turnover, and supply cost increases — providing leadership with a range of possible outcomes rather than a single-point estimate that creates false precision

101. A nurse manager is evaluating the financial impact of implementing a clinical nurse leader role on the unit. The CNL is a master's-prepared nurse who integrates care across the continuum, manages microsystems, and applies evidence-based practice at the point of care. The position costs one hundred ten thousand dollars annually. Evidence from CNL implementation studies shows average outcomes improvements. Which financial metric MOST accurately captures the CNL's value?

A. The CNL's value should be measured through the aggregate improvement in nurse-sensitive indicators — including reduced falls, pressure injuries, infections, and readmissions — translated into avoided costs, combined with the efficiency gains from care coordination improvements and the long-term impact on staff development and retention, compared against the position cost

B. The CNL's value should be measured through the improvement in patient satisfaction scores since the CNL's care coordination role directly affects the patient experience

C. The CNL's value should be measured through the reduction in average length of stay since care coordination is the primary mechanism by which CNLs affect hospital efficiency

D. The CNL's value cannot be quantified because the role's impact is diffused across multiple dimensions that cannot be attributed to a single position

102. A nurse manager is developing a proposal for implementing a nurse-led chronic disease management program. The proposal requires organizational investment, and the CFO has requested a five-year financial projection. Which financial modeling element is MOST critical for the projection's credibility?

A. Clearly stated assumptions underlying each projection element — including the evidence base for projected outcomes, the sensitivity of the financial return to variation in key assumptions, and the breakeven point under different scenario conditions — so that decision-makers can evaluate the projection's reliability and understand which assumptions carry the most financial risk

B. A detailed year-by-year revenue and expense projection for all five years

C. Comparison of the projected financial performance to published outcomes from similar programs at other organizations

D. The projected return on investment calculated at the five-year point

103. A nurse manager is analyzing the unit's case mix index trend over four quarters:

| Quarter | CMI | Admissions | Revenue/Case |

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

| Q1 | 1.38 | 420 | $9,100 |

| Q2 | 1.42 | 435 | $9,350 |

| Q3 | 1.45 | 410 | $9,520 |

| Q4 | 1.51 | 425 | $9,890 |

Which interpretation is MOST financially significant?

A. The increasing CMI indicates the unit is caring for progressively sicker patients, which generates higher per-case revenue but also requires proportional staffing and resource investment

B. The CMI increase may reflect improved clinical documentation capturing true patient complexity rather than an actual increase in patient acuity, in which case the revenue increase represents legitimate reimbursement for previously underdocumented care complexity

C. The volume fluctuation between quarters is more financially significant than the CMI trend since volume directly drives total revenue

D. The rising CMI with corresponding revenue increase from $9,100 to $9,890 per case over four quarters could reflect either genuine acuity increase requiring proportional resource investment, or improved documentation capturing existing complexity — and the distinction is financially critical because genuine acuity increase demands cost investment that offsets the revenue gain, while documentation improvement generates net revenue without additional clinical cost

104. A nurse manager is developing a staffing budget and must determine the appropriate benefit replacement factor. The BRF accounts for the difference between productive hours worked and total paid hours (which include vacation, holiday, sick time, education, and orientation). The unit's historical data shows:

Average vacation hours per FTE: 160

Average holiday hours per FTE: 64

Average sick hours per FTE: 72

Average education hours per FTE: 40

Average orientation hours per FTE: 24

Total paid hours per FTE: 2,080

What is the benefit replacement factor?

A. Non-productive hours per FTE: 160 + 64 + 72 + 40 + 24 = 360. Productive hours: 2,080 − 360 = 1,720. BRF = 2,080 ÷ 1,720 = 1.21. This means the unit must budget 1.21 FTEs for every 1.0 FTE of productive coverage needed, accounting for the twenty-one percent of paid time that is non-productive

B. BRF = 360 ÷ 2,080 = 0.17, meaning seventeen percent of paid time is non-productive

C. BRF = 1,720 ÷ 2,080 = 0.83, meaning eighty-three percent of paid time is productive

D. BRF = 2,080 ÷ 360 = 5.78, meaning each non-productive hour requires 5.78 hours of coverage

105. A nurse manager is evaluating two competing proposals for reducing the unit's overtime costs:

| Proposal | Implementation Cost | Projected Annual OT Reduction | Timeline |

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

| A: Hire 2 additional FTEs | $170,000/year | $180,000 (85% reduction) | Immediate |

| B: Implement flex scheduling technology | $45,000 first year, $15,000/year ongoing | $120,000 (57% reduction) | 6 months |

Current annual overtime cost: $212,000. Which analysis supports the BEST decision?

A. Proposal A produces higher absolute overtime reduction and should be selected since the cost ($170,000) is below the savings ($180,000) for a $10,000 net benefit

B. Compare the net financial benefit of each proposal: Proposal A saves $180,000 − $170,000 = $10,000 net annually. Proposal B saves $120,000 − $15,000 = $105,000 net annually (after first year). Proposal B produces ten times the net benefit because it addresses overtime through efficiency rather than headcount, making it the financially superior choice despite the lower absolute OT reduction

C. Implement both proposals simultaneously to maximize overtime reduction

D. The decision should also consider whether the two additional FTEs in Proposal A provide value beyond overtime reduction — such as improved quality, reduced agency use, and enhanced staff satisfaction — since the headcount investment may produce returns not captured in the overtime reduction comparison alone

106. A nurse manager is implementing a patient-level costing system that tracks the actual resources consumed by each individual patient rather than using average cost-per-day estimates. The system reveals significant cost variation among patients within the same DRG. Which financial insight is MOST valuable from patient-level costing?

A. Identification of specific patients who consume disproportionate resources, enabling prospective case management for similar future patients

B. More accurate cost reporting for organizational financial statements

C. Better negotiation data for managed care contract discussions

D. The ability to identify which specific clinical activities, complications, and care processes drive cost variation within a DRG, enabling targeted improvement that reduces the cost of care for the highest-cost patients without affecting the care of efficient patients — moving from DRG-level average cost management to patient-level precision cost management

107. A nurse manager is developing a financial sustainability plan for a unit that currently operates at a two percent positive margin. The nurse manager wants to improve the margin to five percent within two years. The unit's annual revenue is six million dollars and annual expenses are five million eight hundred eighty thousand dollars. The three-percentage-point margin improvement represents how much in dollar terms, and which strategy is MOST likely to achieve it?

A. 3% × $6,000,000 = $180,000 improvement needed. Focus on revenue enhancement through improved charge capture and documentation

B. $180,000 improvement can be achieved through labor productivity optimization alone since labor is the largest expense category

C. $180,000 improvement through a combination of revenue optimization (improved documentation, charge capture, and payer mix management contributing approximately $80,000) and expense management (supply standardization, workflow efficiency, and premium labor reduction contributing

approximately $100,000) — pursuing both revenue and cost strategies simultaneously since neither alone is likely to achieve the full target

D. $180,000 improvement through volume growth since each additional patient day generates incremental margin

108. A nurse manager is evaluating the financial implications of the unit's patient readmission rate. Under the CMS Hospital Readmissions Reduction Program, hospitals with excess readmissions receive reduced Medicare payments across ALL Medicare discharges, not just the readmitted patients. The hospital's excess readmission ratio for heart failure is 1.08, resulting in a projected payment reduction of $890,000 across the organization. The nurse manager's unit contributes twenty-two percent of the hospital's heart failure admissions. Which financial analysis is MOST relevant at the unit level?

A. The unit's proportional contribution to the penalty: 22% × $890,000 = $195,800

B. The unit's specific heart failure readmission rate compared to the expected rate to determine whether the unit is driving or mitigating the hospital's excess ratio

C. The cost of implementing a unit-level heart failure readmission reduction program compared to the unit's share of the penalty

D. The unit's readmission rate relative to the hospital's overall rate determines whether unit-level improvement would meaningfully affect the hospital's excess readmission ratio and resulting penalty — if the unit's rate is higher than the hospital average, unit-level improvement would reduce the penalty disproportionate to the unit's volume share, making the investment in unit-level readmission reduction financially compelling at the organizational level

109. A nurse manager is developing a comprehensive cost-per-patient-day analysis. The analysis must distinguish between controllable costs (which the nurse manager can influence) and non-controllable costs (which are allocated to the unit but managed at the organizational level). Which cost category is MOST commonly misclassified?

A. Utility and facility maintenance costs allocated to the unit based on square footage, which the nurse manager cannot influence through operational decisions and should be classified as non-controllable despite appearing on the unit's cost report

B. Agency and travel nurse costs, which are sometimes classified as non-controllable because they are arranged through the staffing office, but should be classified as partially controllable since the nurse manager's retention and scheduling practices directly influence the need for premium labor

C. Supply costs, which are sometimes classified as fully controllable but include both controllable elements (usage volume, waste) and non-controllable elements (contract prices negotiated at the organizational level)

D. Pharmacy costs, which are typically managed by the pharmacy department but influenced by nursing activities such as medication waste, override usage, and medication timing

110. A nurse manager is preparing for the annual budget defense meeting where each department justifies its budget request to the finance committee. The nurse manager's request includes a six percent labor budget increase — three percent for contractual wage increases and three percent for two additional FTEs to support a new service line. The finance committee has signaled that only four percent increases will be approved. Which negotiation strategy is MOST effective?

A. Accept the four percent increase and defer the new FTE request to the following fiscal year

B. Present the labor budget as two distinct components — the three percent contractual wage increase (which is non-negotiable since it is contractually obligated) and the three percent new FTE investment (which should be presented with a revenue projection showing the new service line's expected contribution that offsets the FTE cost) — making the case that the total six percent is not a cost increase but rather a three percent obligation plus a three percent investment with projected positive return

C. Request six percent and negotiate downward to five percent as a compromise

D. Present the four percent baseline with a supplemental request for the additional FTEs through a separate capital or strategic investment funding mechanism outside the operating budget

111. A nurse manager is developing a dashboard for presenting financial performance data to nursing staff who have limited financial literacy. Research on financial communication shows that most clinical staff cannot interpret standard financial reports. Which design principle is MOST effective for clinical audience financial communication?

A. Simplify the data by presenting only the most critical financial metric — such as budget variance — and eliminating all other financial information

B. Translate financial metrics into clinical equivalents that staff can understand and influence

C. Provide detailed financial education so staff can interpret standard financial reports

D. Present financial information using visual formats that connect financial metrics to clinical actions — for example, showing how reducing supply waste by one item per patient saves a specific dollar amount annually, or how preventing one fall saves twelve thousand dollars that could fund equipment purchases — making financial performance tangible through clinical examples that staff can relate to their daily practice

112. A nurse manager is evaluating the unit's performance using a balanced scorecard approach. Current scorecard performance:

| Perspective | Key Metric | Score | Target | Status |

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

| Financial | Operating margin | 2.1% | 3.0% | Below |

| Customer | Patient satisfaction | 84th %ile | 75th %ile | Above |

| Internal Process | Falls rate | 2.1/1,000 PD | 2.5/1,000 PD | Above |

| Learning & Growth | Certification rate | 22% | 40% | Below |

Which strategic insight emerges from the balanced scorecard analysis?

A. The unit should focus on improving the operating margin since financial performance is the foundation for all other dimensions

B. The unit's strong customer and process performance may be masking an underinvestment in learning and growth that will eventually undermine the currently strong dimensions

C. The certification rate should be the primary improvement focus since it has the largest gap from target

D. The balanced scorecard reveals a potential sustainability risk — the unit is performing well on current outcomes (satisfaction and quality) but underinvesting in future capacity (learning and growth at

twenty-two percent versus forty percent target), and the below-target financial margin may reflect inefficiencies that a more developed workforce could resolve — suggesting that strategic investment in staff development may simultaneously address both underperforming dimensions

113. A nurse manager is developing a financial impact analysis for implementing hourly leadership rounding. The rounding program requires the nurse manager or designee to round on each patient once per shift, taking approximately ninety minutes per round. The program requires no additional staffing if the rounding is incorporated into the nurse manager's daily schedule. Published evidence shows that leadership rounding reduces patient complaints by forty percent, improves HCAHPS scores by an average of eight percentile points, and identifies service recovery opportunities before patients file formal grievances. Which financial metric provides the STRONGEST justification?

A. The reduction in formal patient complaints, translated into saved investigation time and potential litigation cost avoidance

B. The cost is essentially zero since no additional staffing is required, making any measurable benefit a positive return on investment

C. The HCAHPS improvement translated into value-based purchasing reimbursement impact, which directly affects the hospital's bottom line through CMS payment adjustments

D. The comprehensive value includes zero incremental cost (the ninety minutes is absorbed into existing leadership workflow), complaint reduction savings, HCAHPS-driven VBP reimbursement improvement, service recovery prevention of formal grievances, and the intangible benefit of leadership visibility that improves staff engagement — making leadership rounding one of the highest-ROI interventions available because it produces measurable financial returns at essentially no cost

114. A nurse manager is analyzing the unit's supply cost trends:

| Quarter | Patient Days | Total Supply Cost | Supply Cost/PD |

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

| Q1 | 2,800 | $126,000 | $45.00 |

| Q2 | 2,920 | $138,700 | $47.50 |

| Q3 | 2,850 | $142,500 | $50.00 |

| Q4 | 2,950 | $153,400 | $52.00 |

Which analysis is MOST actionable?

A. The supply cost per patient day has increased by $7.00 (15.6%) over four quarters while volume has increased only 5.4%, indicating that per-patient supply consumption is growing faster than volume — the analysis should identify whether the increase reflects higher-acuity patients requiring more supplies, price inflation from vendors, practice pattern changes such as increased use of higher-cost products, or waste and inefficiency that can be addressed through supply management interventions

B. Total supply cost increases are expected with volume growth and do not require investigation

C. The Q4 supply cost per patient day ($52.00) should be compared to benchmark to determine whether the current level is appropriate regardless of the trend

D. The supply cost increase should be correlated with the unit's case mix index trend to determine whether the higher supply costs reflect caring for sicker patients

115. A nurse manager is conducting a comprehensive year-end financial review and must present the unit's performance to organizational leadership. The unit achieved a positive operating margin for the first time in three years, exceeded quality targets on four of five nurse-sensitive indicators, reduced turnover from twenty-two percent to fourteen percent, and improved patient satisfaction from the fifty-fifth to the seventy-second percentile. The only negative metric is a twelve percent supply cost overage. Which presentation strategy is MOST effective?

A. Present the comprehensive performance narrative as an integrated story showing how the quality, workforce, and satisfaction improvements were strategic investments that produced the positive operating margin — positioning the supply overage as an identified optimization opportunity within an otherwise transformed unit performance, and presenting a specific plan for addressing the supply cost in the upcoming fiscal year while maintaining the momentum on all other dimensions

B. Lead with the positive operating margin achievement since financial performance is the metric leadership values most highly

C. Present each dimension separately with its own improvement narrative and action plan

D. Acknowledge the supply cost overage first to demonstrate accountability before presenting the positive achievements

Answer Key – Exam 15 (with Full Answer Explanations)

1. B — Assessing each patient's individual sensory preferences, communication style, and support needs recognizes that autism spectrum presentations vary widely. Neurodiversity-affirming communication includes direct language, processing time, sensory trigger minimization, and respecting preferred communication modalities rather than applying a uniform approach to all autistic patients.

2. C — The first five minutes of an active threat require pre-rehearsed automatic responses: secure the unit, account for every patient and visitor, assign communication roles, and activate the lockdown checklist. Practiced automatic responses outperform improvised decision-making during high-stress chaos because cognitive function is impaired under acute threat.

3. C — Emotional preparation for the cognitive dissonance of maintaining physiological support for a deceased patient, compassionate family support including cultural and spiritual rituals, and post-recovery debriefing addresses all dimensions. Organ donor care is unique in nursing because the patient is legally deceased yet physiologically maintained.

4. D — Cultural humility approaches each patient as a unique individual whose cultural identity cannot be assumed from demographics, uses open-ended questions about personal beliefs, and continuously examines one's own biases. Unlike cultural competence which implies a finite achievement, cultural humility is a lifelong process of self-reflection and learning.

5. A — Educating staff to recognize that healthcare-related trauma responses mimic non-compliance but are actually protective responses, and training on approaches that restore safety and control, addresses the fundamental misinterpretation. Patients who refuse procedures or become combative may be experiencing trauma activation, not deliberate non-cooperation.

6. C — Face-to-face delivery with honest rationale, identification of affected positions, description of support available, acknowledgment of emotional impact, and commitment to transparent ongoing communication provides the comprehensive approach staff reductions require. The nurse manager must be present, honest, and available afterward.

7. B — Multiple communication channels allowing generational preference while establishing a primary channel for critical information, combined with facilitated discussions about different preferences as legitimate rather than inferior, addresses intergenerational friction constructively. No single channel serves all generations effectively.

8. B — Repeated high-fidelity simulation under stress conditions, structured emergency communication frameworks that become automatic through rehearsal, and focused communication debriefing develops the specific skill of communicating under pressure. Emergency communication skill is built through practice under simulated stress, not classroom instruction.

9. A — Training nurses to proactively ask about cost concerns, normalizing financial discussions as clinically relevant, equipping nurses with financial assistance referral pathways, and integrating cost screening into discharge planning addresses the hidden barrier. Patients who make clinical decisions based on undisclosed cost concerns experience worse outcomes.

10. A — Transparent implementation with shared criteria, self-audit progression to peer audit to trained observer audit builds comfort gradually. Beginning with self-audits where nurses evaluate their own communication using the observation criteria develops self-awareness before external observation is introduced.

11. C — Addressing the family's concerns with clear explanation distinguishing palliative sedation from euthanasia, ongoing emotional support, ensuring understanding of clinical rationale, encouraging continued presence, and involving chaplaincy if moral distress continues provides comprehensive communication. The ethical distinction between symptom relief and life termination must be communicated clearly.

12. B — The identical documentation phrase across sixty charts indicates a documentation habit rather than a clinical activity, meaning patients may be discharged without adequate education. This creates both patient safety risk from inadequate education and legal vulnerability from documentation that does not evidence actual teaching occurred.

13. C — Acknowledging grief as a legitimate professional response, facilitating team discussion, providing a structured goodbye opportunity with professional boundaries, and offering post-departure debriefing addresses the unique emotional challenge of transitioning a long-term patient. Prolonged care relationships create genuine attachment that requires professional processing.

14. B — Creating empathy maps for the most common patient populations by following patients through their complete care journey and redesigning specific touchpoints where the experience fails provides the most valuable application. Empathy mapping reveals the emotional experience at each care moment that satisfaction surveys cannot capture.

15. C — A structured handoff format defining information categories, separating objective data from commentary, establishing that the EHR contains comprehensive history so verbal handoff focuses on current priorities, and including a time checkpoint provides sustainable improvement. The structure replaces informal narrative habits with focused clinical communication.

16. D — Consulting with the patient and established communication partners to determine specific tactile communication methods, arranging trained deaf-blind support, developing a comprehensive communication plan, and ensuring team understanding provides the most appropriate approach. Deaf-blind communication requires individualized assessment since methods vary significantly.

17. B — Structured peer support normalizing reactions, immediate access to trauma-experienced counseling, temporary trigger-avoidant assignment, and longitudinal follow-up addresses secondary traumatic stress comprehensively. Unlike compassion fatigue which develops gradually, secondary traumatic stress results from acute exposure and requires immediate targeted response.

18. C — Explaining honestly that clinically relevant information must be documented, discussing specific confidentiality protections including federal substance use regulations, addressing specific access concerns, and exploring whether fears are based on accurate privacy understanding provides the ethically and clinically appropriate response. Clinical documentation obligations cannot be waived but privacy protections can be explained.

19. C — A brief three-to-four-sentence narrative field capturing the patient's perspective in their own words, with demonstrated handoff quality improvement, provides the most practical implementation. The minimal time investment is offset by improved handoff quality as receiving nurses gain richer patient understanding.

20. A — Reporting to legal and risk management immediately, implementing the recording policy, addressing any clinical concerns in the recordings, and continuing professional care while maintaining awareness provides the comprehensive organizational response. The discovery has legal, clinical, and professional implications requiring coordinated response.

21. C — Brief daily personal connections with two to three staff members through informal conversations that acknowledge contributions, ask about their day, and provide opportunity to raise concerns creates the relational leadership practice. Cycling through the full team weekly ensures every member receives regular personal attention.

22. B — Establishing preferred names and pronouns as a professional communication standard demonstrating respect, training staff, and addressing resistance through education about the connection to patient outcomes makes clear this is a patient care expectation. Respectful communication using the patient's preferred identifiers is a professional standard.

23. D — Educating staff on the distinction between clinical care information and research recruitment, establishing which trial activities nursing performs versus research-trained staff, and ensuring nurses do not influence enrollment decisions provides the essential communication framework. The clinical-research boundary must be clearly defined for patient protection.

24. A — Following the competent patient's decision while facilitating a family meeting with all parties, providing emotional support, and ensuring understanding of patient rights respects patient autonomy. A competent patient's treatment decision is legally and ethically binding regardless of family disagreement.

25. B — A structured nursing contribution framework that includes assessment interpretation, patient concerns not in the record, nursing care priorities, care progression barriers, and explicit recommendations transforms passive data reporting into active clinical partnership during rounds. Nurses who present only data underutilize their clinical expertise.

26. B — Engaging the patient in compassionate conversation exploring values, discussing specific clinical circumstances, clarifying the distinction between the reversible injury and end-of-life hospitalization, and supporting the ultimate decision provides the most ethically appropriate approach. "Do Not Hospitalize" directives typically envision terminal situations, not treatable acute injuries.

27. C — Establishing clear communication structure defining responsibility at each transition point during boarding eliminates the accountability gap. Boarding creates a clinical no-man's-land where neither ED nor inpatient teams feel fully responsible, and defining communication ownership at each stage prevents gaps.

28. D — Night shift nurses may prioritize quiet efficiency to avoid disturbing sleeping patients, but patients awake at night often experience heightened anxiety and need for communication. The efficiency-over-engagement pattern fails patients whose nighttime vulnerability requires more, not less, communication attention.

29. B — Pre-translated emergency phrase cards for critical clinical questions, visual pain scales, anatomical diagrams, documentation of the limitation, and professional interpreter activation as soon as

available provides the essential interim protocol. The interim tools must enable basic clinical assessment without replacing the professional interpreter.

30. A — Evaluating the entire insulin use process from prescribing through monitoring identifies which phase contributes most to hypoglycemic events. The MUE examines prescribing appropriateness, dispensing safety checks, administration accuracy, and monitoring timeliness as an integrated system rather than investigating a single phase in isolation.

31. C — The combination of sequential rather than parallel processes creates cumulative delay. Mapping the current process to identify which steps can be parallelized and which individual step contributes the most dead time is the most effective analysis for reducing a four-hour turnaround to the ninety-minute benchmark.

32. D — A validated behavioral pain assessment tool such as PAINAD or FLACC using observable indicators — facial expression, body movements, vocalizations, and consolability — provides structured, reproducible assessment. Behavioral tools replace subjective impression with standardized evaluation for patients who cannot self-report pain.

33. B — Benchmarking against de-identified data from similar units nationally reveals safety improvement opportunities that unit-level data alone cannot identify. The PSO's aggregate analysis enables pattern recognition across organizations that individual facilities cannot achieve independently.

34. A — The Safety Grade uses twenty-eight measures across four domains, and the nurse manager must identify specific low-scoring measures to determine which are addressable at the unit level versus requiring organizational intervention. Understanding the methodology directs improvement effort to measures with the greatest impact on the grade.

35. D — Analyzing whether specific populations, shifts, or assignments show lower compliance and whether the gap reflects timing discordance, documentation issues, or genuine simultaneous implementation failure identifies the root cause. The gap between individual element compliance and bundle compliance requires specific investigation.

36. C — A formal product evaluation through value analysis with standardized trials, outcome data, cost comparison, staff usability assessment, and evidence-based selection eliminates ad hoc product introduction. Inconsistent wound care from individual product preferences creates variation that undermines quality and increases cost.

37. D — Evidence-based transfer criteria requiring specific recovery milestones, structured PACU-to-floor handoff highlighting ongoing risks, post-transfer monitoring protocol with focused assessments, and floor nurse training on post-anesthesia complications addresses the twenty-eight percent adverse event rate comprehensively.

38. D — Applying the central line bundle rigorously to all PICCs, addressing the lower-risk perception through education, implementing daily PICC necessity assessment, and establishing dedicated PICC surveillance treats PICCs as central lines for all infection prevention purposes. The doubled PICC CLABSI rate directly reflects the perception gap.

39. B — Communication openness and nonpunitive response are the only dimensions below both benchmarks and represent the foundational enablers for all other safety dimensions. Staff who fear punishment and do not feel safe speaking up undermine every other safety mechanism regardless of how well those mechanisms are designed.

40. D — Comprehensive analysis examining protocol parameters, assessment tool sensitivity, concomitant medications, patient-specific risk factors, and monitoring frequency match provides the most thorough investigation. High compliance with continued adverse events suggests the protocol itself may be inadequately designed.

41. C — Outcome measures are influenced by patient factors beyond nursing control, making attribution difficult, while process measures directly reflect nursing performance. The transition requires a balanced approach maintaining process measures as leading indicators while adding outcomes as lagging confirmation.

42. B — Omitted medications represent the most dangerous discrepancy because patients may not receive needed medications. The forty-four percent omission rate suggests over-reliance on patient recall rather than verification against pharmacy records or other objective sources, identifying the specific process gap to address.

43. C — Concurrent platform management creates attention fragmentation that increases clinical error risk because the cognitive load of switching between physical assessment, virtual consultation, and remote monitoring exceeds human capacity for simultaneous multi-modal clinical attention. Each platform demands focused judgment that cannot be safely divided.

44. B — Standing orders allowing night shift nurses to administer first-line agitation medications without waiting for physician response, with required notification afterward, ensures the night shift response matches daytime timeliness. The protocol gap is a communication delay, and standing orders eliminate the delay at its source.

45. D — The gap between information delivery (92%) and meaningful engagement (14%) reveals that the unit meets the regulatory minimum but fails the clinical intent. Patients receive paper but are not supported in actually making advance directive decisions, requiring structured clinical conversations.

46. D — Securing visible physician endorsement, creating co-ownership, implementing the first wave with physician acknowledgment, and celebrating successful removals addresses the empowerment barrier. Twelve months of protocol without effect despite nursing assessment compliance indicates that cultural authority, not clinical knowledge, is the barrier.

47. B — The eighty-two percent non-actionable rate will produce alert fatigue undermining the system for genuine deterioration events. The analysis must determine whether sensitivity can be adjusted to reduce false positives without missing true deterioration, since alert fatigue from excessive false alarms paradoxically reduces safety.

48. B — A tiered observation model matching observer qualifications to patient risk profile uses UAPs for fall/elopement risk and RNs for patients requiring clinical monitoring. This optimizes resource utilization while maintaining appropriate clinical oversight for each risk category.

49. D — A comprehensive investigation examining documentation accuracy, risk adjustment adequacy, protocol compliance, intervention appropriateness, staging accuracy, equipment adequacy, and nutrition integration addresses persistent above-benchmark performance. Standard interventions failing suggests the approach may not match this specific population's characteristics.

50. D — A comprehensive alarm management program including data analysis, parameter customization, notification hierarchy, staff education, daily alarm rounds, and ongoing monitoring of alarm-related events ensures that alarm reduction does not compromise patient safety. Alarm management requires systematic optimization, not simple volume reduction.

51. B — Specific case studies illustrating the human cost of missed sepsis identification alongside data showing the gap between current and top-quartile performance creates urgency through both emotional

connection and performance comparison. Kotter's urgency step requires making the status quo feel more dangerous than the change.

52. C — Structured interviews asking each staff member to describe specific peak performance moments — when they felt most proud, what made it possible — uses concrete personal experiences as evidence of existing excellence capabilities. Appreciative Inquiry's Discovery phase works best with specific stories rather than abstract discussions.

53. B — Engaging the medical director to understand concerns while mobilizing nursing allies to demonstrate support addresses both the high-influence blocker and the moderate-influence supporters. Effective stakeholder management works simultaneously on converting resisters and amplifying allies.

54. C — Redesigning the discharge process through rapid weekly testing of small changes with immediate feedback exemplifies agile QI. Short iterative cycles with fast learning are best suited for process redesign where multiple variables interact and the optimal solution is unknown in advance.

55. A — The soft elements — Style, Staff, Skills, and Shared Values — most commonly explain change failure because organizations plan the hard elements while neglecting the cultural and human dimensions. Strategy and structure cannot produce change when the culture, capabilities, and values do not support it.

56. C — Matching strengths to opportunities — the experienced retained team is uniquely positioned for service expansion and Magnet pursuit — while recognizing that the nursing shortage threat makes existing retention an even more valuable competitive advantage provides the most actionable strategic insight. SWOT power comes from cross-matching quadrants.

57. C — Building coalitions, understanding stakeholder priorities, framing proposals in their language, timing for receptivity, and cultivating genuine mutual-benefit relationships demonstrates political skill. Political skill transforms good ideas into implemented initiatives through strategic relationship management.

58. B — Structured social integration helping new nurses build informal relationships, understand unwritten norms, identify influence networks, and develop belonging addresses the socialization gap. Clinical orientation develops competency; organizational socialization develops commitment and retention.

59. D — Creating generative spaces with permission and time to question practices, propose alternatives, test ideas through safe-to-fail experiments, and share learning without requiring universal success establishes that innovation is valued alongside operational excellence. Generative culture requires protected experimentation space.

60. A — The Learning and Growth perspective measuring staff development, knowledge creation, organizational learning, and innovation capacity is most commonly neglected. It represents the infrastructure enabling performance in all other perspectives, yet its indirect, long-term impact makes it easy to deprioritize.

61. C — Acknowledging the reality of concurrent personal crises, providing individualized support, monitoring performance with compassion while maintaining safety, distributing adjustments equitably, and attending to collective resilience addresses both individual and team-level impact. Multiple simultaneous personal crises create a cumulative team effect beyond individual impact.

62. A — Reducing to five to seven critical metrics with clear status indicators and drill-down capability applies the cognitive processing principle that dashboards should direct attention to what needs attention. Twenty-eight simultaneous metrics exceed processing capacity and fail to guide action.

63. D — A hybrid model maintaining collective leadership for routine operations while establishing pre-designated crisis leadership with automatic activation criteria, defined authority, and communication protocols provides both collaborative culture and crisis clarity. The transition from collective to hierarchical must be automatic rather than negotiated during the crisis.

64. C — Creating conditions for positive outcomes through relationships, information flow, adaptation support, ambiguity tolerance, and trust in emergent patterns rather than attempting to predict and control reflects quantum leadership. Complex systems produce outcomes through agent interaction rather than central direction.

65. A — Viewing resistance as diagnostic information by engaging resisters in dialogue, determining whether objections reveal plan flaws, modifying based on legitimate feedback, and differentiating valid concerns from comfort-driven resistance is most productive. Resistance often contains intelligence about the change that the leader missed.

66. C — A continuous strategic sensing process with a rolling twelve-to-eighteen-month horizon, quarterly recalibration, stable core direction with adaptive tactics, and strategic thinking embedded in

daily practice builds strategic agility. Rigid multi-year plans become obsolete in rapidly changing healthcare environments.

67. D — Acknowledging and respecting the informal leader's influence, seeking understanding, aligning when possible, engaging as a partner, and addressing conflicts through dialogue rather than positional authority recognizes that effective leadership requires cooperation of both formal and informal power holders.

68. A — Addressing moral residue requires acknowledging accumulated psychological impact, creating safe processing forums, connecting staff with specialized support, and implementing systemic changes reducing the conditions that produced the morally distressing situations. Moral residue is both accumulated harm and ongoing organizational problem.

69. C — Developing both disciplines simultaneously through structured opportunities to surface assumptions, trace systemic connections, and examine deeper causes of recurring problems builds the analytical capabilities transforming individual competence into organizational intelligence. Mental models and systems thinking are complementary skills that reinforce each other.

70. D — Empty near-term AND long-term pipelines create a leadership cliff where the departure of immediate-readiness candidates would leave no succession at any stage. Simultaneous investment at both the one-to-two-year and three-to-five-year horizons is necessary to prevent the cliff.

71. C — Engaging actively by providing factual information, sharing leadership perspective transparently, validating accurate interpretations, correcting inaccurate ones, and creating structured collective sense-making opportunities supports productive organizational meaning-making. Leaders who provide information without engaging in the sense-making process cede interpretation to informal channels.

72. A — Structured practice including message rehearsal, conscious body language attention, strategic eye contact, and post-meeting self-assessment develops group presence through the same deliberate practice that builds any performance skill. Group presence is a learnable behavior, not an innate trait.

73. B — Removing barriers to frontline innovation including providing experimentation time, reducing failure fear, simplifying approval, making resources available, and celebrating both successful and unsuccessful attempts creates the conditions for innovation. Most clinical innovations originate from frontline staff, and leadership's role is enabling rather than directing.

74. A — Exploring what feels meaningful and energizing, identifying peak performance moments, and building a plan creating more strength-zone opportunities investigates whether uniform "meets expectations" reflects average capability or suppressed strength. Appreciative performance management looks for the conditions that enable exceptional performance.

75. B — Modeling vulnerability by publicly admitting mistakes, actively seeking challenge from junior staff, responding non-defensively, and visibly rewarding speaking up demonstrates through consistent behavior that interpersonal risk-taking produces positive consequences. Psychological safety is built through leadership behavior, not workshop declarations.

76. C — The resistance represents an adaptive challenge threatening professional identity, beliefs about what nursing is, and competence built over years of disease-focused practice. Adaptive challenges cannot be resolved through education or resources alone but require identity evolution supported through dialogue, mentoring, and gradual integration.

77. C — Helping nurses articulate personal career meaning, connecting daily work to personal purpose, creating opportunities aligned with values, and building a culture acknowledging nursing's significance addresses the career meaning driver. For experienced nurses, career meaning predicts retention more strongly than compensation or conditions.

78. A — Simple, accessible improvement tools taking less than two minutes, visible tracking showing idea status, rapid leadership response, and recognition of small improvements enables continuous improvement at the bedside. Frontline improvement requires tools designed for clinical workflow constraints.

79. B — The program likely focuses on technical competencies while neglecting emotional competencies — managing conflict, absorbing team anxiety, maintaining composure, processing leadership isolation, and navigating the peer-to-authority transition. Twenty-eight percent first-year attrition citing emotional unpreparedness identifies a specific curriculum gap.

80. A — Reflective practice narratives describing how experiences changed practice, demonstrating evidence integration, and tracing clinical judgment evolution provide evidence of professional growth. Unlike credential lists showing what was achieved, reflective narratives show how the nurse has grown as a clinical thinker.

81. B — Research utilization applies individual study findings while EBP integrates best evidence with clinical expertise and patient values. EBP is a broader framework using research as one component rather than the sole driver, making it a more comprehensive approach to clinical decision-making.

82. D — Conducting a scope audit, evaluating activities against the Nurse Practice Act and policy, formalizing legitimate expanded activities, and discontinuing unauthorized activities addresses scope creep comprehensively. Some creep activities may be within legitimate expanded scope and should be formalized rather than eliminated.

83. A — A role clarity initiative with interprofessional shadowing, joint case conferences highlighting each discipline's unique contribution, and collaborative care planning makes each profession's scope and expertise visible. Understanding other roles requires experiential exposure rather than written descriptions.

84. C — The ability to use clinical data and technology tools to support clinical decision-making — including interpreting CDS alerts, understanding data quality impact, using technology for efficiency, and recognizing technology limitations — is the most critical frontline informatics competency. This competency directly affects clinical decisions at the bedside.

85. B — A preceptor resource guide delineating objectives, authorized activities, supervision requirements, and evaluation criteria for each program, with preceptor orientation and faculty communication channels, provides the structured guidance preceptors need. Clarity about differing program expectations is essential when managing students from multiple programs.

86. D — Addressing systemic moral distress through individual support, collective advocacy, organizational engagement in system improvement, and leadership acknowledgment that system constraints create genuine ethical tension validates the nurses' concern while providing multiple response pathways. Treating systemic moral distress as an individual coping deficit misattributes the cause.

87. D — Addressing root causes through workload restructuring, emotional support infrastructure, administrative burden reduction, autonomy advocacy, and facilitated career conversations identifying whether distress is with the profession, organization, or role provides targeted intervention. The appropriate response depends on which level drives the exit consideration.

88. A — Implementing the system with staff education on using flags as preparation rather than prejudgment, bias monitoring, care planning protocols, patient notification, and algorithm audit provides the comprehensive ethical framework. Predictive analytics require safeguards against the bias they may create.

89. D — A portfolio-based model with clinical exemplars, peer evaluations, outcome data, reflective documentation, and professional development activities, supplemented by focused validation for high-risk skills, creates a comprehensive competency picture. Portfolio-based models capture sustained competence rather than point-in-time testing.

90. B — Organizational structures protecting and rewarding moral agency — visible leadership support, transparent investigation, enforced anti-retaliation policies, moral courage recognition, and peer support networks — sustain the emotional and professional cost of advocacy. Moral agents who are isolated and retaliated against will stop advocating.

91. A — Knowledge sharing is a professional obligation under the ANA Code of Ethics. Hoarding violates the standard requiring nurses to contribute to peer development, and the fear of replaceability reflects a misunderstanding — knowledge multipliers become more valuable to organizations, not less.

92. A — Allowing the dual-certified nurse to function as the oncology resource with clear role definition, boundary specification, and appropriate recognition and compensation leverages valuable expertise. Dual certification demonstrates competency that benefits patients when properly governed.

93. B — The failure to account for nurses holding second jobs, creating total hours exceeding safe limits across all employment, is most commonly overlooked. Individual employers' schedules may appear safe while the cumulative effect creates dangerous fatigue that no single employer can monitor.

94. D — Immediate retaliation intervention, documented anti-retaliation protection, confidentiality breach investigation, and organizational commitment reinforcement is most critical. Failure to respond decisively to retaliation suppresses future reporting by every nurse who observes the consequences.

95. A — Integration of all identity dimensions — competence building, values modeling through mentoring, meaningful experiences affirming purpose, honest challenge acknowledgment, peer support, and progressive autonomy — creates holistic professional identity transition. Identity formation requires development across multiple dimensions simultaneously.

96. B — Break-even = Fixed costs ÷ Contribution margin per visit = $8,000 ÷ ($65 − $12) = $8,000 ÷ $53 = 151 visits. Each visit contributes $53 toward covering fixed costs after variable costs are paid. The contribution margin calculation is essential because total revenue per visit overstates the contribution to fixed costs.

97. A — Total contribution: Medicare −$72,000 + Medicaid −$247,000 + Commercial +$380,000 + Self-Pay −$142,000 = −$81,000 net loss. Commercial insurance subsidizes all other payers but insufficiently. Any further commercial volume decline deepens a structural deficit that cannot be resolved through volume growth alone.

98. C — Accurate and timely charge capture for all nursing procedures, supplies, and services at the time of service is the primary mechanism translating nursing services into revenue. Point-of-care charge capture is where revenue leakage most commonly occurs and where nursing practice most directly affects the revenue cycle.

99. A — Zero-based budgeting forces justification of every expense from zero, identifying obsolete expenditures, unnecessary subscriptions, and inflated quantities that incremental budgeting perpetuates. By never questioning the baseline, incremental budgeting carries forward historical spending patterns that may no longer reflect current needs.

100. D — Scenario-based forecasts modeling base, optimistic, and pessimistic cases provide leadership with a range of possible outcomes rather than a single-point estimate. Multiple scenarios enable contingency planning and prevent the false precision that a single forecast creates.

101. A — The CNL's value should be measured through aggregate nurse-sensitive indicator improvement translated into avoided costs, plus efficiency gains and retention impact, compared against position cost. The CNL's impact is diffused across multiple outcome dimensions that must be aggregated for accurate valuation.

102. A — Clearly stated assumptions, evidence base for projections, sensitivity analysis showing which assumptions carry the most risk, and breakeven points under different scenarios provide the credibility that a five-year financial projection requires. Decision-makers need to evaluate projection reliability, not just the projected numbers.

103. D — The rising CMI with corresponding revenue increase could reflect genuine acuity increase requiring proportional cost investment, or improved documentation capturing existing complexity with

no additional clinical cost. The distinction is financially critical because one scenario is cost-neutral while the other requires resource investment.

104. A — BRF = Total paid hours ÷ Productive hours = 2,080 ÷ 1,720 = 1.21. This means budgeting 1.21 FTEs for every 1.0 FTE of productive coverage, accounting for the twenty-one percent of paid time consumed by vacation, holidays, sick leave, education, and orientation.

105. B — Proposal A saves $10,000 net annually ($180,000 − $170,000). Proposal B saves $105,000 net annually after year one ($120,000 − $15,000). Proposal B produces ten times the net benefit through efficiency rather than headcount, though the decision should also consider the non-overtime value of additional FTEs.

106. D — Patient-level costing identifies which specific clinical activities, complications, and care processes drive cost variation within a DRG. This enables targeted improvement reducing costs for high-cost patients without affecting efficient patients — precision cost management rather than average-based management.

107. C — The $180,000 improvement through combined revenue optimization (approximately $80,000 from documentation, charge capture, payer mix) and expense management (approximately $100,000 from supply standardization, workflow efficiency, premium labor reduction) pursues both strategies since neither alone likely achieves the full target.

108. D — The unit's readmission rate relative to the hospital's overall rate determines whether unit improvement would meaningfully affect the organizational penalty. If the unit's rate exceeds the hospital average, unit-level improvement produces disproportionate penalty reduction, making the investment financially compelling.

109. A — Utility and facility costs allocated by square footage are the most commonly misclassified. The nurse manager cannot influence these costs through operational decisions, yet they appear on the unit's cost report and may be held against the manager's performance despite being entirely non-controllable.

110. B — Presenting contractual wage increase as non-negotiable (3%) and new FTE investment as revenue-generating (3%) reframes the request from a 6% cost increase to an obligation plus an investment. Separating the components makes each defensible on its own merits rather than competing within a single budget line.

111. D — Visual formats connecting financial metrics to clinical actions — showing how specific waste reduction saves specific dollar amounts — makes financial performance tangible through clinical examples staff can relate to daily practice. Financial literacy is built through clinical translation, not financial education.

112. C — The balanced scorecard reveals a potential sustainability risk: strong current outcomes (satisfaction, quality) with underinvestment in future capacity (learning and growth at 22% vs 40%). The below-target financial margin may reflect inefficiencies a more developed workforce could resolve, suggesting staff development investment may address both gaps.

113. D — Zero incremental cost combined with complaint reduction, HCAHPS-driven VBP improvement, service recovery savings, and leadership visibility benefits makes leadership rounding one of the highest-ROI interventions available. The ninety minutes absorbed into existing workflow produces measurable financial returns at essentially no cost.

114. A — Supply cost per patient day increased 15.6% while volume increased only 5.4%, indicating per-patient consumption is growing faster than volume. The analysis must identify whether higher acuity, price inflation, practice changes, or waste drives the excess to determine the appropriate intervention.

115. A — Presenting the comprehensive narrative as an integrated story showing how quality, workforce, and satisfaction improvements produced the positive operating margin positions the supply overage as an optimization opportunity within an otherwise transformed performance. The presentation connects investments to outcomes rather than reporting metrics in isolation.