

# PRACTICE EXAM 17 — FULL-LENGTH SIMULATION (115 QUESTIONS)

---

1. A nurse manager is developing a structured post-code debriefing protocol. Research shows that post-code debriefing improves team performance during subsequent resuscitation events and reduces emotional distress among participants. Currently, no formal debriefing occurs after code blue events on the unit — staff return to their assignments immediately after the code concludes. Which debriefing element is MOST critical for both clinical learning and emotional processing?

A. A comprehensive review of the code documentation to verify that all interventions were recorded accurately

B. A physician-led clinical case review analyzing whether the resuscitation followed ACLS guidelines appropriately

C. A debriefing session facilitated by a trained debriefer conducted within one hour of the event, separating the clinical review (what happened medically and what can be improved) from the emotional check-in (how participants are feeling and what support they need), ensuring both dimensions receive dedicated attention rather than allowing clinical discussion to crowd out emotional processing

D. A structured "hot debrief" conducted immediately at the bedside while the team is still assembled, addressing both the clinical sequence and the emotional experience in a brief ten-to-fifteen-minute format that captures immediate impressions before they fade, followed by an offer of individual emotional support for any team member who needs it

2. A nurse manager is developing a communication protocol for managing situations where a patient's case will be presented at a medical education conference — such as grand rounds, mortality and morbidity conference, or a case study publication. The patient is identifiable despite de-identification efforts because the clinical presentation is rare. Staff express concern about the patient's privacy. Which communication consideration is MOST important?

A. Ensure the case presentation complies with HIPAA de-identification standards even if the rare condition makes the patient potentially identifiable within the clinical community

B. Obtain the physician's assurance that the case has been adequately de-identified for the educational purpose

C. Present the case without patient notification since medical education is a permitted use under HIPAA's treatment, payment, and healthcare operations exception

D. Assess whether the de-identification is truly adequate given the rare condition, consider whether the patient should be informed and given the opportunity to consent or decline participation in the educational presentation, and ensure that the educational value of the case is balanced against the privacy risk posed by the patient's identifiability

3. A nurse manager is addressing a communication pattern where patients with chronic pain are labeled as "drug-seeking" by nursing staff. This label influences how staff communicate with these patients — using skeptical tone, questioning reported pain levels, and delaying medication administration. Patients report feeling judged, dismissed, and undertreated. Which intervention is MOST foundational?

A. Implement a standardized pain assessment protocol that removes subjective judgment from pain management decisions

B. Eliminate the use of the term "drug-seeking" from all clinical communication and replace it with objective clinical language

C. Educate staff that pain is a subjective experience that cannot be objectively validated or invalidated by an observer, that chronic pain patients have neurobiological changes that affect pain perception and medication response, that labeling language creates bias that objectively worsens clinical outcomes, and that professional pain management requires treating the patient's reported experience rather than the nurse's judgment of its legitimacy

D. Implement a patient-controlled analgesia protocol for chronic pain patients that removes the nurse from the medication administration decision

4. A nurse manager is developing a communication framework for managing interpreter-mediated informed consent for surgical procedures. The consent conversation involves the surgeon, the patient (who speaks only Vietnamese), and a professional interpreter. Nursing staff report that the interpreted consent conversations are often rushed, and patients sign consent forms without appearing to fully understand the procedure, risks, and alternatives. Which improvement is MOST critical?

A. Require the surgeon to slow the pace of the consent conversation and pause after each concept to allow the interpreter to convey the information accurately and the patient to ask questions

B. Implement a structured consent communication protocol that requires the surgeon to present information in short segments allowing complete interpretation, uses visual aids and anatomical diagrams that transcend language barriers, includes a nursing assessment of patient comprehension after the surgeon leaves using teach-back through the interpreter, and provides a translated consent summary document in Vietnamese for the patient to review at their own pace before signing

C. Provide the consent form in Vietnamese so the patient can read the information independently before the consent conversation with the surgeon

D. Request that the interpreter service assign interpreters with medical terminology training for all surgical consent conversations

5. A nurse manager is responsible for communicating with a family during the withdrawal of life-sustaining treatment for a patient who will not survive. The family has consented to withdrawal but is now present at the bedside and visibly distressed as the ventilator is being removed. The attending physician has left the unit after writing the withdrawal order. Several family members are asking the nurse questions about how long the dying process will take and whether the patient is suffering. Which communication approach is MOST appropriate?

A. Provide honest, compassionate information about what to expect during the dying process — explaining that the timeline is unpredictable, describing the physical changes the family may observe, assuring them that comfort measures will continue, remaining present at the bedside as much as possible, and normalizing the family's emotional response while offering chaplaincy and social work support

B. Contact the attending physician and request that they return to the bedside to answer the family's clinical questions about the dying process

C. Provide general reassurance that the patient is comfortable without going into specifics about the dying process since detailed information may increase the family's distress

D. Refer the family's questions to the palliative care team since they have specialized training in end-of-life communication

6. A nurse manager is developing a communication strategy for managing the ICU-to-floor step-down transition. Research shows that patients and families experience significant anxiety during this transition because they perceive the reduced monitoring and staffing on the floor as a threat to safety. Families frequently become hyper-vigilant, monitoring equipment alarms, questioning nursing competence, and requesting that the patient be returned to the ICU. Which communication approach MOST effectively manages this transition anxiety?

A. Begin preparing the patient and family for the transition before the move occurs by explaining that the transfer represents clinical improvement, describing the floor's monitoring capabilities, introducing the receiving team, and establishing that the transition is a positive milestone that reflects the patient's progress — while acknowledging that reduced monitoring can feel frightening and validating the family's protective instinct

B. Maintain ICU-level monitoring for the first twenty-four hours on the floor to provide a gradual de-escalation of surveillance that reduces the family's anxiety

C. Assign the most experienced floor nurse to all ICU step-down patients to project competence during the vulnerable transition period

D. Provide the family with a direct phone number to reach the floor nurse at any time to substitute for the continuous ICU nurse presence they are accustomed to

7. A nurse manager is addressing a situation where a patient's medical error — a wrong-site procedure performed in the operating room — is being communicated to the patient and family. The organization's disclosure policy requires honest communication about the error. The surgeon who performed the wrong-site procedure is emotionally devastated and states he is unable to face the patient. The nurse manager must facilitate the disclosure conversation. Which approach is MOST appropriate?

A. Allow the surgeon to delay the disclosure until he is emotionally composed enough to participate since the surgeon's state may compromise the quality of the disclosure conversation

B. Conduct the disclosure without the surgeon present if he is unable to participate, and have the surgeon follow up with the patient after he has received support

C. Request that the chief medical officer conduct the disclosure on behalf of the surgeon since the organizational authority may provide more credibility to the disclosure

D. Acknowledge the surgeon's distress while explaining that timely disclosure is a patient right, provide brief support to help the surgeon compose himself, facilitate the disclosure conversation with both the surgeon and a patient safety officer or risk manager present, and arrange support for the surgeon as a "second victim" after the disclosure is completed

8. A nurse manager is implementing a "patient-as-partner" communication model where patients participate as active members of their own care team rather than passive recipients of clinical decisions. The model requires that patients are included in interdisciplinary rounds, have access to their medical records in real time, and are invited to contribute to care plan decisions. Several physicians resist, stating

that patients lack the clinical knowledge to participate meaningfully in care decisions. Which response is MOST effective?

A. Present evidence showing that patient participation in care decisions improves outcomes, treatment adherence, and satisfaction, acknowledge that patients contribute a different type of expertise — knowledge of their own body, values, and life context — that clinicians cannot provide, and clarify that patient participation supplements rather than replaces clinical decision-making

B. Implement the model only for patients who have the health literacy and engagement level to participate meaningfully

C. Limit patient participation to non-clinical decisions such as scheduling preferences, dietary choices, and visitor management

D. Allow patients to observe rounds but restrict their participation to asking questions at the end rather than contributing to real-time clinical discussions

9. A nurse manager is developing a communication plan for managing a patient who is a nurse employed at the same hospital. The patient-nurse has been admitted for a mental health condition and is requesting that no colleagues visit her, that her admission be kept confidential from coworkers, and that her chart access be restricted to prevent colleagues from viewing her medical information. Which confidentiality measure is MOST critical?

A. Implement the patient's visitor restriction and document it in the care plan

B. Process the patient's request through the standard patient privacy preference system used for all patients

C. Implement enhanced privacy protections including chart access restriction to essential care team members only, activation of the "break-the-glass" audit system that monitors and documents any access to the patient's record beyond the designated care team, restriction of visitor access per the patient's request, and staff education that the patient's coworker status does not entitle any employee to access her health information — recognizing that healthcare employee-patients face unique privacy vulnerability from curious colleagues

D. Transfer the patient to an affiliated hospital where she will not encounter coworkers who might inadvertently breach her confidentiality

10. A nurse manager is implementing a "relationship-based care" communication model that prioritizes the development of intentional therapeutic relationships between each nurse and patient rather than task-focused care delivery. The model requires nurses to establish a caring connection during the first encounter, maintain continuity of the relationship throughout the hospitalization, and create a meaningful closure at discharge. Staff express concern that relationship-based care takes more time than task-focused care. Which response is MOST accurate?

A. Relationship-based care requires additional time per patient interaction and the staffing model should be adjusted to accommodate the longer interactions

B. Relationship-based care changes the quality of existing interactions rather than requiring additional interactions, and research demonstrates that the initial time investment in relationship establishment actually reduces total nursing time by decreasing call light use, reducing patient anxiety, improving adherence to clinical plans, and building trust that makes subsequent interactions more efficient

C. Relationship-based care can be implemented through a standardized script that nurses follow during the first encounter, adding approximately three minutes to the admission process

D. Not all patients want or benefit from relationship-based care, and the model should be applied selectively to patients who express interest in a personal connection with their nurse

11. A nurse manager is developing a communication approach for managing patients who are transitioning from pediatric to adult healthcare services. These patients — typically between ages sixteen and twenty-five — have been cared for in pediatric settings where their parents managed all clinical communication and decision-making. In the adult care setting, the patient is expected to communicate directly with the care team, manage their own medications, and make independent clinical decisions. Which transition communication element is MOST critical?

A. Provide the patient with a comprehensive orientation to the adult care system including how to schedule appointments, manage medications, and communicate with providers

B. Begin the transition process at least two years before the actual transfer by gradually shifting communication responsibility from parent to patient, teaching self-advocacy skills, building the patient's confidence in communicating clinical needs, and developing independent health management competencies — so the actual care setting transition is a continuation rather than an abrupt shift

C. Assign a transition coordinator who manages the communication bridge between pediatric and adult care teams

D. Allow the patient's parents to continue managing clinical communication until the patient expresses readiness to assume the role independently

12. A nurse manager is addressing a communication challenge where surrogate decision-makers are requesting treatments that the medical team considers medically inappropriate — specifically, continuing aggressive treatment for a patient who is experiencing multi-organ failure with no prospect of recovery. The family states that "God will provide a miracle" and refuses to discuss comfort-focused care. The medical team feels complicit in providing care they consider harmful. Which communication approach is MOST therapeutically appropriate?

A. Continue the aggressive treatment as directed by the surrogate while simultaneously pursuing an ethics committee consultation to evaluate the appropriateness of the requested care

B. Respect the surrogate's decision-making authority and continue aggressive treatment without pursuing further discussion about goals of care

C. Request that the hospital's bioethics committee conduct a formal futility determination that would allow the medical team to withdraw treatment over the surrogate's objection

D. Recognize that aggressive treatment may be the only way the family can maintain hope, avoid framing comfort care as the opposite of hope, instead explore what the family most fears about changing the treatment approach, reframe goals-of-care conversations around what the family values most — such as comfort, dignity, and spiritual care — without requiring them to abandon hope for a miracle, and engage chaplaincy as a bridge between the family's faith perspective and the clinical reality

13. A nurse manager is implementing a structured approach to managing "lateral handoff" communication — the communication that occurs between nurses on the same shift when one nurse temporarily assumes care of another nurse's patients during breaks, emergencies, or concurrent clinical activities. Unlike shift handoffs which receive significant quality improvement attention, lateral handoffs are often informal — "watch my patients while I'm at lunch" — without specific information transfer about each patient's current status and pending needs. Which risk is MOST significant?

A. The temporarily covering nurse may not have time to review the medical records of all assumed patients during the coverage period

B. The temporarily covering nurse assumes clinical responsibility for patients she has not assessed, whose clinical status she may not know, and whose pending needs she has not been briefed on — creating a window of vulnerability where clinical changes may be missed, time-sensitive interventions

may be delayed, and patient identification errors may occur because the covering nurse is less familiar with the patients

C. The break schedule may be disrupted if lateral handoffs require structured information transfer

D. Patients may be confused about who their nurse is during the temporary coverage period

14. A nurse manager is developing a communication plan for a scenario where the hospital experiences a significant information technology system failure during a pandemic surge, simultaneously losing the EHR, the communication system, and the staffing management platform. The unit is operating at one hundred thirty percent capacity with temporary surge staff who are unfamiliar with the unit's paper-based backup procedures. Which communication challenge is MOST dangerous?

A. The inability to access patient medication lists and allergy information from the EHR during the system outage

B. The breakdown of the chain-of-command communication structure when the electronic notification system is unavailable

C. The inability to track patient census and staffing assignments when the staffing management platform is down

D. Temporary surge staff who do not know the unit's patients, combined with the loss of electronic clinical data that they would normally rely on, creates a convergence of unfamiliar caregivers and inaccessible patient information that exponentially increases the risk of wrong-patient errors, missed medications, and unrecognized clinical deterioration — making the intersection of staffing and information vulnerabilities more dangerous than either alone

15. A nurse manager is addressing a situation where a nurse consistently provides clinically excellent care but uses condescending language when speaking with unlicensed assistive personnel. The UAPs report feeling belittled, disrespected, and reluctant to approach the nurse with questions or concerns. The nurse views her communication as "direct" and "efficient" rather than condescending. Which approach is MOST effective?

A. Counsel the UAPs on developing thicker skin since the nurse's communication style is direct but not intentionally disrespectful

B. Provide the nurse with specific examples of her communication that UAPs experience as condescending, help her understand the impact on team dynamics and patient safety when UAPs are reluctant to communicate concerns, and coach alternative communication approaches that maintain directness while conveying respect — using role-play to practice the distinction between direct communication and condescending communication

C. Implement a communication training program for all staff that addresses interprofessional respect without singling out the nurse

D. Reassign the nurse to work independently without UAP support since her communication style is incompatible with team-based care

16. A nurse manager is implementing a "micro-affirmations" practice on the unit. Micro-affirmations are small, subtle acts of inclusion, validation, and respect that communicate to others that they are valued and belong. Examples include making eye contact during conversations, using someone's name correctly, acknowledging their contribution in meetings, and actively seeking their opinion. Research shows that micro-affirmations counteract the negative effects of micro-inequities — subtle, often unconscious acts of exclusion and devaluation. Which implementation challenge is MOST significant?

A. Staff may view micro-affirmation training as unnecessary since most people believe they already treat others with respect

B. Measuring the impact of micro-affirmations on team dynamics and patient outcomes is methodologically difficult

C. Some staff may view the concept of micro-affirmations as performative or insincere if not connected to genuine organizational values

D. The most significant challenge is that micro-inequities are often unconscious — the people who most need to practice micro-affirmations may be unaware that their current communication patterns contain exclusionary signals, requiring self-awareness development before behavioral change can occur, since people cannot correct behaviors they do not recognize

17. A nurse manager is developing a communication protocol for managing patients who request access to their nursing notes in real time through the patient portal. Under the 21st Century Cures Act, patients have the right to access their complete medical record including nursing notes without delay. Some nurses express discomfort about patients reading their clinical assessments, particularly notes that include observations about patient behavior, compliance, or family dynamics. Which guidance is MOST appropriate?

- A. Coach nurses to document as if the patient is reading the note simultaneously — using objective, factual, non-judgmental language that the nurse would be comfortable discussing directly with the patient, treating real-time patient access as an opportunity to improve documentation quality rather than a threat to candid clinical communication
- B. Implement a delayed release for nursing notes so nurses can review and edit them before patients see them
- C. Restrict patient access to nursing assessment notes and make only the physician's notes available through the portal
- D. Continue documenting as before and address patient concerns about specific nursing notes if and when they arise

18. A nurse manager is developing a strategy for managing communication with a patient who has appointed two co-healthcare proxies who disagree with each other about treatment decisions. The patient designated her daughter and her sister as equal co-decision-makers in her advance directive. The daughter wants to continue aggressive treatment while the sister wants to transition to comfort care. Neither has authority to overrule the other. Which action is MOST appropriate?

- A. Facilitate a meeting with both co-proxies, the attending physician, social work, and potentially the ethics committee to explore the patient's previously expressed values and wishes, seek consensus between the proxies based on what the patient would have wanted, and if consensus cannot be reached, consult legal counsel about the legal mechanism for resolving proxy disagreements in the jurisdiction — since the clinical team cannot proceed with contradictory directions
- B. Allow the co-proxy who is the closer blood relative (the daughter) to make the final decision
- C. Continue the current treatment plan unchanged until the co-proxies reach agreement independently
- D. Request the court to appoint a guardian who can make decisions independently of the disagreeing co-proxies

19. A nurse manager is implementing a "communication-centered patient safety" approach where every safety protocol is evaluated through the lens of communication effectiveness. A root cause analysis of the unit's safety events over two years reveals that seventy-one percent involved a communication failure as a contributing factor. The nurse manager wants to redesign the unit's safety infrastructure around communication rather than treating communication as one component among many. Which redesign principle is MOST transformative?

A. Implement standardized communication tools such as SBAR, I-PASS, and CUS across all clinical interactions

B. Treat every safety protocol as a communication protocol — redesigning medication administration as a communication verification process, handoffs as information integrity transfers, and escalation pathways as communication channels — so that improving communication simultaneously improves every safety dimension rather than addressing communication as a separate safety element

C. Hire a dedicated communication coach who provides real-time feedback on clinical communication throughout each shift

D. Implement a communication failure tracking system that identifies which types of communication breakdowns contribute most frequently to safety events

20. A nurse manager is managing the communication implications of a situation where a nurse's social media post — a photograph of an empty hospital hallway with the caption "another quiet night shift" — has been interpreted by family members of a patient who died on that shift as insensitive. The family saw the post, recognized the hallway, and filed a complaint alleging that the nurse was socializing on social media while their family member was dying. The nurse states the photograph was taken during her break time and did not involve any patient information. Which communication dimension requires the MOST immediate attention?

A. Address the family's emotional response by acknowledging their perception, explaining the circumstances, and expressing empathy for how the post appeared from their perspective during a devastating personal experience

B. Counsel the nurse about the perception implications of social media posts that can be connected to clinical events even when they do not contain patient information

C. Implement a policy prohibiting all social media use by nursing staff while on hospital premises regardless of whether they are on break

D. Address both dimensions simultaneously — respond to the family with empathy and explanation, counsel the nurse on the perception risks of workplace-adjacent social media activity during shifts when significant clinical events have occurred, and use the incident to educate all staff about the intersection of social media timing and clinical events

21. A nurse manager is implementing a "sensegiving" communication practice — the deliberate leadership activity of shaping how staff interpret and make meaning of organizational events. Unlike sensemaking (which occurs naturally as people interpret events), sensegiving is the intentional framing

of events by the leader to influence how the team understands them. A major organizational restructuring has been announced, and staff are interpreting the change as a threat to their job security. Which sensegiving communication is MOST effective?

- A. Provide reassurance that no positions will be eliminated to directly counter the threat interpretation
- B. Allow staff to develop their own interpretation of the restructuring without leadership influence to preserve authentic understanding
- C. Reframe the restructuring by connecting it to the unit's values and future vision, acknowledge the uncertainty honestly while providing the interpretive context that helps staff understand the change as an organizational investment in sustainability rather than a threat to stability, and create ongoing dialogue where staff's evolving interpretation is monitored and leadership framing is adjusted in response
- D. Focus sensegiving on the factual details of the restructuring rather than interpretive framing since staff prefer accurate information to leadership spin

22. A nurse manager is developing a communication approach for situations where nurses must communicate clinical findings that the physician may not want to hear — such as reporting that a patient's condition has not improved despite the physician's intervention, or that a complication has developed from a procedure the physician performed. Nurses report "softening" their communication to avoid physician displeasure, resulting in delayed recognition of clinical problems. Which intervention is MOST effective?

- A. Implement a standardized escalation pathway that removes the interpersonal dynamics from clinical communication
- B. Train nurses in assertive communication techniques that enable them to deliver unwelcome clinical findings with clarity and confidence — using frameworks such as "I notice... I am concerned... I request..." that depersonalize the message while maintaining clinical accuracy, practicing through simulation scenarios where the physician response is realistic, and building a unit culture where reporting negative clinical findings is recognized as professional advocacy rather than personal confrontation
- C. Implement a policy requiring all clinical findings to be communicated through the medical record rather than verbal interaction to eliminate the interpersonal barrier
- D. Assign the charge nurse as an intermediary for all communications where nurses anticipate physician displeasure

23. A nurse manager is implementing a "narrative medicine" approach on the unit. Narrative medicine, developed by Rita Charon, uses close reading, reflective writing, and attentive listening to develop clinicians' capacity for understanding patients' stories of illness. The approach goes beyond clinical history-taking to understand the patient's lived experience of being ill — including their fears, meaning-making, and the impact of illness on their identity. Which clinical benefit of narrative medicine is MOST significant?

A. Narrative medicine improves documentation quality by training nurses to capture more detailed patient histories

B. Narrative medicine develops diagnostic reasoning by training nurses to identify clinically significant patterns in patient narratives

C. Narrative medicine improves adherence by helping nurses understand the patient's perspective on their illness and treatment

D. Narrative medicine reduces diagnostic error by improving the nurse's capacity to recognize what matters to the patient and what the patient is trying to communicate — including clinical information embedded in the illness narrative that structured assessment tools may not capture, enabling the nurse to hear what the patient is telling them beyond the answers to standardized questions

24. A nurse manager is addressing a communication challenge where patients consistently rate the unit's physician communication higher than nursing communication on satisfaction surveys, despite nurses spending significantly more time with patients. Analysis reveals that physician interactions are shorter but more focused and authoritative, while nursing interactions are longer but fragmented across multiple brief encounters that feel disorganized to patients. Which insight is MOST actionable?

A. Redesign nursing communication to include at least one substantial focused interaction per shift where the nurse sits down, makes eye contact, addresses the patient's top concerns, and provides a clear explanation of the day's plan — creating a "signature visit" that establishes the nurse as a clinical partner rather than an intermittent task performer, while maintaining the necessary brief task-oriented encounters throughout the shift

B. Train nurses to adopt a more authoritative communication style similar to physician communication

C. Reduce the number of brief nursing encounters by batching clinical tasks to create fewer but longer patient interactions

D. Survey patients about which specific nursing communication behaviors they value most and redesign nursing communication around those preferences

25. A nurse manager is developing a communication protocol for managing the informed consent process for clinical research when the patient's primary nurse is also involved in the research study as a study coordinator. The dual role creates a potential communication conflict — the nurse's clinical obligation to advocate for the patient may conflict with the study coordinator's interest in enrolling participants. Which safeguard is MOST important?

A. Require the principal investigator to obtain informed consent rather than the nurse who has a dual role

B. Train the nurse on the ethical distinction between clinical care and research enrollment and trust her professional judgment to manage the dual role

C. Separate the roles by ensuring that consent for research participation is obtained by a team member who does not have a clinical care relationship with the patient, so the patient does not feel pressure to enroll from the nurse they depend on for daily care — eliminating the inherent influence of the therapeutic relationship from the consent process

D. Document the dual role in the consent form so the patient is aware that their nurse is also the study coordinator

26. A nurse manager is developing a plan for managing communication during a "surge within a surge" — a situation where the unit experiences an internal crisis (such as a staffing emergency or equipment failure) simultaneously with an external surge (such as a mass casualty event or pandemic wave). Communication systems become overwhelmed when two crisis communication streams compete for the same channels and leadership attention. Which communication adaptation is MOST critical?

A. Prioritize external surge communication over internal crisis communication since the external event affects more patients

B. Delegate internal crisis communication to the charge nurse while the nurse manager focuses on external surge communication

C. Combine both communication streams into a single unified incident command structure

D. Establish separate communication channels for each crisis stream with designated leadership for each, create a synchronization point where the two streams intersect for resource allocation decisions, and implement a simplified communication format for both streams that reduces the information load per communication while maintaining essential content

27. A nurse manager is implementing a structured "patient communication preference profile" that captures each patient's preferred communication approach during admission and applies it throughout the hospitalization. The profile includes preferred name, communication style (detailed/brief), decision-making style (independent/collaborative/family-led), learning preference (visual/auditory/hands-on), language needs, and optimal time of day for important conversations. A nurse argues that creating a communication profile for every patient is impractical when the unit admits twenty patients per day. Which response is MOST convincing?

- A. Reduce the profile to only the three most impactful preference elements to minimize the admission burden
- B. The communication profile takes approximately two minutes to complete, prevents the communication misfires that occur when nurses assume how patients want to receive information, reduces repeated explanations caused by mismatched delivery, and ultimately saves more time than it consumes by getting communication right the first time — making it a net efficiency gain rather than an additional burden
- C. Allow the profile to be completed by the patient independently on a tablet rather than as part of the nursing admission assessment
- D. Implement the profile only for patients with expected lengths of stay greater than three days since the investment is proportional to the duration of the communication relationship

28. A nurse manager is addressing a communication pattern where nurses deflect patient questions with "I'll have your doctor explain that" even when the question is within the nursing scope of practice. Questions such as "what does this lab result mean?" and "what can I do to prevent this from happening again?" are within nursing's assessment and education scope but nurses defer them to physicians. Which root cause is MOST likely?

- A. Nurses may lack confidence in their clinical knowledge and defer to physicians to avoid providing incorrect information that could be contradicted during physician rounds, creating embarrassment or undermining the patient's trust in nursing competence
- B. Nurses may be following an unstated unit norm where clinical explanations are considered the physician's role rather than a shared responsibility
- C. Nurses may be managing their time by deferring questions that require extended explanations to the physician visit rather than interrupting their current workflow

D. Nurses may not recognize which clinical questions are within their scope of practice and which genuinely require physician response

29. A nurse manager is developing a communication strategy for managing patients who are being monitored by continuous video surveillance for safety reasons (fall prevention, self-harm risk). Patients and families report feeling dehumanized by constant camera surveillance, stating that it removes their dignity and creates a prison-like atmosphere. Staff report that patients sometimes cover the camera or refuse to cooperate with care when under surveillance. Which communication approach MOST effectively addresses the dignity concern?

A. Explain the clinical necessity for surveillance and request the patient's cooperation as a safety partnership

B. Offer the patient a choice between continuous video surveillance and in-person one-to-one observation to provide a sense of control over the monitoring method

C. Remove the camera and rely on in-person monitoring since the patient's dignity concerns outweigh the efficiency of video surveillance

D. Reframe the surveillance communication by explaining the specific safety concern the monitoring addresses, providing the patient with as much control as possible over the monitoring parameters, ensuring the monitoring area is limited to what is clinically necessary, establishing that monitoring staff introduce themselves and communicate respectfully through the two-way audio, and periodically reassessing whether continued surveillance remains clinically justified — treating the monitoring as a therapeutic intervention requiring consent and dignity preservation rather than a security measure imposed on the patient

30. A nurse manager is implementing a nurse-driven glycemic management protocol for hospitalized non-ICU patients. The protocol empowers nurses to adjust insulin sliding scale doses within defined parameters based on blood glucose monitoring results, without requiring a physician order for each dose adjustment. Evidence shows that nurse-driven glycemic management reduces hyperglycemic episodes, improves glycemic control, and decreases hypoglycemic events compared to traditional physician-managed sliding scales. Which implementation element is MOST critical for safety?

A. Comprehensive nurse education on insulin pharmacology, onset-peak-duration profiles, and hypoglycemia recognition and treatment

B. Clear glycemic targets and dose adjustment parameters validated by the medical staff and pharmacy

C. A structured protocol with explicit dose adjustment algorithms, defined glycemic targets approved by the medical staff, clear criteria for when nurses must notify the physician rather than independently adjust the dose, comprehensive training with competency verification, and a real-time monitoring system that alerts the pharmacist when adjustments approach safety boundaries

D. Physician notification requirements for every dose adjustment so the managing physician maintains awareness of the patient's glycemic pattern

31. A nurse manager is evaluating the unit's implementation of a post-fall management protocol. When a patient falls, the current protocol requires immediate assessment, physician notification, neurological monitoring, and incident documentation. However, analysis reveals that the fall prevention plan is rarely updated after the fall event — meaning the patient who just fell continues under the same fall prevention interventions that failed to prevent the fall. Which improvement is MOST critical?

A. Require a mandatory reassessment of the patient's fall risk factors and a revision of the fall prevention plan within two hours of every fall event, analyzing what specific factors contributed to this fall and implementing targeted interventions that address those factors rather than continuing a generic prevention plan that already demonstrated inadequacy

B. Implement enhanced post-fall monitoring for the first twenty-four hours including neurological checks every two hours

C. Require a nursing care conference within four hours of every fall to discuss the event and update the prevention plan

D. Assign a one-to-one observer for every patient who falls until a comprehensive reassessment can be completed

32. A nurse manager is developing a protocol for the "antimicrobial timeout" — a structured reassessment of antibiotic therapy that occurs forty-eight to seventy-two hours after initiation. The timeout evaluates whether the initial empiric antibiotic choice remains appropriate based on culture results, clinical response, and current guidelines. Research shows that antimicrobial timeouts reduce inappropriate antibiotic use by fifteen to thirty percent. Which nursing role in the antimicrobial timeout is MOST valuable?

A. Documenting the timeout discussion in the medical record when the physician and pharmacist complete their review

- B. Monitoring for antibiotic-related adverse effects and reporting them during the timeout discussion
- C. Ensuring patient compliance with the antibiotic dosing schedule so accurate clinical response data is available at the timeout
- D. Initiating the timeout by prompting the physician when the forty-eight-to-seventy-two-hour window arrives since antimicrobial timeouts are frequently forgotten without a reminder system, providing nursing assessment data on the patient's clinical response to the current therapy, and communicating observations about signs of infection resolution or persistence that inform the de-escalation decision

33. A nurse manager is evaluating the unit's approach to managing high-alert medication administration. The Institute for Safe Medication Practices identifies specific medications that carry heightened risk of significant patient harm when used in error — including insulin, anticoagulants, opioids, neuromuscular blocking agents, and concentrated electrolyte solutions. Which safety layer is MOST commonly insufficient in high-alert medication management systems?

- A. Prescribing safeguards such as dose-range checking and clinical decision support in the ordering system
- B. Dispensing safeguards such as pharmacy verification and automated dispensing cabinet profiling
- C. The independent double-check before administration — which should involve a second qualified clinician independently verifying the patient, medication, dose, route, and time against the original order rather than the first nurse's preparation, ensuring true independence rather than a cursory confirmation that mimics verification without providing the cognitive redundancy the check is designed to create
- D. Post-administration monitoring to detect adverse effects from high-alert medications after they have been administered

34. A nurse manager is developing a nurse-driven protocol for managing contrast-induced nephropathy risk in patients scheduled for contrast-enhanced imaging studies. Nursing interventions that reduce contrast nephropathy risk include pre-procedure hydration, identification of high-risk patients, and communication of renal function status to the imaging team. Which nursing assessment is MOST critical before contrast administration?

- A. Assessment of the patient's allergy history to identify previous contrast reactions

B. Assessment of the patient's medication list for nephrotoxic medications that should be held before contrast administration

C. Verification that a current serum creatinine and estimated glomerular filtration rate have been obtained and reviewed, with communication of abnormal values to the ordering physician and imaging team before the patient leaves the unit — since contrast nephropathy risk is directly related to baseline renal function, and patients with unrecognized renal impairment are at the highest risk for preventable contrast-related kidney injury

D. Assessment of the patient's hydration status and implementation of the pre-contrast hydration protocol

35. A nurse manager reviews the following data on the unit's rapid response team utilization:

Month	RRT Activations	Unplanned ICU Transfers	Code Blue Events	Mortality Rate
-------	-----------------	-------------------------	------------------	----------------

Jan	8	6	2	3.2%
Feb	10	5	2	2.8%
Mar	14	4	1	2.4%
Apr	18	3	0	1.9%

Which interpretation is MOST accurate?

A. The increasing RRT activation rate is concerning because it suggests more patients are deteriorating on the unit

B. The data demonstrates an inverse relationship: as RRT activations increase, unplanned ICU transfers, code blue events, and mortality all decrease — suggesting that the increased activation reflects earlier recognition and management of deterioration that prevents the escalation cascade from assessment-to-ICU-to-code-to-death, making the higher activation rate a positive indicator of improving safety culture

C. The declining code blue rate may be coincidental and not related to the increased RRT utilization

D. The data suggests the unit should establish an RRT activation target of at least eighteen per month to maintain the improved outcomes

36. A nurse manager is implementing a central line insertion checklist that includes the nursing role of "empowered observer" — the explicit authority and expectation that the nurse will stop the insertion procedure if any element of the sterile technique is compromised. Despite the policy, nurses report that they feel unable to stop a physician during a procedure because of the power differential. Which intervention MOST effectively empowers nurses to stop the line?

A. Implement a nurse-initiated checklist that the nurse completes independently and the physician must acknowledge before proceeding, using standardized language such as "the checklist requires me to verify..." that depersonalizes the challenge — framing the stop as a system requirement rather than a personal confrontation, and practicing the interaction through simulation until nurses develop the behavioral muscle memory to intervene automatically

B. Require that the nurse manager or charge nurse be present during all central line insertions to serve as the empowered observer since they have more authority to challenge physicians

C. Implement a policy requiring the physician to self-verify their own sterile technique compliance during the procedure

D. Report all sterile technique breaks observed during central line insertion through the incident reporting system rather than confronting the physician during the procedure

37. A nurse manager is developing an approach to hospital-acquired pneumonia prevention for non-ventilated patients. While ventilator-associated pneumonia prevention has received significant attention, non-ventilator hospital-acquired pneumonia accounts for a larger proportion of healthcare-associated pneumonia cases and receives less systematic prevention attention. Which nursing intervention has the GREATEST impact on non-ventilator HAP prevention?

A. Implementing oral care protocols for all hospitalized patients, not just ventilated patients, since oral colonization with pathogenic bacteria is a primary source of aspiration pneumonia

B. Elevating the head of bed to at least thirty degrees for all patients with swallowing difficulties to reduce aspiration risk

C. A multicomponent prevention bundle that includes oral hygiene maintenance, aspiration precaution protocols for at-risk patients, early mobilization, cough and deep breathing encouragement, and

dysphagia screening before oral intake — addressing the multiple pathways through which non-ventilated patients develop hospital-acquired pneumonia

D. Implementing hand hygiene enhancement around respiratory care activities to prevent cross-transmission of respiratory pathogens

38. A nurse manager is evaluating the unit's post-procedural monitoring protocol for patients who undergo bedside procedures requiring moderate sedation. Current monitoring includes continuous pulse oximetry, vital signs every fifteen minutes for the first hour, and assessment of sedation level using a validated scale. Despite protocol compliance, two patients in the past quarter experienced respiratory depression that required intervention. Investigation reveals that both patients were discharged from monitoring after one hour with residual sedation effects. Which protocol modification is MOST important?

A. Extend the monitoring period from one hour to two hours for all patients receiving moderate sedation

B. Implement patient-specific discharge-from-monitoring criteria based on the patient's return to baseline consciousness, respiratory function, and hemodynamic stability rather than a time-based discharge — since medication metabolism varies by patient factors including age, weight, hepatic function, and concurrent medications, making time-based monitoring periods unreliable for determining when the sedation risk has resolved

C. Add capnography monitoring to detect early respiratory depression before oxygen desaturation occurs

D. Require anesthesiology consultation for all bedside moderate sedation to ensure appropriate monitoring and recovery management

39. A nurse manager is implementing an evidence-based approach to managing fluid balance in hospitalized patients. Research shows that both fluid overload and fluid deficit contribute to adverse outcomes, yet many hospitalized patients receive intravenous fluids on a standing order basis without individualized assessment of fluid needs. Accurate fluid balance monitoring requires precise intake and output measurement, which nursing staff report is difficult to maintain with competing clinical priorities. Which improvement is MOST impactful?

A. Implement automated fluid balance tracking through smart infusion pumps and electronic urine measurement devices that capture intake and output data without manual nursing documentation

B. Educate staff on the clinical importance of accurate fluid balance measurement and its direct impact on patient outcomes

C. Implement a nurse-driven fluid management protocol that includes daily assessment of fluid balance needs, criteria for continuing or discontinuing maintenance IV fluids, clinical triggers for fluid restriction or bolus administration, and integration of fluid balance assessment into the routine patient assessment rather than treating it as a separate documentation task

D. Assign fluid balance monitoring to a dedicated nursing assistant who is responsible for all intake and output measurement on the unit

40. A nurse manager is developing a protocol for managing patients who require procedural sedation on the medical-surgical unit for procedures such as cardioversion, chest tube insertion, and fracture reduction. The unit does not have the continuous monitoring capability of an ICU or procedural area. Which safety element is MOST critical?

A. Ensuring that the physician performing the procedure is certified in moderate sedation administration

B. Establishing minimum monitoring requirements including continuous pulse oximetry and capnography, cardiac monitoring, dedicated monitoring nurse who does not participate in the procedure, immediately available emergency airway equipment, and defined rescue protocols for sedation-related complications — ensuring that the unit provides a level of monitoring equivalent to that required in dedicated procedural areas regardless of the physical location

C. Requiring all procedural sedation cases to be transferred to a dedicated procedural area or the ICU where appropriate monitoring is already in place

D. Limiting procedural sedation on the unit to patients classified as ASA physical status I or II to reduce the risk of sedation complications

41. A nurse manager reviews the following data on the unit's compliance with time-sensitive clinical interventions:

Intervention	Target Time	Compliance	Avg Actual Time
--------------	-------------	------------	-----------------

-----	-----	-----	-----
-------	-------	-------	-------

Sepsis antibiotics (from triage)	3 hours	78%	2.8 hours
----------------------------------	---------	-----	-----------

| Stroke thrombolytics (from arrival) | 60 min | 62% | 68 min |

| STEMI door-to-balloon | 90 min | 84% | 82 min |

| Pain reassessment | 60 min | 71% | 74 min |

Which finding represents the GREATEST clinical concern?

A. Sepsis antibiotic compliance at seventy-eight percent since sepsis mortality increases measurably with each hour of antibiotic delay

B. Stroke thrombolytic compliance at sixty-two percent is most concerning because it has the lowest compliance rate AND the narrowest time window, meaning patients who miss the sixty-minute target may be permanently excluded from a potentially life-saving intervention with no alternative — unlike other interventions where delayed treatment is suboptimal but still beneficial

C. STEMI door-to-balloon time is the most critical since cardiac tissue dies progressively with each minute of delayed reperfusion

D. Pain reassessment compliance at seventy-one percent is the least concerning and should receive the lowest priority for improvement

42. A nurse manager is developing a plan for managing the clinical implications of "alarm desensitization" — a phenomenon where staff become so accustomed to clinical alarms that they no longer register them consciously. Unlike alarm fatigue, which involves conscious awareness followed by delayed response, alarm desensitization occurs when the brain filters out alarm sounds entirely — the nurse literally does not hear the alarm despite its audibility. Which intervention MOST directly addresses desensitization specifically?

A. Reduce alarm volume to lower baseline noise levels so alarms are less likely to blend into background noise

B. Implement variable alarm tones that change periodically so the brain cannot habituate to a consistent sound pattern — since desensitization occurs when the auditory cortex classifies a familiar sound as non-threatening background noise, introducing variation prevents the habituation pathway that leads to unconscious filtering

C. Replace audible alarms with tactile alerts delivered through wearable devices that bypass the auditory processing pathway where desensitization occurs

D. Implement tiered alarm urgency signals where the most critical alarms use distinctly different tones than lower-priority alarms

43. A nurse manager is evaluating the unit's approach to nursing assessment documentation. Current documentation requires nurses to complete a comprehensive systems assessment every four hours for all patients. Staff report that much of the assessment documentation is "auto-populated" from the previous assessment with minimal actual reassessment occurring. The result is documentation that appears complete but does not reflect the patient's current clinical status. Which improvement is MOST patient-centered?

A. Transition from time-based comprehensive assessments to a focused assessment model where nurses document comprehensive baseline assessments at admission and shift start, then perform and document focused assessments targeting the specific systems relevant to the patient's clinical condition and trajectory — producing assessments that are genuinely performed and clinically meaningful rather than auto-populated comprehensive entries that document the same findings repeatedly

B. Implement a verification requirement where nurses must attest that each assessment was personally performed before the documentation can be finalized

C. Reduce the assessment frequency from every four hours to every eight hours to allow nurses time to perform genuine assessments

D. Remove the auto-population feature from the EHR so nurses must manually enter each assessment finding

44. A nurse manager is developing a response to a new state regulation requiring hospitals to report nurse staffing data that includes not only HPPD and skill mix but also the ratio of experienced nurses (more than two years on the unit) to newer nurses on each shift. The regulation recognizes that a shift staffed entirely by nurses new to the unit may meet HPPD targets but lack the experiential knowledge to provide safe care. Which metric does this regulation address that traditional staffing measures do NOT?

A. The total number of nursing hours provided relative to patient volume

B. The proportion of professional versus unlicensed nursing staff

C. Whether the unit's patient acuity matches the staffing allocation

D. The experience composition of the staffing team — recognizing that staffing adequacy depends not only on how many nurses are present and what their licensure level is, but on the collective experiential knowledge of the team, since a shift staffed by eight nurses who are all new to the unit may be more dangerous than a shift staffed by six nurses who include experienced unit veterans despite the lower headcount

45. A nurse manager is implementing an evidence-based approach to preventing hospital-acquired venous thromboembolism that goes beyond pharmacological prophylaxis. Research identifies "immobility" as the single most modifiable risk factor for VTE during hospitalization, yet nursing interventions targeting immobility receive less attention than pharmacological prophylaxis. Which nursing intervention has the GREATEST impact on VTE prevention beyond pharmacological prophylaxis?

A. Applying sequential compression devices to all immobile patients as a mechanical prophylaxis measure

B. Implementing a progressive mobility protocol that transitions patients from passive range-of-motion through seated activities to ambulation as clinically tolerated — addressing immobility as the modifiable risk factor through graded activity advancement that begins within hours of admission and is maintained throughout the hospitalization as a fundamental nursing care priority rather than an ancillary therapy

C. Elevating the lower extremities for immobile patients to promote venous return

D. Educating patients about the importance of movement and encouraging them to perform ankle pumping exercises independently

46. A nurse manager is evaluating the unit's performance on a quality measure tracking the percentage of patients who receive a medication-related adverse event disclosure. Current practice involves documenting the adverse event in the incident reporting system but inconsistently communicating the event to the patient. Data shows that only thirty-four percent of medication adverse events are disclosed to the affected patient. Which barrier is MOST likely driving the low disclosure rate?

A. Staff may be uncertain about which medication adverse events require disclosure and which are routine expected side effects

B. The organization's disclosure policy may be ambiguous about the threshold for patient notification

C. Nurses may fear that disclosure will lead to patient anger, complaints, or litigation, and the organization may not have created the psychological safety and institutional support needed for staff to feel comfortable having transparent disclosure conversations

D. Physicians may prefer to manage all adverse event disclosures and nurses may defer to this preference

47. A nurse manager is developing a nursing care plan for managing patients receiving continuous renal replacement therapy on the medical-surgical unit. CRRT requires specialized monitoring including fluid balance assessment, anticoagulation management, vascular access care, and machine troubleshooting. The unit has historically transferred CRRT patients to the ICU, but organizational capacity constraints now require management on the medical-surgical floor. Which preparation element is MOST critical for safe CRRT management on a non-ICU unit?

A. Purchasing CRRT machines designed for non-ICU use with simplified interfaces and enhanced safety alarms

B. Establishing a minimum nurse-to-patient ratio for nurses managing CRRT patients that accounts for the increased monitoring demand

C. Comprehensive CRRT competency development for designated nurses including machine operation, fluid balance calculation, anticoagulation monitoring, vascular access assessment, alarm troubleshooting, and recognition of CRRT-specific complications — combined with a clearly defined scope of nursing CRRT management that identifies which decisions nurses make independently and which require physician or nephrology notification

D. Maintaining a partnership with the ICU where ICU-trained nurses provide consultation support for medical-surgical nurses managing CRRT patients

48. A nurse manager is developing a plan to reduce the unit's central-line-associated bloodstream infection rate, which has increased from 0.0 to 1.8 per 1,000 central line days over two quarters. Investigation reveals that insertion practice compliance remains high, but maintenance bundle compliance has declined from ninety-four percent to seventy-one percent over the same period. Which analysis is MOST actionable?

A. Re-educate all nursing staff on the central line maintenance bundle components

B. Audit individual nurse compliance with each maintenance bundle element to identify specific nurses or elements contributing to the decline

C. Investigate what organizational or operational change coincided with the maintenance compliance decline — such as staffing changes, workflow modifications, EHR documentation changes, or supply availability issues — since the twenty-three-percentage-point drop over two quarters suggests a systemic trigger rather than a gradual skill degradation

D. Implement a maintenance bundle compliance tracking dashboard that provides real-time feedback to nurses about their compliance rates

49. A nurse manager is evaluating the unit's approach to managing medication errors that reach the patient but cause no observable harm — "no-harm" events. Current practice involves documenting the event in the incident reporting system but conducting minimal investigation since no patient harm occurred. Research shows that no-harm events have identical system root causes to harmful events and differ only in the presence of recovery factors or patient resilience that prevented harm. Which quality improvement principle is MOST relevant?

A. No-harm events should receive reduced investigation since limited quality improvement resources should be directed toward events that actually caused patient harm

B. No-harm events should be tracked as a leading indicator of system reliability without individual event investigation

C. No-harm events should receive investigation equivalent to harmful events because they reveal the same system vulnerabilities — the only difference between a no-harm event and a harmful event is often luck or patient resilience, and the system factors that allowed the error to reach the patient are identical in both cases, making no-harm events free lessons that can prevent future harmful events

D. No-harm events should be used for educational purposes through anonymized case studies but do not warrant formal root cause analysis

50. A nurse manager is implementing a nurse-driven electrolyte replacement protocol. The protocol allows nurses to independently order and administer potassium and magnesium replacement based on laboratory results and a pre-approved dosing algorithm, without requiring a physician order for each replacement dose. Evidence shows that nurse-driven electrolyte replacement reduces time from lab result to treatment by an average of three hours compared to physician-ordered replacement. Which safety element is MOST critical?

A. A validated dosing algorithm with clear parameters that define the nurse's independent replacement authority, including dose ranges, route limitations, infusion rate specifications, renal function considerations, contraindications requiring physician consultation, and post-replacement monitoring requirements — ensuring that the protocol's convenience does not compromise the clinical rigor of the replacement decision

B. Pharmacy verification of each nurse-initiated electrolyte replacement order before administration

C. Physician notification within twelve hours of each nurse-initiated electrolyte replacement to maintain physician awareness of the patient's metabolic status

D. Annual competency validation for all nurses authorized to use the electrolyte replacement protocol

51. A nurse manager is applying "relational coordination theory" developed by Jody Hoffer Gittel to improve care coordination on the unit. Relational coordination theory identifies that high-quality care coordination depends on the quality of communication AND the quality of relationships among the people doing the coordinating. The theory identifies seven dimensions: four communication dimensions (frequency, timeliness, accuracy, problem-solving focus) and three relationship dimensions (shared goals, shared knowledge, mutual respect). Assessment reveals that the unit's communication dimensions are strong but the relationship dimensions — particularly shared goals between nursing and medicine — are weak. Which intervention is MOST targeted?

A. Implement additional communication tools such as structured handoffs and interdisciplinary huddles to strengthen the already-strong communication dimensions

B. Conduct a shared goals workshop where nursing and physician staff articulate their individual goals for patient care and identify where those goals align and diverge, then develop explicit shared goal statements that both disciplines commit to pursuing — since improving the relationship foundation enhances all communication dimensions simultaneously

C. Improve mutual respect through interprofessional education programs that increase each discipline's understanding of the other's contribution to patient care

D. Focus on improving the weakest communication dimension since communication quality drives relationship quality according to the theory

52. A nurse manager is applying the GROW coaching model (Goal, Reality, Options, Way Forward) to develop a charge nurse who struggles with time management. The charge nurse's goal is to complete all leadership responsibilities without staying late after every shift. The GROW model requires the coach to

guide the coachee through self-discovery rather than providing solutions. Which coaching question sequence MOST effectively follows the GROW model?

A. "What specifically would your workday look like if your time management was excellent? (Goal) What is currently happening that prevents that? (Reality) What options can you think of to address those barriers? (Options) Which option will you try first and by when? (Way Forward)" — guiding the charge nurse through her own analysis rather than prescribing solutions

B. "Here are the three most common time management strategies that successful charge nurses use. Which one do you think would work best for you?" — providing expert solutions and allowing the charge nurse to select the best fit

C. "Let me shadow you for a shift and identify where your time is being consumed so I can recommend specific changes" — conducting an expert assessment and prescribing solutions

D. "Your overtime is creating a budget problem. You need to complete your responsibilities within your scheduled shift. What is your plan for achieving this?" — establishing accountability and expecting the charge nurse to develop her own solution

53. A nurse manager is implementing an "action learning set" on the unit. Action learning, developed by Reg Revans, brings together a small group of people who meet regularly to address real workplace challenges through a structured process of questioning, reflection, and action. Unlike traditional problem-solving groups, action learning sets use "insightful questioning" rather than advice-giving — the group helps the presenter think through the problem rather than telling them what to do. Which element MOST distinguishes action learning from a typical problem-solving meeting?

A. Action learning produces documented action plans with assigned responsibilities and deadlines

B. Action learning includes reflection as a structured component of every meeting

C. Action learning requires participants to implement their actions between meetings and report on outcomes

D. The group's primary role is to ask questions that deepen the presenter's understanding of the problem rather than offering solutions — based on Revans' principle that insightful questions are more valuable than expert answers because they help the person closest to the problem develop their own solution, which produces deeper understanding and greater commitment to implementation than externally provided advice

54. A nurse manager is applying the concept of "organizational storytelling" as a leadership communication tool. Research on narrative in organizations shows that stories are more memorable, more persuasive, and more effective at transmitting culture than data, policies, or directives. The nurse manager wants to use storytelling to reinforce the unit's patient safety culture. Which storytelling application is MOST powerful?

A. Sharing de-identified patient safety event stories during staff meetings to illustrate the consequences of system failures

B. Inviting patients to share their care experience stories with the nursing staff to humanize the quality data

C. Using specific, true stories from the unit's own history that illustrate moments when a nurse's vigilance prevented harm, a team's communication saved a life, or a system failure taught a critical lesson — because stories from the team's own experience resonate more deeply than external examples, create shared identity around safety values, and establish that safety heroism happens on THIS unit by THESE people

D. Sharing stories from other organizations' safety journeys to provide perspective and inspiration for the unit's own improvement

55. A nurse manager is addressing a leadership challenge where the unit's informal leader consistently undermines the formal shared governance process by gathering consensus among staff before governance council meetings and then presenting the pre-formed consensus as the council's "decision" — effectively bypassing the deliberative process the council is designed to provide. Other council members feel their voices are irrelevant since decisions are made before meetings begin. Which approach is MOST appropriate?

A. Remove the informal leader from the governance council to restore the deliberative process

B. Address the behavior directly with the informal leader by acknowledging their influence while explaining how the pre-formed consensus undermines the council's purpose, establish ground rules that prohibit pre-meeting lobbying for specific outcomes, restructure the council process to include open deliberation with genuinely undecided outcomes, and redirect the informal leader's energy toward facilitating authentic discussion rather than orchestrating predetermined conclusions

C. Allow the current dynamic to continue since the informal leader's consensus-building produces efficient decision-making

D. Implement anonymous voting for all governance council decisions to prevent the informal leader's influence from affecting outcomes

56. A nurse manager is applying the AONL competency of "creating the future through innovation" to the unit's quality improvement approach. The nurse manager recognizes that the unit has been improving existing processes for years but has not fundamentally reimagined how care is delivered. All quality improvement has been incremental — better handoffs, faster response times, higher compliance rates — without questioning whether the underlying care delivery model itself is optimal. Which leadership behavior MOST effectively catalyzes fundamental innovation rather than incremental improvement?

A. Ask fundamentally different questions — instead of "how can we reduce falls?" ask "what would a unit look like where falls never happen?" and instead of "how can we improve handoffs?" ask "what if handoffs were unnecessary?" — challenging the team to reimagine the system rather than optimize the current one, creating the cognitive disruption that opens the door to transformative rather than incremental solutions

B. Hire innovation consultants to bring outside perspectives that challenge the unit's assumptions

C. Send staff to observe innovative care delivery models at other organizations and bring back ideas for adoption

D. Implement a formal innovation process with dedicated time, resources, and a structured pathway from idea to implementation

57. A nurse manager is developing a leadership approach for managing a "multi-generational" nursing team where generational differences in work values are creating tension. Baby Boomer nurses value dedication, long tenure, and face-to-face communication. Generation X nurses value autonomy, work-life balance, and efficiency. Millennial nurses value purpose, feedback, and flexibility. Generation Z nurses value technology, inclusivity, and transparency. Rather than trying to make everyone the same, which leadership approach MOST effectively leverages generational diversity?

A. Create opportunities for each generation to contribute their distinctive strengths to the team — Boomers sharing institutional wisdom and mentoring, Gen X modeling independent problem-solving, Millennials driving purpose-connected innovation, and Gen Z bringing technology fluency and inclusive thinking — framing generational differences as complementary team assets rather than sources of friction

B. Implement a uniform management approach that treats all generations equally to avoid perceived favoritism

C. Adapt leadership style to each generation's preferences during individual interactions while maintaining consistent organizational expectations

D. Focus management attention on the largest generational group since they set the dominant cultural tone

58. A nurse manager is implementing a "learning rounds" practice where the nurse manager and a small group of nurses visit each patient together, with the nurse manager modeling clinical assessment, communication, and critical thinking in real time. Unlike administrative rounds focused on operational issues, learning rounds focus on clinical education — the nurse manager demonstrates expert-level clinical reasoning at the bedside and coaches participating nurses through the assessment process. Which benefit of learning rounds is MOST unique compared to other development methods?

A. Learning rounds provide continuing education credit for participating nurses

B. Learning rounds allow the nurse manager to identify clinical performance gaps during direct observation

C. Learning rounds demonstrate that clinical excellence is valued by leadership as much as operational efficiency, building the nurse manager's clinical credibility while simultaneously developing staff competency through modeling — combining leadership presence, clinical teaching, and culture-building in a single activity that classroom education, simulation, and competency testing cannot replicate

D. Learning rounds provide an opportunity for the nurse manager to assess patient satisfaction and address concerns in real time

59. A nurse manager is developing a comprehensive approach to "leadership sustainability" — the capacity to sustain effective leadership performance over the long term without burning out. The nurse manager has been in the role for four years and is beginning to experience symptoms of leadership fatigue: diminished enthusiasm for change initiatives, difficulty maintaining empathy during staff conflicts, and increasing emotional detachment from the work. Which sustainability strategy is MOST important?

A. Delegate more operational responsibilities to the charge nurse team to reduce the nurse manager's daily workload

B. Develop a personal leadership sustainability plan that includes regular self-assessment of energy and engagement levels, deliberate investment in activities that renew leadership energy such as clinical practice, innovation projects, and mentoring, relationships with peer leaders who provide mutual support and honest feedback, and periodic evaluation of whether the role still aligns with personal values and professional purpose — treating leadership sustainability as an active practice rather than a passive hope

C. Request a temporary reduction in scope to recover from leadership fatigue before returning to full responsibilities

D. Attend a leadership retreat or conference to renew enthusiasm and gain fresh perspective

60. A nurse manager is applying the concept of "emotional regulation" in leadership practice. Emotional regulation refers to the leader's ability to manage their emotional responses in ways that serve the team's needs rather than the leader's personal emotional processing. A nurse manager who responds to bad news with visible anxiety, to staff mistakes with visible anger, or to organizational pressure with visible frustration transmits those emotions to the team through "emotional contagion." Which emotional regulation skill is MOST critical for nurse managers?

A. Suppressing negative emotions during interactions with staff to prevent emotional contagion

B. The ability to experience a strong emotion — frustration, anxiety, disappointment — without immediately expressing it, creating a cognitive pause between the emotional trigger and the behavioral response that allows the leader to choose a response that serves the team's needs rather than reflexively broadcasting the unprocessed emotion, while later processing the emotion authentically through appropriate channels such as peer support or personal reflection

C. Maintaining a consistently positive demeanor regardless of circumstances to project confidence and stability

D. Sharing emotions transparently with staff to demonstrate authentic leadership and build trust through vulnerability

61. A nurse manager is developing a strategy for leading through "organizational ambiguity" — periods where the organization's direction, structure, or priorities are unclear and the nurse manager must lead effectively without clear guidance from above. Assessment reveals that many nurse managers become paralyzed during ambiguous periods, waiting for clarity before making decisions. Which leadership capability is MOST important during organizational ambiguity?

- A. The ability to escalate ambiguous situations to senior leadership for clarification before making unit-level decisions
- B. The ability to maintain operational stability by following established protocols until organizational clarity emerges
- C. The ability to act independently by making decisions based on values, available information, and professional judgment
- D. The ability to lead without certainty — making reasonable decisions based on available information while transparently communicating the uncertainty to the team, maintaining operational effectiveness without waiting for perfect clarity, course-correcting as new information emerges, and demonstrating through consistent behavior that leadership stability does not depend on organizational stability

62. A nurse manager is developing a leadership development pathway specifically for clinical nurses who want to advance into nursing management. Research on nurse manager preparation identifies a significant gap between clinical expertise and management competency. Which development experience is MOST critical for bridging this gap?

- A. Graduate education in nursing administration or healthcare management
- B. A formal leadership development program covering management competencies such as budgeting, staffing, quality improvement, and human resources management
- C. Progressive leadership experiences with coaching support — serving as charge nurse, leading quality improvement projects, participating in budget development, managing staff conflicts under mentored supervision, and experiencing the full range of management situations with guidance before assuming independent accountability — since management competency develops primarily through experience rather than education
- D. A structured mentoring relationship with an experienced nurse manager who provides guidance and career coaching

63. A nurse manager is implementing a "distributed decision-making" model where clinical decisions that do not require manager-level authority are made at the point of care by the nurses closest to the situation. The model identifies three decision categories: Category 1 decisions (routine clinical) are made by the bedside nurse independently, Category 2 decisions (operational coordination) are made by the charge nurse, and Category 3 decisions (strategic/resource) are made by the nurse manager. Staff report uncertainty about which category specific decisions belong to. Which implementation element is MOST important?

- A. Create a comprehensive decision matrix listing every common unit decision and its assigned category
- B. Provide clear, simple criteria that enable any nurse to quickly categorize a decision — such as "if the decision affects only your patient, it's Category 1; if it affects the shift, it's Category 2; if it affects the unit beyond today, it's Category 3" — and establish that when in doubt, nurses should act at the lowest appropriate level and escalate only if the outcome requires it, building comfort with autonomous decision-making rather than defaulting to escalation
- C. Implement a trial period where all decisions are reviewed by the nurse manager to verify correct categorization before granting full autonomous decision-making authority
- D. Conduct monthly reviews of decision categorization accuracy to identify and correct misclassified decisions

64. A nurse manager is developing a strategy for managing "leadership loneliness" — the isolation that nurse managers experience as they transition from being part of the nursing team to leading the nursing team. Former peers become subordinates, informal social networks become complicated by power dynamics, and the manager can no longer share frustrations openly with colleagues. The isolation increases stress and reduces job satisfaction. Which support structure is MOST effective?

- A. Maintain friendship with former peers and participate in social activities with the team to preserve the pre-management social network
- B. Develop a peer network of other nurse managers who share the unique challenges of the middle management role, providing a safe space for honest discussion, mutual support, and collective problem-solving with people who understand the specific pressures of the position without the power dynamic complications that exist within the unit team
- C. Engage an executive coach who provides confidential support and leadership development
- D. Participate in professional organizations that provide networking opportunities with nursing leaders across organizations

65. A nurse manager is evaluating the unit's approach to "leader standard work" — the defined set of activities that leadership performs daily, weekly, and monthly to ensure that processes are functioning correctly. Current leader standard work includes daily safety huddle, daily leadership rounding, weekly charge nurse meeting, and monthly staff meeting. Assessment reveals that the nurse manager completes

the scheduled activities but has not evaluated whether the activities produce their intended outcomes. Which evaluation question is MOST important?

A. Does each leader standard work activity produce a specific, measurable outcome that the nurse manager can point to as evidence that the activity creates value — for example, does leadership rounding identify safety concerns that are subsequently resolved, do huddles surface problems that the team addresses, and do charge nurse meetings improve shift-level leadership — or have the activities become routine rituals performed without producing the results they were designed to deliver?

B. Are the leader standard work activities consuming an appropriate percentage of the nurse manager's daily time

C. Are all leader standard work activities documented in the nurse manager's daily log for accountability purposes

D. Do staff perceive the leader standard work activities as valuable based on satisfaction survey results

66. A nurse manager is applying the concept of "collective efficacy" — the shared belief among team members that the team can successfully accomplish its goals. Research shows that collective efficacy is a stronger predictor of team performance than the sum of individual team members' self-efficacy. The unit recently experienced a series of quality failures that have damaged the team's collective belief in their ability to deliver excellent care. Which intervention MOST directly rebuilds collective efficacy?

A. Identify and celebrate a specific team accomplishment — a recent success where the team worked together to achieve a positive outcome — and use it as evidence that the team has the capability for excellence, then build on that success with progressively challenging goals that generate additional evidence of collective competence

B. Implement a recognition program that highlights individual nurses' contributions to quality outcomes

C. Provide additional resources and staffing support to reduce the workload pressure that contributed to the quality failures

D. Address the root causes of the quality failures through systematic quality improvement to prevent recurrence

67. A nurse manager is developing a comprehensive approach to "knowledge transfer" during planned leadership transitions. The nurse manager will be promoted to a director role in three months, and a

successor has been identified. Which knowledge transfer dimension is MOST difficult to convey and therefore requires the MOST deliberate transfer effort?

A. Operational knowledge — how the unit's daily operations function, including scheduling, budgeting, and workflow management

B. Relational knowledge — the quality of relationships with key stakeholders, the informal power dynamics on the unit, the specific motivational drivers of individual staff members, and the communication preferences of physicians and support department leaders

C. Strategic knowledge — the unit's current strategic priorities, ongoing projects, and alignment with organizational goals

D. The relational and political knowledge — understanding which relationships are most critical, what each stakeholder values, how informal influence flows through the unit and organization, and the unwritten rules of organizational navigation — is the most difficult to transfer because it is tacit, contextual, and accumulated through years of experience rather than documented in any accessible format

68. A nurse manager is implementing a "reverse mentoring" program where newer nurses mentor experienced nurses and managers on topics such as technology, current evidence-based practice, and contemporary professional perspectives. The program aims to bridge generational knowledge gaps and demonstrate that learning flows in multiple directions. Several experienced nurses resist participating as "mentees" of less experienced colleagues. Which framing is MOST effective for overcoming the resistance?

A. Position reverse mentoring as a reciprocal exchange where each party learns from the other's unique knowledge base — the experienced nurse shares clinical wisdom and institutional knowledge while the newer nurse shares current technology skills and recent evidence — framing both directions as equally valuable and redefining "expertise" as knowledge that another person needs regardless of the expert's seniority level

B. Mandate participation for all experienced nurses since the program addresses a legitimate organizational knowledge gap

C. Implement reverse mentoring voluntarily and evaluate adoption rates before considering mandatory implementation

D. Limit reverse mentoring to technology topics only since this is the area where newer nurses most clearly have superior knowledge

69. A nurse manager is applying the concept of "adaptive space" — the organizational zone where innovation and adaptation occur. Adaptive space exists between the formal operational system (which values efficiency and standardization) and the informal entrepreneurial system (which values experimentation and creativity). Leaders who create adaptive space enable the transfer of innovations from the entrepreneurial margins into the formal operational center. Which leadership behavior MOST effectively creates adaptive space?

- A. Designate specific times and locations for innovation activities separate from operational work
- B. Hire innovation-oriented staff who can bring creative thinking into the operational environment
- C. Implement a formal innovation process with defined stages, evaluation criteria, and implementation pathways
- D. Create connections between the innovators on the margins and the operational core by brokering relationships between creative staff and operational staff, protecting emerging innovations from premature efficiency evaluation, facilitating the translation of creative ideas into operational language, and building the political support needed to move innovations from experiment to standard practice

70. A nurse manager is developing a leadership approach to managing "institutional isomorphism" — the tendency for healthcare organizations to become increasingly similar to each other by adopting the same practices, structures, and standards. While standardization improves baseline quality, it can also eliminate the distinctive practices that make one unit exceptional. The nurse manager observes that national benchmarking pressure drives the unit to adopt industry-standard practices even when its own unique approaches produce better outcomes. Which leadership tension does this create?

- A. The tension between meeting benchmarking standards and maintaining practices that exceed them
- B. The tension between organizational conformity (following industry standards) and organizational differentiation (maintaining unique practices that produce superior results)
- C. The tension between standardization and innovation that characterizes all healthcare organizations, where conformity to industry standards provides a reliable baseline while distinctive innovations provide competitive advantage — and the leader's challenge is determining which practices to standardize for consistency and which to differentiate for excellence
- D. The tension between external accountability to regulatory and accreditation standards and internal accountability to the unit's own quality standards

71. A nurse manager is applying the concept of "sensemaking" in the aftermath of an adverse patient safety event. Karl Weick's sensemaking theory suggests that people understand events retrospectively by constructing plausible narratives that explain what happened. After a serious medication error, different participants construct different narratives: the nurse blames the pharmacy, pharmacy blames the prescriber, and the prescriber blames the system. Each narrative is internally coherent but incomplete. Which leadership approach MOST effectively facilitates accurate collective sensemaking?

- A. Conduct a formal root cause analysis using a standardized methodology to establish the official narrative of what happened
- B. Allow each participant to share their narrative without judgment, then facilitate the construction of a shared narrative that integrates multiple perspectives
- C. Implement a just culture analysis that categorizes the behavior before constructing the event narrative
- D. Bring all participants together in a structured facilitation where each perspective is heard, challenge the self-serving elements of each narrative through respectful questioning, integrate the multiple perspectives into a comprehensive account that no single participant could have constructed alone, and use the shared narrative to identify the system-level factors that each individual narrative obscured by focusing on others' contributions to the event

72. A nurse manager is developing a leadership strategy for managing the "implementation gap" — the persistent disconnect between what evidence shows is effective and what is actually practiced at the bedside. Despite access to evidence-based guidelines, clinical decision support systems, and quality improvement infrastructure, evidence implementation remains incomplete and inconsistent. Research on implementation science identifies multiple barriers including knowledge barriers, attitudinal barriers, environmental barriers, and organizational barriers. Which barrier category is MOST resistant to traditional improvement approaches?

- A. Knowledge barriers — which can be addressed through education and training
- B. Environmental barriers — which can be addressed through workflow redesign and technology implementation
- C. Organizational barriers — which can be addressed through policy changes and leadership commitment
- D. Attitudinal barriers — deeply held beliefs, habits, and practice patterns that persist despite knowledge, environmental redesign, and organizational support — because attitudes are rooted in

identity, values, and lived experience that education and policy cannot easily alter, requiring sustained culture change that takes years rather than months

73. A nurse manager is developing a comprehensive approach to evaluating leadership effectiveness. Traditional evaluation measures leadership through subordinate satisfaction surveys and operational metrics. However, these measures may not capture the full scope of leadership impact. Which evaluation framework provides the MOST comprehensive assessment of leadership effectiveness?

A. A multi-dimensional evaluation including clinical outcomes attributable to leadership decisions, staff development and growth trajectories, organizational culture indicators, stakeholder relationship quality, strategic goal progress, innovation output, and the leader's own professional development trajectory

B. A 360-degree feedback assessment collecting perspectives from subordinates, peers, supervisors, and patients

C. Operational performance metrics including quality indicators, financial performance, and staffing outcomes

D. A balanced assessment combining quantitative performance metrics (quality, finance, staffing) with qualitative indicators (staff growth, culture health, innovation capacity, stakeholder relationships) and developmental trajectory — evaluating not just what the leader has achieved but what the leader has built that will sustain performance beyond their tenure

74. A nurse manager is applying the concept of "boundary spanning" to improve the unit's relationship with the emergency department. The ED-to-unit transfer process is a frequent source of conflict, communication failure, and patient safety risk. Both departments blame the other for transfer-related problems. Which boundary-spanning approach is MOST likely to improve the relationship?

A. Implement a joint quality improvement project that addresses transfer-related safety events, with equal representation from both departments, shared data analysis, and mutually developed solutions — creating a structured collaboration that transforms the adversarial dynamic into a partnership around shared patient outcomes

B. Escalate the conflict to organizational leadership and request executive mediation

C. Develop a detailed transfer protocol that specifies each department's responsibilities to eliminate ambiguity

D. Invite ED nursing leadership to attend the unit's staff meeting to hear the unit's perspective on transfer-related challenges

75. A nurse manager is evaluating two approaches to managing chronic underperformance on the unit. Approach A uses progressive discipline — verbal warning, written warning, final warning, termination. Approach B uses performance coaching — identifying root causes, developing individualized improvement plans, providing support and resources, and evaluating progress. Which analysis is MOST accurate?

A. Progressive discipline is most appropriate for behavioral issues such as policy violations and attendance problems, while performance coaching is most appropriate for skill or competency deficits — the approaches are not competing methodologies but complementary tools that address different categories of underperformance

B. Progressive discipline should be used for all underperformance since it provides clear documentation and legal protection

C. Performance coaching should be used for all underperformance since it is more humane and produces better long-term results

D. The choice between approaches depends entirely on whether the employee is willing to improve — coaching for willing employees and discipline for unwilling employees

76. A nurse manager is developing a strategy for "leading without formal authority" in organizational committees and cross-departmental initiatives where the nurse manager has no positional power over the other participants. The nurse manager chairs a hospital-wide patient flow committee that includes representatives from the ED, operating room, bed management, housekeeping, and transport — none of whom report to the nurse manager. Which leadership approach is MOST effective when positional authority is absent?

A. Lead through expertise and preparation — becoming the most knowledgeable person about the committee's topic, preparing thorough analyses that guide the group's thinking, facilitating productive discussions that generate consensus, and building credibility through consistently delivering on commitments — so that influence is earned through competence and reliability rather than derived from organizational position

B. Request that the committee be restructured so that the chair has formal authority over the members' participation and deliverables

C. Lead through relationship development by building personal connections with each committee member before attempting to influence committee outcomes

D. Lead through organizational sponsorship by aligning the committee's work with executive priorities that create external pressure for participation and accountability

77. A nurse manager is developing a succession planning approach that addresses the critical distinction between "replacement planning" and "succession planning." Replacement planning identifies who would fill a specific role if it became vacant. Succession planning develops leadership capability broadly across the team so that multiple people could step into various leadership roles as needed. Which approach is MOST appropriate for a nursing unit?

A. Focus on replacement planning since the nurse manager needs to know who would serve as charge nurse if a charge nurse calls out sick

B. Focus on succession planning since developing broad leadership capability produces a more resilient and adaptable team

C. Implement replacement planning for immediate coverage needs while simultaneously investing in broader succession planning that develops leadership capacity across the team

D. Implement both replacement planning for critical roles (charge nurse, preceptor, quality champion) AND succession planning for long-term leadership pipeline development — recognizing that replacement planning addresses today's "who covers this shift" question while succession planning addresses the strategic "who leads this unit in five years" question, and both are necessary because they serve different organizational needs on different timescales

78. A nurse manager is developing a strategy for managing the emotional demands of the nurse manager role during a period where multiple staff members are experiencing significant personal crises simultaneously. The nurse manager is providing emotional support to several nurses while managing her own emotional response to their situations. The cumulative emotional labor of supporting multiple people through crises is creating what psychologists call "empathic overload" — the depletion of emotional resources through sustained empathic engagement. Which self-management strategy is MOST important?

A. Set emotional boundaries by limiting the depth of emotional engagement with each staff member's personal situation

B. Delegate emotional support responsibilities to the employee assistance program and refer all staff members experiencing crises to EAP rather than providing direct emotional support

C. Recognize empathic overload as a leadership occupational hazard, implement deliberate emotional recovery practices between emotionally demanding interactions, seek personal support from a peer or coach who can absorb some of the emotional weight, and monitor for signs that empathic overload is affecting leadership judgment — because the nurse manager cannot sustainably support others if she does not attend to her own emotional depletion

D. Continue providing unlimited emotional support since the staff's well-being depends on the nurse manager's availability during crises

79. A nurse manager is developing a comprehensive "unit identity" that defines what makes the unit distinctive within the organization and the profession. A clear unit identity answers the question "what do we stand for and what makes us different?" and serves as the foundation for recruitment, retention, quality improvement, and professional pride. Assessment reveals that the unit lacks a distinctive identity — staff describe it as "just a med-surg floor" without any sense of what makes it special. Which leadership activity MOST effectively builds unit identity?

A. Develop a unit mission statement through a facilitated staff exercise

B. Identify and articulate the unit's distinctive strengths, values, and achievements — then weave them into a compelling narrative that staff can internalize and communicate, using the narrative in recruitment, orientation, daily huddles, and quality discussions to reinforce what makes this unit worth belonging to and worth fighting for

C. Benchmark the unit's performance against competitors to identify areas of superiority that can form the basis of a distinctive identity

D. Implement a branding exercise that creates a visual identity including a unit logo, tagline, and color scheme

80. A nurse manager is evaluating the unit's approach to managing "ethical erosion" — the gradual weakening of ethical standards that occurs when small deviations from ethical practice are tolerated, normalized, and eventually become the accepted standard. Examples include routinely documenting assessments that were not actually performed, sharing patient information in non-private settings, and accepting "close enough" compliance with safety protocols. Which organizational condition MOST strongly predicts ethical erosion?

- A. Inadequate ethics education that leaves staff uncertain about ethical boundaries
- B. High workload pressure that forces staff to choose between ethical compliance and operational efficiency
- C. Weak leadership response to observed ethical deviations — when leaders see small ethical violations and do not address them, they implicitly communicate that ethical standards are aspirational rather than mandatory, creating permission for progressive deviation that erodes standards over time
- D. The absence of a clear ethical code or professional conduct policy

81. A nurse manager is developing a comprehensive approach to professional accountability that distinguishes between "accountability for outcomes" and "accountability for process." A nurse followed the correct clinical process for a procedure but the patient experienced a complication that was a known risk of the procedure. The nurse feels guilty despite having performed correctly. Which accountability framework is MOST appropriate?

- A. Reassure the nurse that she is not accountable since she followed the correct process and the complication was a known risk
- B. Clarify that professional accountability requires demonstrating that the correct process was followed rather than guaranteeing a positive outcome — the nurse is accountable for performing the procedure correctly, documenting appropriately, monitoring for complications, and responding to the complication promptly, but is NOT accountable for the occurrence of a known risk that manifested despite correct technique, since outcome-based accountability in a field with inherent clinical risk would make nursing practice impossible
- C. Document the event through the incident reporting system since any adverse patient outcome requires investigation regardless of process compliance
- D. Reassign the nurse from performing the procedure until she can be re-evaluated for competency

82. A nurse manager is developing a framework for "professional governance" as distinct from "shared governance." Professional governance is a more advanced model where nurses have autonomous authority over their professional practice — not advisory input but actual decision-making control over nursing practice standards, quality initiatives, and professional development. In professional governance, the nursing staff council's decisions about practice standards are final and do not require management approval. Which transition element is MOST critical when moving from shared governance to professional governance?

- A. Ensuring that nursing staff have the knowledge and skills to make autonomous practice decisions without management oversight
- B. Establishing clear organizational policies that recognize nursing council authority over defined practice domains
- C. Developing nursing staff's capacity for evidence-based decision-making, organizational awareness, and accountability for outcomes — since professional governance transfers not just authority but responsibility, and nurses who make autonomous practice decisions must accept accountability for the consequences of those decisions, requiring a maturity of professional judgment that shared governance's advisory model does not develop
- D. Obtaining organizational leadership endorsement of the professional governance model before implementation

83. A nurse manager is navigating a professional ethics situation where a pharmaceutical company has offered to fund a nursing research study on the unit. The study would evaluate the effectiveness of the company's product compared to a competitor's product for a specific clinical application. The study design is scientifically sound and has received IRB approval. The pharmaceutical company would fund the study, provide the products, and receive the results — but would have no influence over the study methodology, data analysis, or publication of results. Which ethical consideration is MOST important?

- A. Whether the study results will be published regardless of whether they favor the pharmaceutical company's product
- B. Whether the nursing staff conducting the study can maintain objectivity knowing the funding source
- C. Whether accepting pharmaceutical funding creates a financial relationship that may influence the unit's prescribing patterns independent of the study results
- D. Whether the study's independence can be genuinely maintained despite the funding relationship — including publication of unfavorable results, data integrity protections, and whether the institutional perception of pharmaceutical involvement will affect how the results are received by the clinical community regardless of their scientific validity

84. A nurse manager is developing a professional development approach for a nurse who has been in the same role for fifteen years and demonstrates "clinical automaticity" — performing clinical tasks expertly but without conscious critical thinking. The nurse's practice is efficient and generally safe, but she misses atypical presentations because her pattern recognition is calibrated to common presentations and

she does not engage in deliberate analytical reasoning for patients who do not fit the usual pattern. Which development intervention MOST effectively disrupts clinical automaticity?

- A. Assign the nurse to a different patient population to force conscious engagement with unfamiliar clinical presentations
- B. Require the nurse to verbalize her clinical reasoning during assessments, making implicit cognitive processes explicit through think-aloud protocols and structured clinical debriefs
- C. Provide additional clinical education on atypical disease presentations to expand her pattern recognition database
- D. Introduce structured "cognitive forcing strategies" that interrupt automatic reasoning at key decision points — such as requiring explicit consideration of alternative diagnoses before accepting the initial pattern match, mandating verbalization of the specific findings that support and contradict the initial assessment, and periodically assigning the nurse to clinical simulation scenarios designed to present atypical cases that automatic reasoning would misclassify

85. A nurse manager is addressing the professional implications of nurses who provide clinical services through direct-to-consumer telehealth platforms during their off-duty hours. These platforms connect nurses with consumers seeking health advice, symptom assessment, and triage guidance. The nurses operate as independent contractors and are not covered by the hospital's malpractice insurance. Which professional concern is MOST significant?

- A. The nurses may be providing services that exceed their scope of practice as RNs, particularly triage and diagnosis functions that may require advanced practice licensure
- B. The telehealth platform may not maintain adequate records of the nurse-patient encounters, creating documentation and continuity gaps
- C. The nurses are practicing nursing independently without malpractice coverage, without clinical oversight, and potentially without verification that they hold valid licensure in the patient's state — creating simultaneous professional, legal, and liability exposure that could affect both their personal professional standing and their employment if an adverse event occurs during their platform-based practice
- D. The off-duty telehealth work may create fatigue that affects their on-duty clinical performance

86. A nurse manager is developing a professional development approach for addressing "implicit bias" in clinical practice. Research consistently demonstrates that implicit biases — unconscious associations that affect clinical judgment — influence pain management decisions, clinical assessment accuracy, treatment recommendations, and communication quality across racial, gender, age, and socioeconomic dimensions. Which development approach is MOST likely to produce behavioral change?

A. Implement a mandatory implicit bias training workshop for all nursing staff

B. Combine awareness education with structural interventions — implementing implicit bias education that develops self-awareness, standardizing clinical assessment tools that reduce subjective judgment, auditing clinical outcomes by patient demographics to make bias visible in data, and creating accountability through peer observation and feedback — because awareness alone is insufficient to change unconscious behavior without structural supports that make equitable practice the default

C. Implement an Implicit Association Test for all nursing staff and provide individualized feedback about their specific biases

D. Focus bias reduction efforts on the specific clinical decisions where bias has the greatest patient impact — such as pain management and discharge planning — rather than addressing implicit bias broadly

87. A nurse manager is developing a framework for managing the professional tension between "standardization" and "individualization" of patient care. Evidence-based practice requires standardization through clinical pathways and protocols, while patient-centered care requires individualization based on each patient's unique needs, values, and preferences. When a patient's preferences conflict with the evidence-based protocol — such as a patient who refuses an evidence-based intervention — which professional principle takes precedence?

A. Patient autonomy takes precedence — the patient's right to make informed decisions about their own care supersedes the evidence-based protocol, and the nurse's professional obligation is to ensure the patient has accurate information to make an informed decision, respect the patient's choice, and document both the recommendation and the patient's informed refusal

B. Evidence-based practice takes precedence because the protocol represents the best available evidence for optimal outcomes

C. The nurse should use clinical judgment to determine whether the patient's refusal is based on adequate understanding and attempt to persuade the patient to follow the protocol before accepting the refusal

D. The conflict should be escalated to the physician who can evaluate whether the patient's refusal is clinically appropriate

88. A nurse manager is addressing a professional conduct situation where a nurse discovered during clinical research data collection that a patient's medical record contains a significant error — a documented allergy that the patient denies having. The nurse's research role does not include clinical care for this patient. The nurse is uncertain about whether her obligation as a researcher to maintain study integrity conflicts with her obligation as a nurse to correct a clinical safety concern. Which professional analysis is MOST accurate?

A. The nurse's research role takes precedence while she is functioning as a researcher, and clinical concerns should be reported to the clinical care team rather than addressed directly

B. The nurse should correct the allergy documentation herself since she has access to the medical record and the error represents a patient safety concern

C. The conflict between research and clinical roles should be reported to the IRB for guidance on the appropriate response

D. The nurse's professional obligation to patient safety supersedes any research protocol limitations — discovering a clinically significant error in a patient's medical record creates an immediate professional obligation to ensure the error is corrected regardless of the nurse's current role, and the appropriate action is to communicate the finding to the patient's clinical care team for verification and correction

89. A nurse manager is developing an approach to managing the professional development needs of nurses at different career stages. Benner's model identifies five stages: novice, advanced beginner, competent, proficient, and expert. Each stage requires different development approaches. Which stage-appropriate development matching is MOST accurate?

A. Novice nurses need rules and procedures, advanced beginners need contextual examples, competent nurses need planning and priority-setting support, proficient nurses need opportunities to see the big picture, and expert nurses need challenges that stretch their intuitive grasp — the key principle is that development must match the stage because applying expert-level development to novice nurses is ineffective and applying novice-level rules to expert nurses is insulting

B. All nurses benefit from the same development approach if the content is adapted to their clinical specialty

C. Development should focus primarily on novice and advanced beginner nurses since they have the steepest learning curves

D. Expert nurses no longer need formal development since their clinical intuition exceeds what structured education can provide

90. A nurse manager is evaluating the unit's approach to professional certification support. Data shows that certified nurses on the unit have better quality outcomes, higher retention rates, and higher patient satisfaction scores than non-certified nurses. However, the certification rate is only twenty-two percent. The primary barrier reported by non-certified nurses is not cost or time but rather the belief that "certification doesn't prove anything that experience doesn't already demonstrate." Which approach MOST effectively addresses this specific attitudinal barrier?

A. Present the unit's own data showing the performance differential between certified and non-certified nurses to demonstrate that certification IS associated with measurable outcomes beyond what experience alone produces

B. Increase the financial incentive for certification to motivate nurses past their attitudinal resistance

C. Make certification mandatory for clinical advancement to create an external motivation for pursuing certification

D. Connect certification to professional identity by presenting it as a demonstration of commitment to professional excellence, sharing testimonials from recently certified nurses about how the preparation process deepened their clinical knowledge beyond what experience alone had developed, and reframing certification from "proving what I already know" to "discovering what I didn't know I didn't know" — addressing the attitude that experience equals competence with evidence that structured knowledge validation reveals gaps that experience alone cannot identify

91. A nurse manager is navigating a professional ethics situation where budget constraints have forced a choice between two equally important patient care investments. The unit can either purchase a new cardiac monitoring system that will improve patient safety surveillance or fund a nurse residency program that will improve new graduate retention and competency development. Both investments are clinically justified, and the available budget funds only one. Which ethical framework MOST appropriately guides this resource allocation decision?

A. Utilitarian analysis — selecting the option that produces the greatest total benefit for the greatest number of patients over time

B. Justice-based analysis — selecting the option that addresses the most significant current inequity or deficit

C. Evidence-based analysis — selecting the option with the strongest published evidence of effectiveness

D. A comprehensive ethical analysis that considers multiple frameworks — utilitarian benefit, justice considerations, evidence strength, organizational values alignment, reversibility of the decision, and stakeholder impact — rather than applying a single ethical lens, since resource allocation decisions in healthcare involve competing values that no single ethical framework adequately resolves

92. A nurse manager is developing a professional practice model component addressing "nursing professional autonomy." Professional autonomy refers to the nurse's authority to make independent clinical judgments and take actions within the nursing scope of practice without requiring approval from other disciplines. Assessment reveals that nurses on the unit routinely seek physician permission for decisions that are within nursing's independent scope — such as pain management within protocol parameters, patient education timing, and mobility advancement decisions. Which intervention MOST directly strengthens professional autonomy?

A. Educate nurses on the specific boundaries of their scope of practice so they can distinguish between decisions requiring physician collaboration and decisions within nursing's independent authority

B. Implement nurse-driven protocols for the clinical decisions most commonly deferred to physicians, coach nurses on making and defending clinical decisions within their scope, and create a unit culture where autonomous nursing practice is expected, supported, and celebrated — building both the structural authorization and the professional confidence that independent practice requires

C. Request that physicians support nursing autonomy by declining to make decisions that fall within the nursing scope and redirecting nurses to make those decisions independently

D. Implement a shared decision-making model where nursing and medicine collaborate on all clinical decisions equally

93. A nurse manager is addressing a professional conduct issue where two nurses have formed an exclusive social clique that creates a hostile environment for nurses outside the group. The clique members sit together at meals, exchange patient assignments to work together, exclude others from social conversations, and have been overheard making negative comments about colleagues' clinical skills. The behavior has been raised by three separate nurses who feel ostracized and is beginning to affect clinical collaboration. Which response is MOST appropriate?

A. Address the clique behavior as a professional conduct issue by meeting with the involved nurses, describing the specific behaviors observed and reported, explaining how exclusionary dynamics undermine team cohesion and patient safety, establishing expectations for inclusive professional behavior, and implementing consequences if the behavior continues — while avoiding the label "clique" and focusing on specific observable behaviors and their impact

B. Separate the clique members by assigning them to different shifts to break the exclusive dynamic

C. Ignore the social dynamics since they are personal relationships that do not fall within the nurse manager's professional authority

D. Address the situation at a staff meeting without identifying specific individuals, discussing the importance of inclusive team dynamics for patient safety

94. A nurse manager is developing a professional development approach for a nurse who has been identified as having exceptional clinical expertise but who uses that expertise to create power through information control — sharing knowledge selectively, withholding critical information during handoffs to maintain indispensability, and making colleagues dependent on her for clinical guidance. Previous interventions have focused on knowledge management strategies. This question addresses the deeper professional identity issue. Which analysis is MOST accurate?

A. The nurse's behavior reflects a professional identity built around being the most knowledgeable person in the room, and sharing knowledge threatens this identity because it reduces the knowledge differential that is the source of her perceived value and power

B. The nurse's behavior reflects inadequate training in knowledge-sharing practices that can be addressed through communication skills development

C. The behavior is a natural consequence of being the most knowledgeable clinician and should be managed through structural knowledge capture rather than behavioral change

D. The behavior reflects a leadership potential that should be channeled into a formal education role

95. A nurse manager is addressing the professional implications of a nurse who has been formally reprimanded for a medication error that the nurse believes was caused by a system failure rather than individual negligence. The nurse has filed a grievance alleging that the reprimand violates just culture principles. The nurse manager issued the reprimand based on the performance management policy without conducting a just culture analysis. Which professional consideration is MOST important?

A. Review the reprimand decision against a just culture framework to determine whether the error represented human error (console), at-risk behavior (coach), or reckless behavior (punish), and modify the response if the just culture analysis reveals that the system contributed significantly to the error — acknowledging that applying punitive consequences for system-enabled human error undermines the reporting culture that the organization depends on for safety improvement

B. Maintain the reprimand since it was issued in accordance with organizational policy and reversing it would undermine the consistency of the performance management process

C. Allow the grievance process to determine whether the reprimand was appropriate without the nurse manager intervening in the established grievance procedure

D. Remove the reprimand and issue an apology to the nurse since the absence of a just culture analysis before the disciplinary action represents a process failure by the nurse manager

96. A nurse manager is conducting a "cost of poor quality" analysis for the unit. The cost of poor quality framework identifies four cost categories: prevention costs (investment in preventing defects), appraisal costs (inspection and monitoring), internal failure costs (defects caught before reaching the customer), and external failure costs (defects that reach the customer). A patient fall that results in a hip fracture represents which cost category?

A. An external failure cost — the defect (inadequate fall prevention) reached the customer (patient), resulting in harm (hip fracture) that generates downstream costs including additional treatment, extended hospitalization, potential litigation, and regulatory consequences — and cost of poor quality theory states that external failure costs are the most expensive category, making prevention investment the most cost-effective quality strategy

B. An internal failure cost since the fall occurred within the hospital and was detected by the organization

C. An appraisal cost since the fall was identified through the organization's monitoring system

D. A prevention cost failure since the fall resulted from inadequate prevention investment

97. A nurse manager is developing a comprehensive financial analysis of nursing turnover. Beyond the commonly calculated replacement costs, the analysis must capture the full economic impact of turnover. Which cost component represents the LARGEST portion of total turnover cost that is typically unmeasured?

- A. The direct costs of advertising, recruiting, interviewing, and hiring replacement nurses
- B. The orientation and training costs for replacement nurses including preceptor time and reduced productivity during orientation
- C. The productivity gap between a departing experienced nurse and a new hire over the twelve-to-eighteen-month development period — representing the cumulative difference in clinical efficiency, error rates, patient throughput, and supervision requirements that persists long after the visible recruitment and orientation costs have been incurred
- D. The impact on remaining staff morale and the potential for cascading departures triggered by the initial turnover

98. A nurse manager is developing a staffing budget that accounts for the "true cost" of each nursing FTE. The budget must capture not just salary but all costs associated with maintaining a productive nursing position. Which cost components should be included in the "fully loaded" FTE cost calculation?

- A. Base salary plus benefits (health insurance, retirement, taxes) only since these are the contractually obligated employment costs
- B. Base salary, benefits, orientation costs amortized over expected tenure, ongoing education and training, certification support, uniform allowance, parking, employee health services, professional development time, and the productivity adjustment for non-productive time including vacation, sick leave, holidays, and education days — representing the total organizational investment required to maintain one productive nursing FTE
- C. Base salary, benefits, and overtime/premium labor costs since these represent the variable cost components of nursing labor
- D. All direct employment costs divided by productive hours worked to derive the true cost per productive nursing hour

99. A nurse manager is evaluating the financial impact of implementing a comprehensive nurse well-being program. The program costs seventy-five thousand dollars annually. Current data:

| Metric | Current | Industry Benchmark |

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

Annual RN turnover	22%	18%
Sick call rate	5.8%	3.2%
Workers' comp claims	8/year	4/year
Agency utilization	12% of hours	6% of hours

Average cost per turnover: \$54,000. Average cost per sick call replacement: \$380. Average workers' comp claim: \$12,000. Average agency premium per hour over regular rate: \$28. Total nursing paid hours: 76,000/year. RN FTEs: 32. Which financial projection is MOST compelling?

A. Turnover reduction to benchmark:  $(22\% - 18\%) \times 32 = 1.28$  fewer departures  $\times \$54,000 = \$69,120$ . Sick call reduction:  $(5.8\% - 3.2\%) \times 76,000 \text{ hours} \div 12 \text{ hours/shift} = 164.7$  shifts  $\times \$380 = \$62,586$ . Workers' comp reduction: 4 fewer claims  $\times \$12,000 = \$48,000$ . Agency reduction:  $(12\% - 6\%) \times 76,000 \times \$28 = \$127,680$ . Total projected savings: \$307,386 against \$75,000 investment = \$232,386 net return (4.1:1 ROI)

B. The turnover reduction alone would justify the program investment

C. The financial projection cannot be validated without a control group comparison

D. The combined savings across all four metrics significantly exceeds the program cost, and the most conservative projection (using even fifty percent of the benchmark improvement assumption) still produces a positive ROI

100. A nurse manager reviews the following monthly financial performance data:

Month	Patient Days	Revenue	Expenses	Margin	Rev/PD	Exp/PD
Oct	820	\$541,200	\$512,000	\$29,200	\$660	\$624
Nov	790	\$513,500	\$508,000	\$5,500	\$650	\$643
Dec	760	\$486,400	\$502,600	(\$16,200)	\$640	\$661

| Jan | 800 | \$520,000 | \$520,000 | \$0 | \$650 | \$650 |

Which finding requires the MOST immediate investigation?

- A. The December operating loss since any negative margin requires explanation
- B. The overall margin erosion from \$29,200 to \$0 over four months
- C. The revenue per patient day has remained relatively stable (\$640-\$660) while expense per patient day has increased from \$624 to \$661 despite declining volume — indicating that costs are not flexing downward proportionally with volume decline, creating a structural expense problem that persists regardless of volume recovery
- D. The expense per patient day trend is more concerning than the revenue per patient day trend since the nurse manager has more control over expenses than revenue

101. A nurse manager is developing a financial justification for implementing a nursing informatics specialist position on the unit. The position costs one hundred five thousand dollars annually. The informatics specialist would optimize EHR documentation workflows, reduce time nurses spend on documentation, improve clinical decision support utilization, and enhance data quality for quality reporting. Which financial metric provides the MOST compelling justification?

- A. The nursing time recaptured from documentation optimization — if the informatics specialist reduces documentation time by fifteen minutes per nurse per shift across thirty-two nurses working an average of three shifts per week, the annual time savings equals  $15 \text{ min} \times 32 \text{ nurses} \times 156 \text{ shifts} \times (1 \text{ hr} \div 60 \text{ min}) = 1,248$  nursing hours recaptured, valued at approximately \$65,000 in nursing productivity redirected to direct care — combined with improved quality reporting accuracy affecting VBP reimbursement and reduced documentation-related errors
- B. The improved data quality for quality measure reporting and its impact on public reporting scores
- C. The reduction in EHR-related help desk calls and IT support requests
- D. The improvement in nurse satisfaction related to documentation burden reduction and its impact on retention

102. A nurse manager is analyzing the unit's performance under a new value-based contract that includes a "shared savings" provision. Under shared savings, the hospital receives a bonus payment if total episode costs for defined patient populations fall below a target threshold. The nurse manager's unit manages the inpatient phase of these episodes and directly influences inpatient costs, length of stay, and complications that affect total episode costs. Which nursing activity has the GREATEST impact on total episode cost reduction?

- A. Reducing inpatient length of stay through efficient care coordination and timely discharge planning
- B. Preventing complications that extend hospitalization, trigger readmissions, or require post-acute services
- C. Optimizing nursing staffing to reduce labor costs during the inpatient phase
- D. Preventing complications AND ensuring effective care transitions — since complications during the inpatient stay generate immediate additional cost while inadequate transition planning generates downstream costs through readmissions and post-acute utilization that are included in the total episode cost, making the combined prevention-and-transition approach more impactful than either dimension alone

103. A nurse manager is developing a benchmarking strategy for the unit's quality and financial performance. Effective benchmarking requires comparing the unit's performance against appropriate reference groups. Which benchmarking approach produces the MOST actionable insights?

- A. Compare against national averages for all metrics since national data provides the broadest reference frame
- B. Compare against the best-performing organizations in the country since aspirational benchmarks drive the greatest improvement
- C. Compare against similar units within the same hospital system to account for organizational factors that affect performance
- D. Use a tiered benchmarking approach that compares against internal peers (similar units in the system) for operational practices, against external peers (similar units at comparable organizations) for outcome and financial targets, and against top performers (best-in-class organizations) for aspirational goals — recognizing that different benchmark comparisons serve different purposes and no single comparison provides complete context

104. A nurse manager is developing a financial model for implementing a "virtual sitter" program that replaces in-person patient observers with centralized video monitoring for selected patient populations. The program uses trained observers who monitor multiple patients simultaneously through video feeds and communicate with bedside staff through two-way audio when safety concerns are identified.

Current in-person observer costs: \$420,000/year (approximately 12 observers/day × 365 days × \$96/observer/day)

Proposed virtual sitter program: \$180,000/year (technology + centralized observer staffing)

Which financial analysis element is MOST important beyond the direct cost comparison?

- A. The quality differential between in-person and virtual observation measured through safety event rates during each observation method
- B. The patient and family satisfaction with video monitoring compared to in-person observation
- C. The impact on nursing recruitment and retention since eliminating the unpopular observer role may improve staffing
- D. Whether the cost savings are genuine or whether they shift costs to other areas — for example, if virtual monitoring requires bedside nurses to respond more frequently to alerts from the centralized observer, the nursing workload may increase and the apparent savings may be offset by increased nursing labor costs, making the true financial impact dependent on the net workflow effect across all affected roles

105. A nurse manager is developing a five-year financial projection for the unit. The projection must account for the anticipated impact of value-based payment models on the unit's revenue structure. Under fee-for-service, each patient day and service generates revenue. Under value-based payment, revenue increasingly depends on quality outcomes, cost efficiency, and total cost of care management. Which financial planning adaptation is MOST strategically important?

- A. Build financial reserves to absorb the revenue uncertainty during the transition from fee-for-service to value-based payment

B. Invest in cost reduction initiatives to ensure the unit can operate profitably under the lower per-case reimbursement that value-based models typically produce

C. Focus on improving publicly reported quality metrics since these drive competitive positioning under value-based models

D. Shift the unit's financial strategy from maximizing volume and services (the fee-for-service optimization) to maximizing value — investing in care coordination, complication prevention, readmission reduction, and patient engagement that reduce total cost of care while improving outcomes, even when these investments increase per-case cost, because value-based payment rewards the total outcome rather than the individual service

106. A nurse manager is developing a supply chain cost management strategy. Analysis reveals that the unit's supply costs have increased fourteen percent over two years while patient volume has increased only four percent. The ten-percentage-point gap between supply cost growth and volume growth suggests either price inflation, utilization increase, or waste. Which analysis MOST accurately identifies the cost driver?

A. Compare the unit's supply cost per patient day to peer unit benchmarks to determine whether the cost level is appropriate regardless of the growth rate

B. Decompose the fourteen percent increase into its component parts — price inflation (contract-driven increases beyond the unit's control), volume-driven growth (the four percent proportional to patient volume), utilization change (more supplies per patient day reflecting practice changes), and waste (expired, damaged, or unused supplies) — since each component requires a different intervention and the management strategy depends on which component dominates the growth

C. Audit the unit's supply ordering patterns to identify nurses who order excessive supplies

D. Negotiate with vendors for price reductions since procurement cost is the primary driver of supply expense growth

107. A nurse manager is evaluating the financial impact of the unit's nurse residency program over a three-year period. The following data is available:

Year	Program Cost	Residents	1st-Year Retention	Pre-Program Retention	Departures Prevented
-----	-----	-----	-----	-----	-----

| 1 | \$165,000 | 8 | 75% (6 retained) | 50% (4 retained) | 2 |

| 2 | \$170,000 | 10 | 80% (8 retained) | 50% (5 retained) | 3 |

| 3 | \$175,000 | 12 | 83% (10 retained) | 50% (6 retained) | 4 |

Replacement cost per departure: \$54,000. Which three-year cumulative ROI analysis is MOST accurate?

A. Total prevented departures: 9. Savings:  $9 \times \$54,000 = \$486,000$ . Total program cost: \$510,000. Three-year net:  $-\$24,000$  (negative ROI)

B. The program has not yet achieved cumulative positive ROI but the trajectory shows improving returns each year, with Year 3 producing \$216,000 in savings against \$175,000 in cost — and if the trend continues, Year 4 is projected to produce significant positive cumulative ROI

C. The three-year analysis shows a cumulative net loss of \$24,000 in direct retention savings alone — but the complete financial analysis must include the non-retention benefits including faster time to productivity, reduced agency utilization during the residency development period, improved quality outcomes from better-prepared new graduates, and the compound effect of retaining nurses who will generate value over multi-year careers rather than departing within twelve months

D. The negative three-year ROI demonstrates that the program is not financially justified and should be discontinued

108. A nurse manager is developing a proposal for implementing a dedicated discharge planning nurse position. The position costs eighty-eight thousand dollars annually. Current data shows:

Average LOS: 4.8 days (benchmark: 4.2 days)

Average delay from discharge order to departure: 3.2 hours (benchmark: 1.5 hours)

Annual patient days: 8,760

Estimated reducible excess patient days: 520 per year

Average cost per patient day: \$2,100. Which calculation provides the MOST compelling financial justification?

A.  $520 \text{ excess patient days} \times \$2,100/\text{day} = \$1,092,000$  in potentially avoidable costs. Even capturing twenty percent of this through the discharge nurse position = \$218,400, exceeding the \$88,000 position cost by \$130,400

B. The financial justification should focus on the revenue from freed bed capacity rather than avoided costs since the beds will be filled by new admissions

C. The discharge delay reduction from 3.2 to 1.5 hours per patient translates into earlier bed availability, improved patient flow, reduced ED boarding, and enhanced patient satisfaction

D. The full financial value includes both the avoided excess patient day costs AND the downstream revenue from patients who can be admitted into the freed capacity — since each excess day consumed by a delayed discharge is a day unavailable for a new admission, making the discharge nurse position's value both cost avoidance and revenue enablement

109. A nurse manager is evaluating the unit's performance on the CMS Hospital Value-Based Purchasing program. The VBP program adjusts Medicare payments based on performance across four domains. Analysis reveals that the unit's contribution to the hospital's VBP score is strongest in Clinical Outcomes and Safety but weakest in Person and Community Engagement (patient experience). The total VBP adjustment for the hospital is a positive one point two percent payment increase, generating approximately eight hundred thousand dollars in additional revenue. Which analysis is MOST important for the nurse manager?

A. Determine how much of the \$800,000 VBP revenue the unit directly influenced through its quality performance

B. Identify which specific Person and Community Engagement measures the unit scores lowest on and determine whether targeted nursing interventions could improve those scores enough to increase the hospital's total VBP adjustment

C. Quantify the potential additional VBP revenue that would result from improving the Person and Community Engagement domain to match the Clinical Outcomes and Safety performance level, then calculate whether the nursing interventions required to achieve that improvement cost less than the additional revenue they would generate — creating a specific investment-to-return calculation for patient experience improvement

D. Focus on maintaining the current strong Clinical Outcomes and Safety performance since these domains contribute the most to the existing positive VBP adjustment

110. A nurse manager is developing a financial dashboard that translates complex financial data into actionable insights for clinical staff. The dashboard must communicate the unit's financial performance in a way that motivates specific nursing behaviors. Which design principle is MOST effective?

A. Display the most important financial metrics with clear visual indicators showing whether each metric is above or below target

B. Connect each financial metric to a specific nursing behavior that staff can influence — for example, linking supply cost per patient day to waste reduction behaviors, linking HPPD to efficient task management, and linking readmission costs to discharge education quality — so that staff understand exactly which actions they take daily that affect the numbers on the dashboard

C. Display financial metrics alongside quality metrics to demonstrate the relationship between clinical excellence and financial performance

D. Present financial trends over time to show whether performance is improving, stable, or declining

111. A nurse manager is evaluating the financial implications of two competing approaches to managing the unit's weekend staffing challenge. Current weekend staffing relies on mandatory rotation (requiring all nurses to work every other weekend) supplemented by premium pay incentives. Staff satisfaction with weekend scheduling is low and contributes to turnover.

Approach A: Dedicated weekend staff (Baylor plan) — hire 6 nurses who work only weekends at premium pay

Approach B: Flexible scheduling — allow nurses to self-schedule with a minimum weekend requirement and premium incentives

Which financial analysis is MOST important for the comparison?

- A. The direct labor cost comparison between the two approaches including base salary, differentials, and premium pay
- B. The total cost comparison including direct labor, recruitment/retention impact, agency utilization effect, and quality outcome differential — since the approach that costs more in direct labor may cost less in total when reduced turnover, eliminated agency use, and improved quality outcomes are included in the calculation
- C. The impact on nurse satisfaction and its downstream effect on retention and recruitment
- D. The flexibility of each approach to accommodate census variation and unexpected staffing needs

112. A nurse manager is preparing the unit's annual budget request and must justify a twelve percent increase in the education budget from the current sixty-five thousand dollars to seventy-three thousand dollars. The increase is driven by three new competency requirements: point-of-care ultrasound training, telehealth clinical skills, and pharmacogenomics education. Which justification approach is MOST likely to secure approval?

- A. Present each new competency requirement with its regulatory or clinical mandate, the cost of training, and the consequence of not providing the training — framing the increase as compliance-driven investment required to maintain the unit's operational authorization rather than discretionary spending
- B. Compare the unit's current education budget to peer units and demonstrate that the current budget is below average
- C. Present the education budget increase as a percentage of the total labor budget to demonstrate its relative insignificance
- D. Justify the increase by projecting the quality improvement and error reduction that the new competencies will produce

113. A nurse manager is conducting a comprehensive analysis of the unit's overtime patterns and discovers an unexpected finding: overtime costs are highest on the unit's lowest-census days. Investigation reveals that on low-census days, nurses are sent home ("flexed off") early in the shift, but patient acuity increases later in the shift, requiring callback of staff who then work overtime hours. Which staffing model modification MOST directly addresses this paradox?

- A. Implement a delayed flex-off decision that assesses both census AND acuity trends before releasing staff, using predictive indicators of afternoon acuity surges to avoid premature flexing that creates the later callback-and-overtime cycle
- B. Eliminate the flex-off practice and maintain full staffing regardless of census to prevent the callback-overtime pattern
- C. Implement a standby pay model where flexed-off nurses receive a reduced hourly rate to remain available for callback without generating full overtime when recalled
- D. Adjust the shift scheduling model so the afternoon shift begins later, aligning peak staffing with the period when acuity surges typically occur

114. A nurse manager is developing a financial model for implementing a nurse-led transitional care program for heart failure patients. The program provides a thirty-day post-discharge nursing support service including home visits, telehealth monitoring, medication management, and care coordination. Published evidence shows that nurse-led transitional care programs reduce heart failure readmissions by twenty to forty percent. The program requires one FTE nurse coordinator at eighty-five thousand dollars annually plus ten thousand dollars in technology and supplies.

Unit heart failure discharge volume: 220 patients/year

Current 30-day readmission rate: 24%

Average readmission cost: \$12,500

CMS readmission penalty contribution: estimated \$85,000/year

Which financial model is MOST comprehensive?

- A. Readmission reduction (conservative 20%):  $220 \times 24\% \times 20\% = 10.56$  fewer readmissions  $\times$  \$12,500 = \$132,000 in direct cost avoidance
- B. Direct savings (\$132,000) + penalty reduction (portion of \$85,000) against program cost (\$95,000) = significant positive ROI
- C. The model should include direct readmission cost avoidance, CMS penalty contribution reduction, freed bed capacity revenue from prevented readmission days, improved publicly reported quality scores

affecting competitive positioning, and the program's potential expansion to other diagnoses — projecting the total value across all affected financial dimensions rather than calculating readmission savings alone

D. The financial model should project a range of outcomes based on the twenty-to-forty-percent readmission reduction evidence, showing the break-even point and the ROI at conservative, moderate, and optimistic reduction rates — combined with a sensitivity analysis identifying which assumptions carry the most financial risk, and a sustainability plan showing how the program becomes self-funding through documented savings

115. A nurse manager is conducting a comprehensive year-end financial review and must present a forward-looking strategy to organizational leadership. The unit achieved all quality targets, improved patient satisfaction to the eighty-second percentile, and maintained a positive operating margin of two point four percent. However, three concerning trends emerged during the year: (1) the commercial payer mix declined by six percent, (2) nurse turnover increased from fourteen to nineteen percent, and (3) supply costs grew at twice the rate of patient volume. Which forward-looking strategic presentation is MOST compelling?

A. Present the positive achievements prominently and address the three concerning trends as areas for focused improvement in the upcoming year

B. Present the three concerning trends as an integrated strategic challenge: declining commercial mix reduces revenue per patient, rising turnover increases premium labor costs, and accelerating supply costs erode margins from a third direction — creating a "triple margin compression" that the current two point four percent margin cannot sustain, and propose an integrated strategy addressing all three simultaneously through payer mix management, retention investment, and supply chain optimization rather than treating each as an independent problem

C. Focus the presentation on the quality and satisfaction achievements since these protect the organization's value-based purchasing revenue and competitive market position

D. Present a budget request that increases spending on retention and supply management to address the concerning trends proactively

## **Answer Key – Exam 17 (with Full Answer Explanations)**

1. D — A structured hot debrief conducted immediately while the team is still assembled, addressing both clinical sequence and emotional experience in a brief format, captures immediate impressions before they fade. The immediacy of the debrief is critical because details deteriorate rapidly after resuscitation events, and the emotional processing window is most effective while the experience is fresh.

2. D — Assessing whether de-identification is truly adequate given the rare condition, considering whether the patient should be informed and given the opportunity to consent, and balancing educational value against privacy risk provides the most comprehensive analysis. Rare conditions may be identifiable despite standard de-identification, creating a privacy vulnerability that HIPAA compliance alone may not address.

3. C — Educating staff that pain is subjective, that chronic pain involves neurobiological changes, that labeling creates measurable outcome-worsening bias, and that professional management requires treating reported experience rather than nursing judgment of legitimacy is the most foundational intervention. The "drug-seeking" label creates a self-reinforcing cycle where bias worsens undertreatment.

4. B — A structured protocol requiring short-segment information delivery, visual aids, post-conversation nursing comprehension assessment through teach-back, and a translated summary document addresses all dimensions of interpreter-mediated consent. Rushed interpreted consent produces signature without comprehension.

5. A — Providing honest, compassionate information about the dying process, explaining unpredictable timeline and physical changes, assuring comfort measures continue, remaining present, normalizing emotional responses, and offering support addresses the family's needs during withdrawal. Families need information, presence, and permission to grieve.

6. A — Beginning transition preparation before the move by explaining that transfer represents improvement, describing floor capabilities, introducing the receiving team, and validating that reduced monitoring feels frightening manages anxiety proactively. Transition anxiety is best addressed before the move rather than after the family is already distressed.

7. D — Acknowledging the surgeon's distress while explaining timely disclosure obligations, providing brief support for composure, facilitating disclosure with both surgeon and patient safety officer present, and arranging second-victim support afterward addresses all dimensions. Disclosure and second-victim support must occur concurrently.

8. A — Presenting evidence that patient participation improves outcomes, acknowledging that patients contribute different expertise — knowledge of their own body, values, and context — and clarifying that participation supplements rather than replaces clinical decision-making addresses physician resistance effectively.

9. C — Enhanced privacy protections including chart access restriction, break-the-glass audit monitoring, visitor restriction, and staff education that coworker status does not entitle access addresses healthcare employee-patients' unique privacy vulnerability. Employees are at heightened risk of privacy breaches from curious colleagues.

10. C — Relationship-based care changes the quality of existing interactions rather than requiring additional ones, reducing call light use, anxiety, non-adherence, and building trust that makes subsequent interactions more efficient. Research demonstrates a net time savings, not a time burden.

11. B — Beginning the transition two years before transfer by gradually shifting communication responsibility, teaching self-advocacy, building confidence, and developing independent health management creates a continuation rather than an abrupt shift. Transition preparedness must begin years before the actual care setting change.

12. A — Continue aggressive treatment as directed while simultaneously pursuing ethics consultation. The family's decision-making authority must be respected while the clinical team seeks guidance on the appropriateness of the requested treatment through established organizational channels.

13. B — The temporarily covering nurse assumes clinical responsibility for unassessed patients whose status and pending needs she has not been briefed on, creating a vulnerability window where clinical changes may be missed and time-sensitive interventions delayed. Lateral handoffs receive minimal quality improvement attention despite carrying significant risk.

14. D — The convergence of unfamiliar surge staff with inaccessible electronic clinical data exponentially increases wrong-patient, missed-medication, and unrecognized-deterioration risk. Either vulnerability alone is manageable, but their simultaneous occurrence creates a multiplicative rather than additive danger.

15. B — Providing specific examples of condescending communication, helping the nurse understand the team dynamics and patient safety impact when UAPs are reluctant to communicate concerns, and coaching alternative approaches through role-play develops the specific behavioral distinction between directness and condescension.

16. D — Micro-inequities are often unconscious, and people who most need to practice micro-affirmations may be unaware their communication patterns contain exclusionary signals. Self-awareness

must be developed before behavioral change can occur since people cannot correct behaviors they do not recognize.

17. A — Coaching nurses to document as if the patient is reading simultaneously — using objective, factual, non-judgmental language — treats real-time access as an opportunity to improve documentation quality. This approach elevates documentation standards rather than restricting patient access.

18. A — Facilitating a meeting with both co-proxies, the care team, and potentially the ethics committee to explore the patient's wishes and seek consensus, with legal counsel consultation if consensus fails, provides the structured resolution that contradictory proxy directions require.

19. B — Treating every safety protocol as a communication protocol — medication administration as verification, handoffs as information integrity transfers, escalation as communication channels — makes communication improvement simultaneously improve every safety dimension rather than addressing it as a separate element.

20. D — Addressing both the family's emotional response with empathy and explanation AND counseling the nurse on perception risks of workplace-adjacent social media during shifts when significant events occurred provides the comprehensive response. Both the family's pain and the nurse's professional judgment deserve attention.

21. C — Reframing the restructuring by connecting it to values and vision, acknowledging uncertainty while providing interpretive context, and creating ongoing dialogue where staff interpretation is monitored and leadership framing adjusted provides effective sensegiving. Leaders who shape interpretation rather than merely providing facts help teams navigate ambiguity constructively.

22. B — Training nurses in assertive communication using depersonalizing frameworks, practicing through realistic simulation, and building a culture where reporting negative findings is recognized as advocacy rather than confrontation develops the specific skill of delivering unwelcome clinical information. The "I notice, I am concerned, I request" framework depersonalizes the message.

23. B — Narrative medicine develops diagnostic reasoning by training nurses to identify clinically significant patterns in patient narratives. Wait — the key says B but let me re-check. Actually, looking at the options again:

The correct answer is B — narrative medicine develops the nurse's capacity to recognize what matters to the patient and what they are trying to communicate, including clinical information embedded in the illness narrative that structured tools may not capture.

24. A — Redesigning nursing communication to include at least one substantial focused "signature visit" per shift where the nurse sits, makes eye contact, addresses top concerns, and explains the day's plan establishes the nurse as a clinical partner. The fragmented brief-encounter pattern explains the satisfaction gap despite longer total contact time.

25. C — Separating roles so consent is obtained by a team member without a clinical care relationship eliminates the therapeutic relationship's inherent influence from the consent process. Patients should not feel pressure to enroll from the nurse they depend on for daily care.

26. D — Establishing separate communication channels for each crisis with designated leadership, creating a synchronization point for resource decisions, and implementing simplified formats that reduce information load while maintaining essential content manages the competing communication streams of a dual crisis.

27. B — The communication profile takes approximately two minutes, prevents mismatched delivery that causes repeated explanations, and ultimately saves more time than it consumes by getting communication right the first time. It is a net efficiency gain rather than an additional burden.

28. A — Nurses may lack confidence in their clinical knowledge and defer to physicians to avoid providing incorrect information that could be contradicted during rounds, creating embarrassment or undermining trust. The root cause is confidence deficit rather than scope confusion, knowledge gap, or time management.

29. D — Reframing surveillance communication by explaining the safety concern, providing patient control over monitoring parameters, limiting the monitored area, ensuring respectful communication from monitoring staff, and periodically reassessing clinical justification treats monitoring as a therapeutic intervention requiring dignity preservation.

30. C — A structured protocol with explicit algorithms, medical-staff-approved targets, clear physician notification criteria, comprehensive training with competency verification, and pharmacist safety alerts provides the comprehensive framework nurse-driven glycemic management requires. Independent nursing dose adjustment needs both clinical authority and safety guardrails.

31. A — Mandatory reassessment of fall risk factors and revision of the prevention plan within two hours of every fall, analyzing what specific factors contributed, addresses the critical gap. Continuing the same prevention interventions that failed to prevent the fall ensures the next fall as well.

32. D — Initiating the timeout by prompting the physician when the assessment window arrives, providing nursing clinical response data, and communicating observations about infection resolution or persistence provides the most valuable nursing contribution. Antimicrobial timeouts are frequently forgotten without a reminder system.

33. C — The independent double-check is most commonly insufficient because it often becomes a cursory confirmation rather than true independent verification. A genuine independent double-check requires the second clinician to verify against the original order independently, not simply confirm the first nurse's preparation.

34. C — Verifying that current creatinine and eGFR have been obtained and reviewed, with communication of abnormal values to the ordering physician and imaging team before the patient leaves the unit, is most critical. Contrast nephropathy risk is directly related to baseline renal function, and unrecognized impairment creates the highest preventable risk.

35. B — The inverse relationship demonstrates that increased RRT activation reflects earlier recognition and management of deterioration that prevents the escalation cascade from assessment-to-ICU-to-code-to-death. Higher activation rates are a positive indicator of improving safety culture when accompanied by declining downstream events.

36. A — A nurse-initiated checklist with standardized depersonalizing language such as "the checklist requires me to verify..." frames the stop as a system requirement rather than personal confrontation. Simulation practice builds the behavioral muscle memory to intervene automatically despite the power differential.

37. C — A multicomponent prevention bundle addressing oral hygiene, aspiration precautions, early mobilization, cough and deep breathing, and dysphagia screening addresses the multiple pathways through which non-ventilated patients develop HAP. Single-intervention approaches address only one pathway.

38. B — Patient-specific discharge-from-monitoring criteria based on return to baseline consciousness, respiratory function, and hemodynamic stability rather than time-based discharge accounts for individual

medication metabolism variation. Time-based monitoring is unreliable because sedation duration varies by patient factors.

39. C — A nurse-driven fluid management protocol with daily assessment, continuation/discontinuation criteria, clinical triggers, and integration into routine assessment rather than separate documentation provides the most impactful improvement. Fluid management becomes a clinical assessment activity rather than a documentation burden.

40. B — Establishing minimum monitoring equivalent to dedicated procedural areas including continuous pulse oximetry, capnography, cardiac monitoring, dedicated monitoring nurse, emergency airway equipment, and rescue protocols ensures safety regardless of physical location. The monitoring standard follows the procedure, not the room.

41. B — Stroke thrombolytic compliance at sixty-two percent has the lowest compliance AND the narrowest time window, and patients who miss the target may be permanently excluded from a life-saving intervention with no alternative. Other time-sensitive interventions remain beneficial when delayed; missed thrombolytic windows are irreversible.

42. C — Variable alarm tones that change periodically prevent the auditory cortex from classifying the sound as non-threatening background noise. Desensitization occurs through habituation to consistent sound patterns, and variation disrupts the habituation pathway that leads to unconscious filtering.

43. A — Transitioning to focused assessments targeting systems relevant to the patient's condition produces assessments that are genuinely performed and clinically meaningful rather than auto-populated comprehensive entries. Focused assessments capture clinical reality; auto-populated comprehensive assessments capture documentation compliance.

44. D — The experience composition metric recognizes that staffing adequacy depends on the collective experiential knowledge of the team. A shift of eight new-to-unit nurses may be more dangerous than six nurses including experienced veterans, despite the higher headcount.

45. B — A progressive mobility protocol transitioning from passive range-of-motion through seated activities to ambulation addresses immobility as the most modifiable VTE risk factor. Graded activity advancement beginning within hours of admission directly targets the pathophysiology of stasis-related thrombosis.

46. C — Nurses may fear that disclosure will lead to anger, complaints, or litigation, and the organization may not have created the psychological safety for transparent conversations. The disclosure gap is driven by fear of consequences rather than uncertainty about which events require disclosure.

47. C — Comprehensive CRRT competency development including machine operation, fluid balance calculation, anticoagulation monitoring, vascular access assessment, alarm troubleshooting, and complication recognition combined with a clearly defined scope of independent versus physician-required decisions provides the essential preparation.

48. D — Investigating what organizational change coincided with the compliance decline identifies the systemic trigger. A twenty-three-percentage-point drop over two quarters suggests a specific precipitating factor rather than gradual skill degradation.

49. C — No-harm events reveal identical system vulnerabilities to harmful events, differing only in recovery factors or patient resilience. The system factors that allowed the error to reach the patient are the same in both cases, making no-harm events free lessons for preventing future harmful events.

50. A — A validated dosing algorithm with clear parameters including dose ranges, route limitations, infusion rates, renal considerations, contraindications requiring physician consultation, and monitoring requirements ensures clinical rigor while enabling the protocol's efficiency benefit.

51. C — Relational coordination theory identifies that shared goals between disciplines drive coordination quality. A shared goals workshop where nursing and medicine articulate individual goals, identify alignment and divergence, and develop explicit shared goal statements improves the relationship foundation that enhances all communication dimensions.

52. A — The GROW question sequence guides the coachee through self-discovery: "What would excellence look like?" (Goal), "What currently prevents that?" (Reality), "What options can you identify?" (Options), "Which will you try and by when?" (Way Forward). The coach guides analysis rather than prescribing solutions.

53. D — The group's primary role is asking questions that deepen the presenter's understanding rather than offering solutions. Revans' principle holds that insightful questions are more valuable than expert answers because they develop the problem-owner's understanding and commitment to implementation.

54. C — Stories from the unit's own history resonate more deeply than external examples because they create shared identity around safety values and establish that safety heroism happens on THIS unit by THESE people. Own-experience narratives build culture more effectively than borrowed examples.

55. B — Addressing the behavior directly while acknowledging influence, establishing anti-lobbying ground rules, restructuring for open deliberation with undecided outcomes, and redirecting energy toward authentic discussion facilitates genuine governance rather than orchestrated consensus.

56. A — Asking fundamentally different questions — "what would a unit where falls never happen look like?" instead of "how can we reduce falls?" — creates cognitive disruption that opens the door to transformative solutions. Incremental questions produce incremental answers; transformative questions challenge the system itself.

57. A — Creating opportunities for each generation to contribute distinctive strengths frames generational differences as complementary team assets rather than friction sources. Each generation brings unique knowledge and perspective that strengthens the team when valued rather than suppressed.

58. C — Learning rounds demonstrate that clinical excellence is valued alongside operational efficiency, building clinical credibility while developing staff through modeling — combining leadership presence, clinical teaching, and culture-building in a single activity that other development methods cannot replicate.

59. B — A personal leadership sustainability plan including regular self-assessment, deliberate energy-renewal activities, peer support relationships, and periodic values-purpose alignment evaluation treats sustainability as an active practice. Leadership sustainability requires intentional investment rather than passive endurance.

60. B — The ability to experience strong emotion without immediately expressing it, creating a cognitive pause between trigger and response that allows the leader to choose a response serving the team's needs, is the most critical emotional regulation skill. The pause prevents reflexive emotional contagion while preserving authentic later processing.

61. D — Leading without certainty by making reasonable decisions on available information, communicating uncertainty transparently, maintaining operational effectiveness without waiting for clarity, and course-correcting as information emerges demonstrates that leadership stability does not depend on organizational stability.

62. C — Progressive leadership experiences with coaching support develop management competency primarily through experience. Serving as charge nurse, leading QI projects, participating in budgeting, and managing conflicts under mentored supervision builds capability that education alone cannot provide.

63. B — Simple criteria enabling quick categorization — patient-only decisions are Category 1, shift-affecting are Category 2, beyond-today are Category 3 — with guidance to act at the lowest level and escalate only if needed builds autonomous decision-making. Simple rules enable rapid categorization better than comprehensive decision matrices.

64. B — A peer network of other nurse managers provides safe space for honest discussion with people who understand the unique middle-management pressures without the power dynamic complications that exist within the unit team. Peer manager relationships address the specific isolation of the middle management role.

65. A — Whether each activity produces a specific measurable outcome as evidence of value creation is the most important evaluation. Activities that do not produce identifiable results have become rituals performed without generating the intended benefit.

66. B — Identifying a specific team accomplishment, using it as evidence of collective capability, then building with progressively challenging goals rebuilds collective efficacy through demonstrated success. Belief in team capability is rebuilt through concrete evidence of team accomplishment.

67. D — Relational and political knowledge — understanding critical relationships, stakeholder values, informal influence flows, and unwritten organizational rules — is the most difficult to transfer because it is tacit, contextual, and accumulated through years of experience rather than documented in any format.

68. A — Positioning reverse mentoring as reciprocal exchange where each party learns from the other's unique knowledge base redefines expertise as knowledge another person needs regardless of seniority. Bidirectional framing eliminates the hierarchy objection.

69. D — Creating connections between innovators and the operational core, protecting innovations from premature efficiency evaluation, facilitating creative-to-operational translation, and building political support most effectively enables innovation transfer from the margins to standard practice.

70. C — The tension between conformity to industry standards and differentiation through unique superior practices, where conformity provides a reliable baseline and innovation provides competitive advantage, represents the leader's challenge of determining which practices to standardize and which to differentiate.

71. D — Bringing all participants together, hearing each perspective, challenging self-serving elements, integrating perspectives into a comprehensive account no single participant could construct alone, and identifying system factors that individual narratives obscured facilitates accurate collective sensemaking.

72. C — Attitudinal barriers — deeply held beliefs, habits, and practice patterns rooted in identity and values — persist despite knowledge, environmental redesign, and organizational support. They require sustained culture change measured in years rather than months.

73. D — A balanced assessment combining quantitative performance metrics with qualitative indicators and developmental trajectory evaluates not just what the leader has achieved but what the leader has built that will sustain performance beyond their tenure.

74. A — A joint quality improvement project with equal representation, shared data analysis, and mutually developed solutions transforms the adversarial ED-unit dynamic into a partnership around shared patient outcomes. Structured collaboration around shared goals is the most effective boundary-spanning approach.

75. D — Progressive discipline is most appropriate for behavioral issues while performance coaching addresses skill or competency deficits. They are complementary tools for different categories of underperformance, not competing methodologies.

76. A — Leading through expertise and preparation — becoming the most knowledgeable, preparing thorough analyses, facilitating productive discussions, and building credibility through delivered commitments — earns influence through competence when positional authority is absent.

77. D — Implementing both replacement planning for immediate coverage AND succession planning for long-term pipeline development recognizes that each serves different needs on different timescales. "Who covers this shift" and "who leads this unit in five years" require different but equally necessary planning.

78. C — Recognizing empathic overload as a leadership occupational hazard, implementing emotional recovery practices, seeking personal support, and monitoring for judgment impact enables sustainable emotional leadership. The manager cannot support others from an emotionally depleted state.

79. B — Identifying and articulating the unit's distinctive strengths, values, and achievements, then weaving them into a compelling narrative used in recruitment, orientation, and daily operations reinforces what makes the unit worth belonging to. Identity is built through shared narrative rather than mission statements or branding.

80. D — Weak leadership response to observed ethical deviations implicitly communicates that standards are aspirational rather than mandatory. When leaders see small violations and do not address them, they create permission for progressive deviation that erodes standards over time.

81. B — Professional accountability requires demonstrating correct process rather than guaranteeing outcomes. The nurse is accountable for technique, documentation, monitoring, and response but NOT for the occurrence of a known risk that manifested despite correct practice. Outcome-based accountability in a field with inherent risk would make nursing impossible.

82. C — Professional governance transfers both authority and responsibility, requiring maturity of professional judgment that shared governance's advisory model does not develop. Nurses making autonomous practice decisions must accept accountability for consequences, requiring evidence-based decision-making capacity.

83. D — Whether independence can be genuinely maintained including publication of unfavorable results, data integrity protections, and institutional perception of pharmaceutical involvement affecting how results are received provides the most important ethical analysis. Funding source perception may affect clinical adoption regardless of scientific validity.

84. D — Cognitive forcing strategies that interrupt automatic reasoning at key decision points — requiring consideration of alternative diagnoses, mandating verbalization of supporting and contradicting findings, and presenting atypical simulation cases — most effectively disrupt clinical automaticity. These strategies interrupt the automatic pattern recognition that misses atypical presentations.

85. B — Nurses practicing independently through direct-to-consumer platforms without malpractice coverage, clinical oversight, or state licensure verification face simultaneous professional, legal, and

liability exposure. The convergence of these vulnerabilities creates the most significant professional concern.

86. B — Combining awareness education with structural interventions — standardizing assessments, auditing outcomes by demographics, and creating accountability through peer observation — produces behavioral change because awareness alone is insufficient to alter unconscious behavior without structural supports making equitable practice the default.

87. A — Patient autonomy takes precedence — the patient's right to make informed decisions supersedes evidence-based protocols. The nurse's obligation is to ensure informed decision-making, respect the patient's choice, and document both the recommendation and the informed refusal.

88. D — The nurse's professional obligation to patient safety supersedes research protocol limitations. Discovering a clinically significant error creates an immediate professional obligation to ensure correction regardless of the nurse's current role. The appropriate action is communicating the finding to the clinical care team.

89. A — Each Benner stage requires stage-appropriate development: novices need rules, advanced beginners need contextual examples, competent nurses need priority-setting support, proficient nurses need big-picture opportunities, and experts need challenges stretching their intuition. Development must match the stage to be effective.

90. C — Connecting certification to professional identity, sharing testimonials about how preparation deepened knowledge beyond experience, and reframing from "proving what I know" to "discovering what I didn't know" addresses the specific attitudinal barrier that experience equals competence. Certification reveals gaps that experience alone cannot identify.

91. D — A comprehensive ethical analysis considering utilitarian benefit, justice, evidence strength, values alignment, reversibility, and stakeholder impact is most appropriate since resource allocation decisions involve competing values that no single ethical framework adequately resolves.

92. B — Implementing nurse-driven protocols, coaching autonomous decision-making, and creating a culture where independent practice is expected, supported, and celebrated builds both structural authorization and professional confidence. Autonomy requires both the authority to decide and the confidence to exercise that authority.

93. A — Addressing the behavior as a professional conduct issue by meeting with involved nurses, describing specific behaviors and their impact, establishing inclusive behavior expectations, and implementing consequences addresses the clique directly. Focusing on specific observable behaviors and their impact avoids subjective characterization.

94. C — The nurse's professional identity is built around being the most knowledgeable person, and sharing knowledge threatens this identity by reducing the knowledge differential that is her perceived source of value and power. The behavior reflects an identity need rather than a skill deficit.

95. A — Reviewing the reprimand against a just culture framework to determine whether the error was human error, at-risk behavior, or reckless behavior, and modifying the response if the system contributed significantly, acknowledges that punitive consequences for system-enabled error undermine reporting culture.

96. A — A patient fall with hip fracture is an external failure cost — the defect reached the customer causing harm that generates downstream costs. Cost of poor quality theory identifies external failure as the most expensive category, making prevention investment the most cost-effective strategy.

97. C — The productivity gap between the departing experienced nurse and the new hire over twelve-to-eighteen months represents the largest unmeasured turnover cost. This cumulative difference in efficiency, error rates, throughput, and supervision needs persists long after visible recruitment and orientation costs are incurred.

98. B — The fully loaded FTE cost includes base salary, benefits, amortized orientation, ongoing education, certification support, uniform allowance, parking, employee health, professional development time, and non-productive time adjustments. These represent the total organizational investment required per productive FTE.

99. A — Total projected savings of \$307,386 (turnover \$69,120 + sick call \$62,586 + workers' comp \$48,000 + agency \$127,680) against \$75,000 investment produces \$232,386 net return at 4.1:1 ROI. The comprehensive multi-metric analysis demonstrates that well-being investment generates returns across multiple cost categories simultaneously.

100. D — Revenue per patient day has been relatively stable while expense per patient day increased from \$624 to \$661 despite declining volume, indicating costs are not flexing downward proportionally.

This structural expense problem persists regardless of volume recovery and requires immediate investigation.

101. A — The informatics specialist recaptures approximately 1,248 nursing hours (\$65,000 value) through documentation optimization, combined with improved quality reporting accuracy affecting VBP reimbursement and reduced documentation-related errors. The productivity recapture alone approaches the position cost before quality reporting benefits are added.

102. D — Preventing complications AND ensuring effective transitions reduces both immediate inpatient costs and downstream readmission and post-acute costs included in total episode cost. The combined approach impacts more of the total cost than either dimension alone.

103. C — A tiered approach comparing against internal peers for operations, external peers for outcomes and finances, and top performers for aspirational goals recognizes that different benchmarks serve different purposes. No single comparison provides complete context.

104. A — Whether the cost savings are genuine or shift costs to other areas is most important. If virtual monitoring increases bedside nursing workload through more frequent alert responses, apparent savings may be offset by increased labor costs, making true financial impact dependent on the net workflow effect across all roles.

105. D — Shifting from maximizing volume to maximizing value — investing in coordination, prevention, and engagement that reduce total cost while improving outcomes — represents the fundamental strategic adaptation. Value-based payment rewards total outcome management rather than individual service volume.

106. C — Decomposing the fourteen percent increase into price inflation, volume-driven growth, utilization change, and waste identifies which component dominates and determines the appropriate intervention. Each component requires a different management strategy.

107. C — The cumulative net loss of \$24,000 in direct retention savings does not capture the complete financial picture. Non-retention benefits including faster productivity, reduced agency, improved quality, and the compound career-length value of retained nurses likely bring the total return above the investment.

108. B — The full financial value includes both avoided excess patient day costs and downstream revenue from patients admitted into freed capacity. Each delayed discharge day simultaneously consumes resources and blocks revenue-generating admissions, making the position's value both cost avoidance and revenue enablement.

109. C — Quantifying additional VBP revenue from improving Person and Community Engagement to match Clinical Outcomes performance, then calculating whether the required nursing interventions cost less than the revenue they generate, creates a specific investment-to-return calculation for patient experience improvement.

110. B — Connecting each financial metric to a specific nursing behavior staff can influence — supply cost to waste reduction, HPPD to task management, readmission costs to discharge education — enables staff to understand which daily actions affect the dashboard numbers.

111. A — The total cost comparison including direct labor, recruitment/retention impact, agency effect, and quality differential captures the complete financial picture. The approach costing more in direct labor may cost less when turnover, agency, and quality are included.

112. A — Presenting each requirement with its mandate, training cost, and consequence of non-training frames the increase as compliance-driven investment required for operational authorization. Regulatory mandates create the strongest justification because non-compliance carries defined organizational consequences.

113. B — A delayed flex-off decision assessing both census AND acuity trends before releasing staff uses predictive indicators to avoid premature flexing that creates the later callback-and-overtime cycle. The paradox exists because flex decisions are based on current census without anticipating acuity changes.

114. D — Direct readmission savings plus penalty reduction against program cost demonstrates significant positive ROI. The comprehensive model should include freed capacity revenue and expansion potential, but the core savings-versus-cost comparison provides the essential financial justification.

115. B — Presenting the three trends as an integrated "triple margin compression" challenge and proposing an integrated strategy addressing all three simultaneously demonstrates strategic thinking.