PRACTICE EXAM 18 — FULLLENGTH SIMULATION (115 QUESTIONS)

1. A nurse manager is implementing the AIDET communication framework — Acknowledge, Introduce, Duration, Explanation, Thank You — to standardize patient interactions across the unit. After six months of implementation, HCAHPS communication scores have improved for "nurses explained things clearly" but have NOT improved for "nurses listened carefully." Staff compliance with AIDET is ninety-one percent. Which analysis BEST explains the discrepancy?

A. AIDET compliance is likely being measured through documentation rather than observed behavior, inflating the reported rate

B. HCAHPS scores have a significant lag time and may not yet reflect the recent AIDET improvement

C. The ninety-one percent compliance rate has a nine percent gap that may include the patients who are providing negative survey responses

D. AIDET is fundamentally a delivery framework — it structures what the nurse communicates TO the patient but does not include a listening component where the nurse receives information FROM the patient, meaning staff can execute AIDET perfectly while still failing to demonstrate the receptive listening behaviors that patients evaluate when responding to "listened carefully"

2. A nurse manager is developing a de-escalation communication protocol for nurses who encounter verbally aggressive patients. Research on verbal de-escalation identifies specific techniques: maintaining a calm low tone, using the patient's name, acknowledging the patient's emotion without agreeing with the behavior, offering limited choices, and avoiding confrontational language. A nurse reports that during a recent encounter with an agitated patient, she "did everything right" but the patient's aggression escalated. She is discouraged and reluctant to attempt de-escalation again. Which coaching response is MOST effective?

A. Review the specific encounter details to identify whether the nurse may have inadvertently used an escalating behavior

B. Reassure the nurse that de-escalation works in most cases and encourage her to continue practicing the technique

C. Explain that de-escalation is a probabilistic skill — it increases the likelihood of successful resolution but cannot guarantee it in every encounter, since some patients are in states of agitation that exceed the

threshold where verbal techniques can be effective, and the measure of competence is correct technique application rather than guaranteed patient response

D. Pair the nurse with a more experienced de-escalation practitioner so she can observe effective technique in real situations

3. A nurse manager is implementing structured interdisciplinary bedside rounding where the physician, nurse, pharmacist, and case manager round together at each patient's bedside. The physician has traditionally rounded independently and is resistant to the new model, stating that it "wastes time" and "slows down my workflow." The evidence supporting interdisciplinary rounding shows improvements in communication accuracy, care plan alignment, and length of stay reduction. Which engagement strategy is MOST effective for gaining physician participation?

A. Present the evidence supporting interdisciplinary rounding and appeal to the physician's commitment to evidence-based practice

B. Propose a structured two-week trial with specific efficiency metrics — demonstrating that interdisciplinary rounding actually reduces the physician's total communication burden by consolidating the phone calls, pages, and clarification conversations that currently occur throughout the day into a single coordinated interaction, and measuring the physician's actual time expenditure during the trial versus the current fragmented communication model

C. Request that the chief medical officer mandate physician participation in interdisciplinary rounding as a hospital policy

D. Allow the physician to continue independent rounding and have the nursing staff coordinate with the physician afterward

4. A nurse manager is developing a communication strategy for managing families who use video recording during patient care. Several families have begun recording nursing assessments, medication administration, and clinical conversations on their smartphones. Some nurses feel surveilled and report modifying their behavior — becoming more rigid, less conversational, and less willing to share clinical impressions verbally. Which response BEST balances patient rights with staff communication quality?

A. Implement a hospital policy prohibiting all video recording during clinical care to protect staff privacy and prevent communication chilling

B. Inform families that video recording is permitted in public areas of the hospital but not during direct patient care activities

C. Allow recording but require families to obtain consent from each staff member before recording, and provide nurses with communication scripts for politely declining to be recorded

D. Develop a transparent recording policy that acknowledges families' desire to document their loved one's care, establishes reasonable guidelines about when recording may need to be paused for clinical reasons, and coach nurses to view recording as a quality assurance tool that supports rather than threatens excellent practice — reframing recording from surveillance to documentation of the quality care they already provide

5. A nurse manager is implementing a standardized handoff communication tool. The unit currently uses an informal narrative approach where outgoing nurses describe the patient in their own style. Handoff quality varies dramatically — some nurses provide thorough, organized reports while others provide fragmented, incomplete information. The manager has selected a structured handoff format. Three months after implementation, compliance is only fifty-four percent. Observation reveals that nurses who do not comply state the structured format "doesn't let me communicate what's really important about this patient." Which modification is MOST appropriate?

A. Mandate one hundred percent compliance and address non-compliance through progressive counseling

B. Modify the structured format to include a dedicated "clinical priority" section where the nurse identifies the one to three most critical issues for the incoming nurse — preserving the structure that ensures essential information is communicated while creating a space for the clinical judgment and prioritization that experienced nurses need to express, acknowledging that effective handoff requires both standardized data transfer AND clinical narrative

C. Revert to the narrative format since experienced nurses clearly prefer it and their clinical judgment should be respected

D. Survey the non-compliant nurses to identify specific elements of the structured format they find restrictive and revise the tool based on their feedback

6. A nurse manager is developing a communication approach for conducting goals-of-care conversations with patients who have chronic progressive illnesses. Research shows that these conversations occur too late — often during a crisis admission rather than during stable periods when patients can thoughtfully consider their values and preferences. Nurses report that they avoid initiating goals-of-care conversations because they "don't want to take away hope" and fear that discussing end-of-life preferences will damage the therapeutic relationship. Which reframing MOST effectively addresses the nurse's reluctance?

A. Reframe goals-of-care conversations as "goals OF care" rather than "end of care" — emphasizing that the conversation explores what the patient values most and how care can be aligned with those values at EVERY stage of illness, not only at the end, and that research consistently shows patients who

have these conversations experience LESS anxiety, not more, because uncertainty about the future is more distressing than honest conversation about preferences

B. Provide nurses with a scripted conversation guide that structures the goals-of-care discussion so they feel prepared

C. Assign goals-of-care conversations to social workers or chaplains who specialize in these discussions

D. Require physicians to initiate goals-of-care conversations since the medical plan drives the discussion

7. A nurse manager is addressing a communication breakdown between day shift and night shift nurses. Day shift nurses report that night shift nurses do not complete assigned tasks and "leave everything for us." Night shift nurses report that day shift nurses assign unrealistic tasks at the end of their shift and do not acknowledge the different workflow demands of nighttime care. The conflict has escalated to formal complaints from both sides. Which intervention is MOST effective?

A. Conduct individual interviews with each nurse involved to identify specific examples of the communication breakdown

B. Implement a task tracking system that documents what was completed on each shift and what remains

C. Facilitate a structured joint meeting between representatives from both shifts where each side describes their workflow reality — including staffing levels, patient acuity patterns, available resources, and task feasibility — to build mutual understanding of the different operational environments and collaboratively develop realistic cross-shift expectations that acknowledge the legitimate constraints each shift faces

D. Assign the charge nurses from each shift to manage inter-shift communication and task allocation

8. A nurse manager discovers that a commonly used abbreviation on the unit — "D/C" — has caused a near-miss event. A physician wrote "D/C vancomycin" intending "discontinue vancomycin," but the nurse read it as "discharge vancomycin" and administered a discharge dose. The Joint Commission's "Do Not Use" abbreviation list includes "D/C" specifically because of this dual-meaning risk. Investigation reveals that eighteen additional prohibited abbreviations are routinely used on the unit. Which improvement approach is MOST effective?

A. Distribute the "Do Not Use" abbreviation list to all staff and require written acknowledgment of compliance

B. Implement a system-level intervention that makes prohibited abbreviations difficult to use — such as EHR blocks that reject prohibited abbreviations, pharmacy verification that flags orders containing

them, and nursing authority to clarify any order containing a prohibited abbreviation before acting on it — addressing the error at the system design level rather than relying on individual memory of the prohibited list

C. Focus improvement on the highest-risk abbreviations first, starting with "D/C" since it has already produced a near-miss event

D. Conduct a unit-wide education session explaining the rationale behind each prohibited abbreviation and the harm each can cause

9. A nurse manager is implementing a "Speak Up" culture where all team members — regardless of role or seniority — are empowered to voice patient safety concerns. Despite organizational endorsement of the Speak Up philosophy, a survey reveals that forty-one percent of nurses on the unit would hesitate to question a physician's order even if they believed it was wrong. The primary reason cited is "fear of being labeled as difficult or confrontational." Which intervention MOST directly addresses this specific barrier?

A. Provide additional education on the professional obligation to advocate for patient safety

B. Implement scripted assertive communication tools — such as CUS (I am Concerned, I am Uncomfortable, this is a Safety issue) — that give nurses a standardized, organizationally endorsed language for raising concerns, combined with physician education that these phrases are safety signals requiring a clinical pause, removing the interpersonal risk by making the challenge a system protocol rather than a personal confrontation

C. Share examples of patient harm that resulted from nurses not speaking up to illustrate the consequences of silence

D. Establish an anonymous safety reporting system so nurses can report concerns without personal exposure

10. A nurse manager is developing a communication strategy for managing patients who are experiencing acute psychiatric symptoms — specifically paranoid ideation — while receiving care on a medical-surgical unit. These patients may interpret routine nursing activities as threatening: medication administration may be perceived as poisoning, vital sign monitoring as surveillance, and closed doors as imprisonment. Standard communication techniques may inadvertently reinforce paranoid interpretation. Which communication principle is MOST important for medical-surgical nurses caring for these patients?

A. Communicate with radical transparency — narrate every action before performing it, explain the clinical purpose of each activity, offer the patient choices about the sequence and timing of care

whenever clinically safe to do so, maintain an open and unhurried presence, and avoid approaching the patient from behind or making sudden movements — recognizing that paranoia is driven by perceived loss of control and unpredictability, and that maximizing the patient's sense of control and predictability reduces the threat perception that fuels paranoid interpretation

B. Minimize unnecessary interactions to reduce the number of encounters that could trigger paranoid interpretation

C. Assign the same nurse to the patient for the duration of the hospitalization to build trust and familiarity

D. Request a psychiatric consultation and defer all non-urgent care activities until the psychiatric team provides specific communication recommendations

11. A nurse manager is addressing a pattern where patient satisfaction scores for "communication about medications" are consistently below the fiftieth percentile despite nurses reporting that they always explain medications. Direct observation reveals that nurses typically provide medication information using clinical terminology — stating the drug name, dose, and route — but do not explain the medication's purpose in patient-accessible language, expected effects, potential side effects, or what symptoms should prompt the patient to call for help. Which root cause BEST explains the discrepancy between nurse perception and patient experience?

A. Nurses define "explaining medications" as providing drug identification data, while patients define it as receiving information that enables them to understand WHY they are taking each medication, what it will DO, how they will FEEL, and what they should WATCH FOR — creating a definitional gap where both parties believe communication occurred but evaluated different content

B. Patient satisfaction surveys may have low response rates, creating sampling bias that does not represent the actual patient population's experience

C. The unit's staffing levels may not allow adequate time for comprehensive medication education

D. Some patients may have low health literacy that prevents them from understanding medication education regardless of how it is delivered

12. A nurse manager is developing a communication training program specifically for managing family members who are healthcare professionals. These family members — physicians, nurses, pharmacists, and other clinicians — present unique communication challenges: they may challenge clinical decisions using medical authority, request access to systems beyond their role as a family member, second-guess bedside nursing assessments, or attempt to direct the care plan. Staff report feeling intimidated by families who "know more than I do." Which communication guidance is MOST effective?

A. Establish a clear policy that healthcare professional family members are treated as family members — not as clinical consultants — regardless of their professional credentials

B. Coach nurses to acknowledge the family member's healthcare expertise while clearly delineating their role — saying "I respect your medical knowledge and I know this is especially difficult because you understand what's happening clinically; your role right now is as [patient's] loved one, and our role is the clinical team, and we want to work together within those roles" — validating their knowledge without conceding clinical authority, and escalating to the attending physician if the family member persists in directing care

C. Assign the most experienced nurse to patients whose family members are healthcare professionals since they are less likely to feel intimidated

D. Include the healthcare professional family member in clinical discussions and rounding to channel their expertise constructively

13. A nurse manager is implementing a communication-based approach to managing chronic pain patients who have been on long-term opioid therapy and are being transitioned to a multimodal pain management approach per organizational protocol. These patients fear that their pain will become unmanageable without their current opioid regimen. Several patients have accused the nursing staff of "not caring about their pain" and "punishing them." Which communication element is MOST critical during this transition?

A. Validate the patient's fear as legitimate and understandable rather than dismissing it as drug-seeking behavior, explain that the transition is motivated by a desire to improve their pain management rather than reduce it, describe specifically how the multimodal approach targets pain through multiple mechanisms, provide a clear timeline with incremental steps rather than abrupt changes, and ensure the patient knows that their pain will be continuously assessed and the plan adjusted based on their response — communicating that the change comes from caring about their well-being, not from judgment about their opioid use

B. Provide educational materials explaining the evidence supporting multimodal pain management superiority over long-term opioid monotherapy

C. Have the physician conduct the opioid transition conversation since the prescribing decision is a medical one

D. Implement the transition protocol gradually without extensive discussion to avoid provoking anticipatory anxiety

14. A nurse manager is developing a communication protocol for nursing staff who serve as medical interpreters for patients who speak the same non-English language as the nurse. While professional medical interpreters are required by policy, bilingual nurses frequently perform informal interpretation

during routine care activities — medication administration, assessments, and comfort conversations — without involving the interpreter service. This practice builds rapport but creates documentation and accuracy risks. Which guideline is MOST appropriate?

A. Prohibit nurses from using their bilingual skills during patient care and require professional interpreter services for all clinical communication

B. Distinguish between categories of clinical communication — allowing bilingual nurses to communicate in the patient's language for routine care interactions such as comfort measures, orientation, and basic instructions, while requiring professional interpreter services for clinical decisions, informed consent, discharge education, and any communication that will be documented as a basis for clinical action — recognizing that rapport-building in the patient's native language has therapeutic value that should not be eliminated entirely

C. Allow bilingual nurses to interpret only if they have passed a validated medical interpreter competency assessment

D. Defer to the bilingual nurse's judgment about when professional interpretation is necessary since they can assess the conversation's complexity in real time

15. A nurse manager is addressing a recurring communication failure during multidisciplinary care conferences. A review of care conference documentation reveals that nursing assessments and observations are consistently underrepresented in care plan decisions. Nurses attend the conferences but contribute minimally — typically confirming physician observations rather than offering independent nursing perspectives. Post-conference interviews reveal that nurses feel their input is "not valued" because physicians dominate the discussion and redirect the conversation when nurses attempt to contribute nursing-specific observations about pain patterns, functional status, or psychosocial concerns. Which intervention MOST effectively elevates nursing voice in care conferences?

A. Provide nurses with assertive communication training to increase their confidence in contributing to multidisciplinary discussions

B. Assign the nurse manager to attend all care conferences to model effective nursing contribution

C. Restructure the care conference format to include a designated "nursing assessment" agenda segment with a defined time allocation where the nurse presents a structured report of nursing-specific observations — including functional assessment, pain management response, psychosocial status, discharge readiness, and patient/family concerns — creating a structural expectation for nursing contribution that does not depend on the nurse competing for floor time against physician-dominated discussion

D. Raise the issue with medical leadership and request that physicians create more space for nursing contributions during conferences

16. A nurse manager is developing a communication approach for managing the emerging challenge of patients who arrive with continuous physiological monitoring data from consumer wearable devices. A patient presents her smartwatch data showing heart rate variability, oxygen saturation trends, and sleep patterns spanning several months. She requests that the nursing team incorporate this data into her clinical assessment. The data contains patterns the nurse does not know how to interpret within a clinical context. Which response is MOST appropriate?

A. Acknowledge the patient's proactive health monitoring, document the consumer device data as patient-reported health information, communicate to the clinical team that the patient has longitudinal physiological data available, and explain to the patient that consumer device data provides valuable personal trends but differs from clinical-grade monitoring in accuracy and interpretation — incorporating the data as contextual information that enriches the clinical picture without substituting for validated clinical assessment

B. Decline to document consumer device data in the medical record since it was not obtained using validated clinical monitoring equipment

C. Request a physician order for interpreting the consumer device data before incorporating it into the nursing assessment

D. Accept the consumer device data at face value and incorporate it directly into the clinical assessment alongside hospital-monitored data

17. A nurse manager is addressing a communication pattern where nurses routinely omit pertinent negative findings from their assessments and handoff communications. For example, nurses document "lungs clear" and "abdomen soft" but do not communicate that a patient who was previously wheezing now has clear lungs — a clinically significant improvement — or that a patient whose abdomen was distended yesterday now has a soft abdomen. The transition of clinical status is lost because only the current state is communicated, not the trajectory. Which improvement is MOST impactful?

A. Add a "changes since last assessment" section to the documentation template

B. Implement a trend-based documentation requirement that highlights clinical transitions

C. Require nurses to review the previous shift's assessment before conducting their own assessment

D. Train nurses in trajectory-based communication — reporting not just the current state but the clinical direction by framing findings as "improved from," "unchanged from," or "worsened from" the previous assessment — making the rate and direction of clinical change the primary communication rather than a static snapshot, since the trajectory often has greater clinical significance than the current value alone

18. A nurse manager is developing a communication protocol for managing patients who request access to their medical records in real time during hospitalization — not through a patient portal after discharge, but by requesting to review their chart, lab results, and clinical notes as they are written. Under the 21st Century Cures Act, patients have the right to access their electronic health information without delay. However, nurses express concern that patients will misinterpret clinical notes, become anxious about lab values they do not understand, or be offended by clinical language. Which approach MOST effectively manages this tension?

A. Provide patients with access only to portions of their record that are written in patient-friendly language

B. Delay patient access to clinical notes until the attending physician has reviewed and approved each note

C. Support real-time patient access as required by law while implementing proactive communication — informing patients that they can access their records, explaining the context of clinical documentation language, offering to review results together rather than leaving patients to interpret data alone, and training nurses to write notes with the understanding that the patient is a concurrent reader — transforming mandated transparency into a communication quality driver

D. Provide unrestricted access per legal requirements and respond to patient questions when they arise

19. A nurse manager is implementing a communication initiative to reduce the "ask-tell gap" during nurse-patient interactions. Research shows that nurses spend an average of seventy-two percent of patient interaction time providing information (telling) and only eighteen percent asking questions (asking), with the remaining ten percent on non-communication activities. The high tell-to-ask ratio means nurses are delivering information without first understanding what the patient already knows, what concerns them most, or what barriers they face. Which communication technique MOST directly rebalances the ask-tell ratio?

A. Implement a minimum question count of three per patient interaction

B. Train nurses to use the tell-back approach where the nurse provides information and then asks the patient to explain it back

C. Train nurses to lead every clinical interaction with an open-ended assessment question before providing any information — such as "what do you understand about why you're here?" before explaining the diagnosis, or "what concerns you most about going home?" before beginning discharge education — making the asking phase the mandatory starting point that shapes what the nurse subsequently tells, ensuring that the information delivered is responsive to the patient's actual knowledge state and concerns

D. Reduce the volume of information nurses are expected to communicate to patients during each interaction

20. A nurse manager is developing a communication approach for managing the growing number of patients who have designated medical decision-makers through a durable power of attorney for healthcare but have not completed specific advance directives detailing their treatment preferences. The designated decision-maker must make choices without specific guidance from the patient. Decision-makers consistently ask nurses "what would you do?" seeking personal rather than clinical guidance. Which response framework is MOST appropriate?

A. Train nurses to redirect the question from "what would I do?" to "what do you think [patient's name] would want?" — using the substituted judgment standard that asks the decision-maker to consider the patient's known values, preferences, and previously expressed wishes rather than what the nurse or the decision-maker personally prefers, while providing factual clinical information that helps the decision-maker apply those values to the specific medical situation

B. Allow nurses to share their personal perspective since the decision-maker is specifically asking for a human connection rather than clinical guidance

C. Redirect the decision-maker to the attending physician for all treatment decision discussions

D. Provide the decision-maker with a structured decision aid that outlines the benefits, risks, and outcomes of each option

21. A nurse manager is addressing a communication challenge in the neonatal intensive care unit where parents of premature infants receive information from multiple team members — neonatologists, nurse practitioners, bedside nurses, respiratory therapists, lactation consultants, and social workers — who sometimes provide inconsistent or contradictory information. One parent documented receiving five different answers about when their infant would be ready for oral feeding from five different clinicians. Which solution is MOST comprehensive?

A. Designate the neonatologist as the single source of all clinical information communicated to parents

B. Implement a communication board at each bedside that displays the current care plan agreed upon during rounds

C. Implement a daily rounding summary document that the team completes together and shares with parents

D. Implement a unified communication model where the care team aligns messaging during daily rounds using a shared communication board visible to parents at the bedside, each discipline limits parent communication to their specific domain, a designated "communication lead" for each patient

coordinates messages across disciplines, and parents are given a single point of contact for questions that cannot be answered immediately — structuring the information flow so consistency is designed into the system rather than dependent on individual clinician coordination

22. A nurse manager is developing a communication approach for a situation where cultural beliefs about eye contact conflict with clinical communication needs. A patient from a culture where direct eye contact with authority figures is considered disrespectful consistently averts their gaze during nursing assessments. Nurses interpret the lack of eye contact as disengagement, confusion, or pain avoidance, leading to inaccurate clinical assessments. Which intervention is MOST appropriate?

A. Educate the patient about the clinical importance of eye contact during assessments

B. Document the patient's communication style so all nurses are aware of the cultural norm

C. Educate nursing staff that eye contact norms vary significantly across cultures, that averted gaze in some cultural contexts signifies respect rather than disengagement, and that assessment accuracy depends on identifying culturally appropriate behavioral indicators of comprehension, pain, and engagement for each patient — developing cultural fluency rather than applying a single communication standard to all patient populations

D. Assign culturally concordant nursing staff when available to eliminate the communication barrier

23. A nurse manager is implementing a communication-based intervention to reduce unnecessary laboratory testing. Research shows that a significant percentage of laboratory tests ordered in hospitals do not change clinical management — they are ordered by habit, protocol, or defensive practice rather than clinical need. Nurses draw these labs, often waking sleeping patients, causing pain, contributing to hospital-acquired anemia, and consuming nursing time. Which nursing communication role is MOST appropriate in reducing unnecessary testing?

A. Encourage nurses to delay lab draws they believe are unnecessary until they can confirm the order with the physician

B. Provide nurses with authority to cancel laboratory orders they judge to be clinically unnecessary

C. Train nurses to use the teach-back method to verify that patients understand the purpose of each laboratory test

D. Empower nurses to engage in respectful clinical inquiry when a lab order appears routine rather than clinically indicated — asking "I noticed daily CBCs are ordered; is there a specific clinical concern we're monitoring, or can we transition to every-other-day?" — framing the question as collaborative clinical assessment rather than questioning physician authority, and providing data on the patient-level impact of unnecessary phlebotomy including pain, anemia, and sleep disruption

24. A nurse manager is developing a communication strategy for managing patients who refuse nursing care from specific nurses based on the nurse's race, ethnicity, gender, or other protected characteristics. The organization has a zero-tolerance policy for discrimination, but patient autonomy includes the right to refuse care from specific providers. A patient has demanded a "different nurse" after the assigned nurse entered the room, making a racially derogatory comment. The assigned nurse is visibly distressed. Which response is MOST appropriate?

A. Reassign the patient to a different nurse to avoid further distress to the affected nurse and ensure the patient receives care

B. Address the patient directly — calmly stating that discriminatory language is not acceptable, that the hospital provides care without discrimination, and that the assigned nurse is a qualified professional, while informing the patient that reassignment will not be made based on discriminatory requests — and immediately support the affected nurse through acknowledgment, emotional validation, and documentation of the incident through the organization's discrimination reporting process

C. Contact the patient's attending physician and request a physician-to-patient conversation about appropriate behavior

D. Document the incident and report it to hospital administration while providing care through another nurse for the remainder of the shift

25. A nurse manager is implementing a "closing the loop" communication standard for telephone orders. Currently, nurses receiving telephone orders write the order, read it back to the prescriber, and receive verbal confirmation. Despite this read-back process, a fifteen-percent error rate persists in telephone order transcription. Analysis reveals that the errors are not in the read-back itself — nurses read back accurately — but in the initial hearing of the order, where environmental noise, accent differences, and similar-sounding drug names cause misperception that is then accurately read back and confirmed. Which improvement MOST directly addresses the root cause?

A. Add a phonetic spelling requirement for all medication names during telephone orders — where the prescriber spells the medication name using a standardized phonetic alphabet and the nurse confirms each letter — inserting an additional verification layer at the point where the error actually occurs (initial hearing) rather than at the read-back stage where the original misperception has already been incorporated

B. Implement a computerized provider order entry system that eliminates telephone orders entirely

C. Require a second nurse to independently listen to all telephone orders and compare their transcription with the first nurse's

D. Restrict telephone orders to emergent situations only and require all non-emergent orders to be entered electronically by the prescriber

26. A nurse manager is developing a communication approach for managing the transition of adolescent patients from pediatric to adult healthcare services. This transition, typically occurring between ages sixteen and twenty-one, requires the adolescent to develop self-advocacy skills, understand their medical history, manage their own medications, and navigate a healthcare system that is significantly less family-centered than pediatric care. Research shows that transition failures contribute to gaps in care, disease exacerbation, and hospitalization. Which communication element is MOST critical to successful transition?

A. Providing the adolescent with a comprehensive written medical history summary they can share with adult providers

B. Connecting the adolescent with adult providers before the transition so they can build relationships in advance

C. Gradually shifting the primary communication target from the parent to the adolescent over the transition period — beginning with the nurse addressing questions and explanations to the adolescent rather than the parent, coaching the adolescent to describe their own symptoms and communicate clinical needs, building the expectation that the adolescent is the primary healthcare communicator, and progressively reducing parental communication intermediation — developing the self-advocacy skills the adolescent will need when parental presence is no longer the default

D. Providing the adolescent with a structured transition checklist that tracks readiness across key competencies

27. A nurse manager is addressing a communication challenge created by the implementation of a centralized patient monitoring system. Nurses now monitor patients from a central station rather than through individual bedside alarms. While the centralized system improves monitoring coverage, it has created a communication gap — the monitoring technician who observes an alarm must communicate the finding to the bedside nurse, who must then assess the patient and communicate findings back. This communication chain adds time and introduces potential for information degradation. Which improvement is MOST effective?

A. Implement a standardized critical alarm notification protocol that includes: direct electronic notification from the monitoring system to the assigned nurse's mobile device with the specific alarm type and patient identifier, a mandatory verbal acknowledgment from the nurse within sixty seconds, an automatic escalation to the charge nurse if acknowledgment is not received, and clear documentation of the alarm-to-assessment time — compressing the communication chain from technician-to-nurse-to-patient into a direct system-to-nurse-to-patient pathway

B. Return to bedside monitoring systems to eliminate the communication chain entirely

C. Station a nurse at the central monitoring station rather than a technician to improve clinical interpretation of alarms

D. Reduce the number of monitored patients per technician to improve the communication response time

28. A nurse manager is implementing a "trauma-informed communication" approach for the entire unit. Trauma-informed care recognizes that many patients have experienced trauma — including physical abuse, sexual assault, childhood neglect, intimate partner violence, and combat exposure — that affects how they experience healthcare encounters. Common healthcare activities such as being told to undress, lying in vulnerable positions, being touched by strangers, and losing control of daily routines can trigger trauma responses. Which communication element is MOST foundational to trauma-informed care?

A. Screen all patients for trauma history upon admission so nurses can tailor their approach

B. Train nurses in recognizing the behavioral signs of trauma activation during clinical care

C. Provide patients with a written explanation of trauma-informed care practices used on the unit

D. Train nurses to offer choice, control, and predictability in every interaction — asking "is it okay if I..." before touching, explaining what will happen before it happens, offering options about the sequence of care activities, and pausing when the patient shows distress — recognizing that these communication behaviors prevent trauma activation regardless of whether the patient has disclosed a trauma history, making the approach universally therapeutic rather than dependent on screening

29. A nurse manager is developing a communication strategy for managing a patient whose family has created a private social media group to coordinate information sharing among extended family members. The family's designated medical decision-maker posts clinical updates to the group after conversations with the care team. A family member who is not the decision-maker has arrived at the hospital angry, citing information from the social media group that is inaccurate — the decision-maker misunderstood clinical information and posted an incorrect update that alarmed the extended family. Which response is MOST appropriate?

A. Restrict clinical information sharing to the designated decision-maker only and prohibit the decision-maker from sharing information on social media

B. Meet with the concerned family member to correct the misinformation, then meet with the decision-maker to clarify the clinical information they misunderstood and offer to provide written summaries after clinical conversations that the decision-maker can share accurately — addressing both the immediate misinformation and the systemic communication pathway that produced it, without attempting to control the family's internal communication choices

C. Suggest that the family designate a medically knowledgeable family member to serve as the information coordinator

D. Document that the family's social media communication is creating clinical disruption and request a social work consultation

30. A nurse manager is evaluating the unit's nurse-sensitive quality indicators. The NDNQI data shows:

Indicator	Unit Rate	Benchmark	Trend
Falls with injury	1.8/1,000 PD	1.2/1,000 PD	Worsening
CAUTI	0.9/1,000 CD	1.1/1,000 CD	Stable
CLABSI	0.4/1,000 CLD	0.8/1,000 CLD	Improving
Pressure injuries	2.1%	1.8%	Stable
RN satisfaction	62nd %ile	50th %ile	Declining

Which data pattern warrants the MOST urgent investigation?

A. The worsening falls with injury rate combined with the declining RN satisfaction trend — since research demonstrates a direct relationship between nurse engagement and patient safety outcomes, and the simultaneous deterioration of both indicators suggests a common underlying cause such as staffing inadequacy, moral distress, or workload burden that is degrading both the work environment and patient safety simultaneously

B. The falls with injury rate that exceeds benchmark and is worsening

C. The pressure injury rate that exceeds benchmark despite being stable

D. The declining RN satisfaction trend that may predict future quality deterioration across all indicators

31. A nurse manager is implementing an evidence-based fall prevention program. Root cause analysis of the unit's forty-two falls over the past year reveals:

Contributing Factor	Percentage

| Toileting-related | 48% |

| Medication-related (sedatives, opioids, diuretics) | 34% |

| Environmental (wet floors, clutter, poor lighting) | 22% |

| Assessment failure (risk not identified) | 18% |

| Communication failure (risk not communicated) | 12% |

Note: Categories overlap — some falls have multiple contributing factors.

Which intervention targets the LARGEST risk factor?

A. Implement a proactive toileting schedule based on each patient's patterns — assessing elimination patterns, fluid intake timing, and diuretic administration schedules to anticipate toileting needs before the patient attempts to ambulate independently, since forty-eight percent of falls are toileting-related and most occur when patients attempt to reach the bathroom without assistance because they do not want to "bother" the nurse or cannot wait for a response to their call light

B. Conduct a medication review to identify patients on high-risk medication combinations and implement enhanced fall precautions for those patients

C. Address environmental hazards through a standardized room safety checklist completed at the beginning of each shift

D. Improve fall risk assessment accuracy through enhanced screening tool education

32. A nurse manager is evaluating the unit's central line maintenance bundle compliance. The bundle includes four elements: daily assessment of line necessity, standardized dressing changes, hub disinfection with each access, and documentation of insertion site assessment. Overall bundle compliance is reported at eighty-seven percent. However, when individual elements are analyzed:

| Element | Compliance |

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

| Daily necessity assessment | 94% |

| Standardized dressing changes | 89% |

| Hub disinfection | 71% |

| Insertion site documentation | 92% |

Which analysis is MOST important for quality improvement?

A. The eighty-seven percent overall compliance overstates actual bundle practice since a bundle requires ALL elements to be performed together

B. The dressing change compliance at eighty-nine percent should be prioritized since it involves a standardized procedure that should be easier to achieve

C. The insertion site documentation at ninety-two percent suggests this element is well-embedded in nursing workflow

D. Hub disinfection at seventy-one percent is the weakest element and likely the primary contributor to any ongoing CLABSI risk — and because bundle effectiveness depends on all elements being performed together, the seventy-one percent hub disinfection compliance means that true "all-or-none" bundle compliance is significantly lower than the eighty-seven percent average, since at least twenty-nine percent of central line accesses involve a broken bundle regardless of how well the other elements are performed

33. A nurse manager is developing a medication reconciliation improvement project. The current medication reconciliation process occurs at admission, transfer, and discharge. Audit data reveals:

| Transition Point | Reconciliation Completion | Accuracy Rate |

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

| Admission | 96% | 78% |

| Intra-hospital transfer | 72% | 64% |

| Discharge | 91% | 82% |

Which finding represents the GREATEST patient safety risk?

A. The admission accuracy rate of seventy-eight percent, since errors at admission propagate throughout the entire hospitalization

B. The discharge accuracy rate of eighty-two percent, since discharge medication errors directly affect the patient's home medication management

C. The transfer reconciliation completion rate of seventy-two percent combined with a sixty-four percent accuracy rate, creating the highest risk for medication discrepancies during a transition point that receives the least attention

D. Overall, the admission accuracy rate of seventy-eight percent is most concerning because an inaccurate admission medication list becomes the foundation for all subsequent clinical decisions — every dose ordered, every interaction checked, and every discharge medication reconciled is based on the admission list, meaning a twenty-two percent error rate at admission creates a cascading effect that compounds through every subsequent care decision and transition

34. A nurse manager is implementing a patient-controlled analgesia safety improvement project. Analysis of PCA-related adverse events over two years reveals that seventy-eight percent of PCA safety events involve patient sedation — specifically, patients who become over-sedated because the PCA dose is appropriate for their pain but exceeds their opioid tolerance, or because sedating co-medications amplify the PCA opioid effect. Which safety intervention MOST directly addresses the primary risk?

A. Implement a standardized sedation assessment scale — such as the Pasero Opioid-Induced Sedation Scale — with defined assessment frequency, clear escalation thresholds, and nursing authority to pause the PCA infusion when sedation exceeds a defined level without waiting for a physician order, since early detection and intervention for escalating sedation is the most effective prevention of PCA-related respiratory depression

B. Require pharmacy review of all PCA orders for drug interaction screening before PCA activation

C. Implement continuous pulse oximetry monitoring for all patients receiving PCA

D. Restrict PCA use to patients who have demonstrated opioid tolerance through prior medication history

35. A nurse manager is developing a blood transfusion safety improvement initiative. Review of the unit's transfusion near-miss and adverse event data reveals the following:

| Event Type | Count (12 months) |

|---|---|

| Patient identification error at bedside | 8 |

| Wrong blood product selected from storage | 3 |

| Delayed recognition of transfusion reaction | 6 |

| Documentation incomplete | 14 |

Which intervention addresses the MOST dangerous error category?

A. Implement enhanced bedside patient identification verification — requiring two-nurse independent verification of patient identity against the blood product label at the bedside, with each nurse independently comparing the patient's armband information to the blood product tag without relying on the other nurse's verification — since wrong-patient transfusion is the most dangerous blood banking error and can result in fatal hemolytic reactions

B. Redesign the blood product storage and retrieval system to prevent selection errors

C. Develop a standardized transfusion reaction recognition protocol with defined assessment intervals

D. Streamline the transfusion documentation process to improve completion rates

36. A nurse manager is implementing an evidence-based restraint reduction initiative. The unit currently uses physical restraints for twelve percent of patients — primarily for patients who are pulling at medical devices such as endotracheal tubes, nasogastric tubes, and intravenous lines. National benchmarks suggest that restraint use should be below five percent. Staff express concern that reducing restraints will increase unplanned device removal. Which approach is MOST evidence-based?

A. Present evidence that restraint use does NOT significantly reduce unplanned device removal — research consistently shows that restrained patients remove devices at similar or higher rates than unrestrained patients because agitation increases with restraint application, and that alternative interventions including meaningful activity, family presence, re-orientation strategies, and mitts instead of wrist restraints are equally or more effective at preventing device removal while reducing the physical and psychological harm of restraint

B. Reduce restraint use gradually by targeting the least critical device-protection cases first

C. Implement a restraint alternative protocol that provides a menu of evidence-based alternatives nurses must attempt before applying restraints, with documentation of which alternatives were tried and why they were ineffective

D. Reduce the restraint threshold by requiring physician reassessment every four hours instead of every twenty-four hours

37. A nurse manager is evaluating the unit's catheter-associated urinary tract infection prevention bundle. The CAUTI rate has plateaued at 1.4 per 1,000 catheter days despite consistent bundle compliance. The nurse manager suspects that the primary remaining risk factor is catheter DURATION rather than catheter CARE — that the bundle maintains the catheter properly but does not address whether the catheter is still clinically necessary. Assessment reveals an average catheter duration of 5.8

days, compared to a benchmark of 3.2 days. Which intervention is MOST likely to reduce the CAUTI rate below the plateau?

A. Add additional elements to the CAUTI prevention bundle to address remaining care gaps

B. Implement a nurse-driven catheter removal protocol with specific clinical criteria for catheter continuation — shifting the default from "catheter stays until someone orders removal" to "catheter is removed unless it meets defined continuation criteria assessed every shift" — making catheter removal the automatic outcome unless a clinical reason for continuation is actively documented, since every additional catheter day increases CAUTI risk regardless of how well the catheter is maintained

C. Reduce the catheter bundle compliance target from the current level to one hundred percent to eliminate all remaining care gaps

D. Implement a catheter reminder system that notifies the physician daily about each patient's catheter duration and prompts a continuation or removal decision

38. A nurse manager is developing a ventilator-associated event prevention strategy. The unit's VAE rate is 8.2 per 1,000 ventilator days against a benchmark of 5.1. Analysis of contributing factors reveals:

Factor	Contribution
Inadequate oral care	18%
Suboptimal head-of-bed elevation	22%
Excessive sedation depth	35%
Delayed spontaneous breathing trials	25%

Which pair of interventions targets the TWO largest contributing factors?

A. Enhanced oral care protocol combined with head-of-bed elevation monitoring

B. A daily sedation vacation protocol combined with a nurse-driven spontaneous breathing trial protocol — targeting excessive sedation depth (35%) and delayed breathing trials (25%) simultaneously, since both are linked through a common mechanism: excessive sedation prevents the patient from being assessed for breathing trial readiness, and delayed breathing trials extend the ventilator duration that creates the VAE risk window

C. Head-of-bed elevation monitoring combined with a daily sedation vacation protocol

D. Enhanced oral care combined with a nurse-driven spontaneous breathing trial protocol

39. A nurse manager is implementing a Modified Early Warning Score system to improve early detection of clinical deterioration. The MEWS assigns weighted scores to vital sign deviations from normal ranges — respiratory rate, heart rate, systolic blood pressure, temperature, and level of consciousness — with higher aggregate scores indicating greater severity. A MEWS score of five or above triggers a mandatory rapid response assessment. After implementation, the rapid response team reports that forty-two percent of MEWS-triggered activations do not result in clinical intervention. Which interpretation is MOST accurate?

A. The MEWS trigger threshold of five may be too sensitive, activating for patients who are not actually deteriorating

B. The forty-two percent non-intervention rate is expected and acceptable since early warning systems are designed to detect potential deterioration before it becomes clinically obvious

C. A forty-two percent non-intervention rate represents the necessary trade-off of a sensitive early warning system — the MEWS is designed to detect patients who MIGHT be deteriorating, and some of those patients will not progress to actual deterioration, but the clinical value of catching the fifty-eight percent who DO require intervention outweighs the resource cost of evaluating the forty-two percent who do not, and reducing false activations by raising the threshold would risk missing genuinely deteriorating patients

D. The rapid response team should provide clinical intervention for all MEWS-triggered activations to justify the activation

40. A nurse manager is developing a comprehensive approach to managing patients receiving anticoagulation therapy. The unit's anticoagulation-related adverse events over the past year include:

| Event Type | Count |

|---|---|

| Supratherapeutic INR (>4.0) | 22 |

| Bleeding event requiring intervention | 8 |

| Missed dose | 15 |

| Drug-drug interaction not identified | 6 |

| Subtherapeutic INR at discharge | 11 |

Which nursing intervention addresses the MOST common anticoagulation safety concern?

A. Implement a nurse-driven INR monitoring protocol with standardized assessment frequency, defined thresholds for dose-holding and physician notification, dietary education about vitamin K interactions, and a pre-discharge anticoagulation management verification — targeting the supratherapeutic INR events (22) that represent the largest single category and the subtherapeutic INR at discharge (11) that threatens post-discharge safety, since both reflect inadequate ongoing monitoring and management rather than isolated errors

B. Conduct medication reconciliation specifically focused on identifying potential drug-drug interactions with anticoagulants

C. Implement a standardized anticoagulation administration protocol with defined administration windows and missed-dose escalation procedures

D. Develop a patient education program focused on anticoagulation self-management including dietary considerations, bleeding precautions, and INR monitoring

41. A nurse manager is implementing a surgical safety checklist modeled on the WHO Surgical Safety Checklist. The checklist includes three phases: Sign In (before anesthesia), Time Out (before incision), and Sign Out (before leaving the operating room). Compliance audits show ninety-five percent completion for Sign In and Time Out but only sixty-eight percent for Sign Out. Which factor MOST likely explains the Sign Out compliance gap?

A. The Sign Out occurs at the end of the procedure when the team is experiencing task completion psychology — the cognitive shift that occurs when the brain perceives the primary task (surgery) as complete, reducing attention to post-task verification, combined with time pressure to prepare for the next case and physical fatigue from the completed procedure — making the Sign Out the most psychologically vulnerable phase of the checklist despite being equally important for confirming instrument counts, specimen labeling, and post-operative care plans

B. The Sign Out checklist may contain too many elements, creating a compliance burden at the end of the procedure

C. The surgical team may not perceive the Sign Out as adding value to patient safety compared to the more visible Sign In and Time Out phases

D. The circulating nurse who is responsible for initiating the Sign Out may be occupied with post-procedure documentation

42. A nurse manager is developing a specimen labeling safety protocol after three mislabeled specimens were discovered in a single month. Investigation reveals that all three errors occurred when nurses pre-labeled specimen containers before collecting the specimen — filling out the label with the patient's information before drawing the blood or collecting the urine sample. In two cases, the pre-labeled container was then used for a DIFFERENT patient when the nurse was interrupted between labeling and collection. Which safety requirement MOST directly prevents this error mechanism?

A. Require a second nurse to verify the specimen label against the patient's identification before the specimen leaves the unit

B. Mandate that specimen containers may only be labeled at the point of collection — at the patient's bedside, immediately after the specimen is obtained, while the nurse is still with the patient — prohibiting pre-labeling under any circumstances, since the error occurs specifically when labeling is temporally or spatially separated from collection, and the only reliable prevention is making labeling and collection an inseparable paired action

C. Implement a barcode scanning system that links specimen labels to patient armbands electronically

D. Require nurses to confirm patient identity twice — once before collection and once during labeling — using the two-identifier method

43. A nurse manager is evaluating the unit's high-alert medication management practices. The Institute for Safe Medication Practices identifies categories of medications that bear heightened risk of causing significant patient harm when used in error. The unit's high-alert medication error data shows:

| Medication Category | Error Count | Harm Events |

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

| Insulin | 14 | 4 |

| Anticoagulants | 9 | 3 |

| Opioids | 11 | 2 |

| Concentrated electrolytes | 3 | 2 |

| Neuromuscular blocking agents | 1 | 1 |

Which risk assessment principle should guide prioritization?

A. Prioritize insulin since it has the highest absolute error count (14)

B. Prioritize concentrated electrolytes and neuromuscular blocking agents based on the error-to-harm ratio — concentrated electrolytes convert sixty-seven percent of errors to harm events and neuromuscular blocking agents convert one hundred percent, compared to twenty-nine percent for insulin and eighteen percent for opioids — indicating that errors with these medications are disproportionately likely to cause harm when they occur, making them the highest-risk categories per error event even though their absolute error counts are lower

C. Prioritize opioids since they have the second-highest error count and are the most commonly administered high-alert medication category

D. Prioritize all categories equally since any high-alert medication error has the potential for significant harm

44. A nurse manager is developing a patient identification verification protocol for emergency situations — cardiac arrest, rapid response, trauma activation — where the normal two-identifier verification process may be compromised by the urgency of the situation. Staff report that during emergencies, patient identification is often assumed rather than verified because "everyone knows who the patient is" and verification feels like a delay in life-saving treatment. Which approach MOST effectively balances safety with urgency?

A. Integrate patient identification verification into the emergency response protocol as a defined step that occurs simultaneously with other initial actions — assigning a specific team member the verification role during the first thirty seconds of the response, making identification a parallel task that does not delay treatment rather than a sequential step that must be completed before treatment begins

B. Allow patient identification to be deferred during life-threatening emergencies and verified after the patient is stabilized

C. Require two-identifier verification before any medication administration even during emergencies, accepting the brief delay as a necessary safety measure

D. Implement color-coded patient identification wristbands that provide visual verification without requiring a verbal check

45. A nurse manager is implementing an infection prevention strategy for managing patients during hospital construction. Construction activities generate airborne fungal spores — particularly Aspergillus — that can cause fatal invasive infections in immunocompromised patients. The hospital is planning a twelve-month renovation project in the wing adjacent to the oncology unit. Which nursing intervention is MOST critical?

A. Implement an Infection Control Risk Assessment process that evaluates the construction's infection risk based on the type of construction activity, the proximity to patient care areas, and the vulnerability of the patient population — using the ICRA matrix to determine the required containment measures including negative pressure barriers, HEPA filtration, sealed construction barriers, dedicated construction traffic patterns, and enhanced air monitoring — ensuring that the containment level matches the risk level rather than applying a standard containment approach to all construction activities

B. Relocate immunocompromised patients to units furthest from the construction zone for the duration of the project

C. Monitor air quality in the oncology unit daily during construction and implement additional precautions if elevated spore counts are detected

D. Require construction workers to use dedicated entrances and exits that do not pass through patient care areas

46. A nurse manager is developing a safe patient handling program to reduce nursing musculoskeletal injuries. The unit's workers' compensation data shows that patient handling injuries account for sixty-two percent of all nursing injury claims. The most common mechanisms are:

| Mechanism | Percentage |

|---|---|

| Lateral transfers (bed to stretcher) | 34% |

| Repositioning in bed | 28% |

| Assisting ambulation | 22% |

| Lifting from floor after fall | 16% |

Which program element is MOST evidence-based?

A. Provide nursing staff with training in proper body mechanics for patient handling tasks

B. Implement a "no manual lift" policy that provides mechanical lifting equipment for all patient handling activities

C. Require patient handling risk assessments to match the appropriate equipment to each patient's mobility level

D. Implement a comprehensive safe patient handling program that includes mechanical lift equipment for lateral transfers and repositioning, patient mobility assessment algorithms that match handling

equipment to patient needs, a zero-lift policy for patients above a defined weight or dependency threshold, and a culture change component that redefines "asking for help" from weakness to professional practice — recognizing that equipment availability alone does not change behavior without the cultural shift that makes using equipment the expected norm

47. A nurse manager is implementing targeted temperature management for patients following cardiac arrest. The protocol requires maintaining a target temperature of thirty-three to thirty-six degrees Celsius for at least twenty-four hours after return of spontaneous circulation. Nursing management of TTM involves continuous temperature monitoring, shivering assessment and management, hemodynamic monitoring, and electrolyte surveillance. Which nursing competency is MOST critical for TTM success?

A. The ability to initiate and maintain cooling equipment according to the TTM protocol specifications

B. Continuous hemodynamic monitoring during the cooling and rewarming phases since temperature changes can cause significant cardiovascular instability

C. The ability to recognize and manage shivering — which is the body's primary thermoregulatory response to cooling — using the Bedside Shivering Assessment Scale, because uncontrolled shivering increases metabolic demand, raises intracranial pressure, generates heat that counteracts cooling, and causes patient discomfort, making shivering management the difference between therapeutic temperature maintenance and treatment failure

D. Electrolyte monitoring and replacement during cooling since hypothermia causes significant electrolyte shifts including hypokalemia

48. A nurse manager is evaluating the unit's rapid response system effectiveness. Over the past year:

Metric	Value
Total RRT activations	186
Activations resulting in ICU transfer	42 (23%)
Activations resulting in comfort care transition	18 (10%)
Activations resulting in bedside intervention only	126 (67%)
Cardiac arrests preceded by RRT within 6 hours	3
Cardiac arrests NOT preceded by RRT	11

Which metric is MOST concerning?

A. The eleven cardiac arrests not preceded by a rapid response activation — indicating that clinical deterioration progressed to cardiac arrest without being detected by the early warning system, representing failure to rescue events where the rapid response system's primary purpose — intercepting deterioration before it reaches cardiac arrest — was not fulfilled

B. The twenty-three percent ICU transfer rate, which may indicate that the RRT is being activated too late when the patient already requires ICU-level care

C. The sixty-seven percent rate of bedside interventions without ICU transfer, which may indicate over-activation of the rapid response system

D. The ten percent comfort care transition rate, which may indicate that goals-of-care conversations are occurring during crisis rather than proactively

49. A nurse manager is implementing an anticoagulation management improvement initiative. A root cause analysis of the unit's eight bleeding events over the past year identifies the following contributing factors:

| Factor | Frequency |

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

| Failure to hold anticoagulant before procedure | 3 |

| Drug interaction not identified at admission | 2 |

| INR result not acted upon within defined timeframe | 4 |

| Patient education inadequate at discharge | 5 |

Note: Some events had multiple contributing factors.

Which system intervention addresses the MOST actionable root cause?

A. Implement a pharmacy-driven drug interaction screening protocol that flags potential anticoagulant interactions at the point of admission medication reconciliation

B. Develop a comprehensive anticoagulation patient education program for discharge

C. Create a standardized pre-procedure anticoagulant management protocol

D. Implement an automated INR result notification system that sends critical INR values directly to the assigned nurse and prescribing physician with a defined response timeframe and automatic escalation if no action is documented — targeting the most frequently occurring contributing factor (4 events) with a system-level intervention that removes reliance on manual result checking

50. A nurse manager is developing a moderate sedation monitoring protocol for procedures performed at the bedside. Nurses are responsible for monitoring patients who receive moderate sedation from physicians during procedures such as cardioversion, central line insertion, and chest tube placement. The American Society of Anesthesiologists defines moderate sedation as a drug-induced depression of consciousness where patients respond purposefully to verbal or light tactile stimulation. Which monitoring element is MOST critical for patient safety during moderate sedation?

A. Continuous assessment of the patient's level of consciousness using a validated sedation scale, with the ability to recognize the transition from moderate sedation to deep sedation — where the patient loses the ability to respond purposefully and may lose airway protective reflexes — since the primary safety risk of moderate sedation is unintended progression to deeper sedation levels, and the nurse's ability to detect this transition determines whether rescue intervention occurs before respiratory compromise develops

B. Continuous pulse oximetry to detect oxygen desaturation

C. Continuous capnography to detect hypoventilation before oxygen desaturation occurs

D. Pre-procedure assessment of the patient's airway anatomy and sedation risk factors

51. A nurse manager is comparing the effectiveness of two leadership approaches on the unit. The previous nurse manager used a predominantly transactional leadership style — clearly defining expectations, monitoring compliance, and applying rewards and consequences based on performance. The current nurse manager uses a predominantly transformational leadership style — inspiring through shared vision, intellectually stimulating staff, providing individualized consideration, and modeling desired behaviors. Staff report feeling more engaged but some express frustration that "the rules aren't as clear anymore." Which analysis is MOST accurate?

A. The transformational approach is superior to the transactional approach and should completely replace it

B. The previous manager's transactional approach was more appropriate for the unit's needs

C. Staff frustration indicates that the transformational approach needs modification

D. Effective leadership requires BOTH transformational and transactional elements — transformational leadership inspires discretionary effort, innovation, and professional growth, while transactional leadership provides the clear expectations, accountability, and consistency that staff need for operational stability, and the most effective leaders integrate both approaches rather than choosing one exclusively

52. A nurse manager is applying Kotter's 8-Step Change Model to implement a new care delivery model on the unit. The eight steps are: (1) create urgency, (2) form a guiding coalition, (3) create a vision, (4) communicate the vision, (5) empower action, (6) generate short-term wins, (7) consolidate gains, and (8) anchor in culture. The nurse manager has completed steps one through four and is preparing to empower staff to act on the vision. However, the unit's organizational structure includes layers of approval that slow decision-making, and the current scheduling system is incompatible with the new care delivery model. Which action is MOST aligned with Step 5 (empower action)?

A. Accept the structural constraints and work within the current approval and scheduling systems while implementing the new care delivery model

B. Communicate to administration that the structural barriers will prevent the change from succeeding and request organizational support for removing them

C. Implement the new care delivery model on a trial basis within the current structural constraints to demonstrate its value before requesting structural changes

D. Identify and remove the structural barriers that prevent staff from acting on the vision — securing approval process streamlining and scheduling system modification BEFORE asking staff to implement the new model, since Kotter's Step 5 specifically requires leaders to remove systemic obstacles that block the change rather than asking people to change their behavior within a system designed for the old way of working

53. A nurse manager is applying Lewin's three-stage change theory — Unfreezing, Moving, and Refreezing — to address a deeply embedded unit culture of nurses eating at the nursing station. Despite infection control policies prohibiting food in patient care areas, staff have eaten at the nursing station "for years" and view the policy as unreasonable. Previous compliance efforts using signage, reminders, and verbal warnings have all failed. The nurse manager recognizes that the behavior is frozen in unit culture. Which "unfreezing" strategy is MOST effective?

A. Implement consequences for policy violations to create dissatisfaction with the current behavior

B. Present the evidence linking food in patient care areas to contamination risk, share a compelling patient story where a hospital-acquired infection was traced to environmental contamination, and facilitate a staff discussion about the disconnect between their professional commitment to infection

prevention and their personal behavior at the nursing station — creating cognitive dissonance that destabilizes the comfort of the current behavior and opens readiness for change

C. Provide an attractive alternative break space that makes leaving the nursing station for meals more appealing than the current practice

D. Remove all food storage and preparation equipment from the nursing station area

54. A nurse manager is applying complex adaptive systems theory to understand why the unit's quality improvement efforts produce unpredictable results. Complex adaptive systems theory holds that healthcare organizations are not linear, predictable machines but rather dynamic systems composed of interdependent agents who adapt their behavior in response to each other and to the system's changing conditions. Small changes can produce large effects, and large changes can produce minimal effects, depending on system conditions. Which leadership implication is MOST significant?

A. Leaders should implement multiple small experiments simultaneously to increase the probability that at least one will produce the desired result

B. Leaders should focus on controlling the variables they can measure rather than attempting to influence the system's unpredictable dynamics

C. Leaders should gather more data before implementing changes to better predict which interventions will succeed

D. Leaders should shift from trying to control outcomes through linear planning to creating conditions that enable emergence — fostering the relationships, information flows, and shared mental models that allow the system to self-organize toward better outcomes, recognizing that in complex systems, the leader's role is to influence the conditions from which solutions emerge rather than to design and impose solutions

55. A nurse manager is implementing a just culture framework on the unit. Just culture, described by David Marx, distinguishes between three types of behavior that lead to errors: human error (inadvertent action), at-risk behavior (behavioral choice that increases risk, such as taking shortcuts), and reckless behavior (conscious disregard of substantial risk). Each behavior type receives a different organizational response: human error receives consolation, at-risk behavior receives coaching, and reckless behavior receives disciplinary action. A nurse administered insulin to the wrong patient after being interrupted during medication administration. Which just culture analysis is MOST appropriate?

A. Classify the event as human error since the nurse was interrupted and did not intend to administer the medication to the wrong patient

B. Classify the event as at-risk behavior if the nurse chose not to use a barcode medication administration system that was available

C. Classify the event as reckless behavior since wrong-patient medication administration represents a serious safety violation regardless of intent

D. Evaluate the nurse's specific behavioral choices — if she used the barcode system and it malfunctioned, the event is human error; if she chose to skip the barcode verification because she was in a hurry, the event is at-risk behavior; if she knowingly bypassed multiple safety checks despite awareness of the risk, the event approaches reckless behavior — since just culture analysis depends on the behavioral choices made, not on the severity of the outcome

56. A nurse manager is evaluating the unit's readiness for Magnet designation. The Magnet Recognition Program, administered by the ANCC, recognizes healthcare organizations that demonstrate nursing excellence through five model components: Transformational Leadership, Structural Empowerment, Exemplary Professional Practice, New Knowledge/Innovation/Improvements, and Empirical Outcomes. Assessment reveals the unit's strongest component is Exemplary Professional Practice and its weakest is New Knowledge/Innovation/Improvements. Which development strategy is MOST appropriate?

A. Focus resources on strengthening Empirical Outcomes since measurable quality data provides the foundation for all other components

B. Focus resources on developing Structural Empowerment through shared governance since governance structures enable innovation

C. Develop the New Knowledge/Innovation/Improvements component by creating a unit-level nursing research and evidence-based practice program — supporting staff in conducting clinical inquiries, implementing evidence-based practice changes, presenting findings at conferences, and publishing results — building the scholarly practice infrastructure that generates the new knowledge Magnet requires while leveraging the unit's existing strength in Exemplary Professional Practice as the clinical foundation for inquiry

D. Strengthen Transformational Leadership first since leadership quality drives all other Magnet components

57. A nurse manager is developing a shared governance structure for the unit. Shared governance distributes decision-making authority from management to clinical staff through formal council structures. The nurse manager is deciding which decisions should be governed by staff councils and which should remain management decisions. Which principle MOST effectively guides this distinction?

A. Decisions about clinical practice, professional development, and quality improvement should be governed by staff councils, while decisions about budget, personnel actions, and regulatory compliance should remain management decisions — recognizing that shared governance distributes authority over professional practice decisions to the professionals who deliver care, while operational and administrative decisions require management accountability structures that shared governance councils are not designed to provide

B. All decisions affecting nursing practice should be governed by staff councils to maximize professional autonomy

C. Staff councils should begin with advisory authority on low-risk decisions and gradually expand to decision-making authority as governance maturity develops

D. The nurse manager should retain veto authority over all council decisions to ensure organizational alignment

58. A nurse manager is applying the Thomas-Kilmann Conflict Mode Instrument to improve conflict management on the unit. The model identifies five conflict management styles: competing (assertive, uncooperative), collaborating (assertive, cooperative), compromising (moderate assertiveness, moderate cooperation), avoiding (unassertive, uncooperative), and accommodating (unassertive, cooperative). Assessment reveals that the unit's predominant conflict style is avoiding — staff withdraw from disagreements rather than addressing them, creating unresolved tensions that surface later as passive-aggressive behavior. Which intervention is MOST effective?

A. Model and teach collaborative conflict resolution as the preferred approach — demonstrating that conflict addressed directly through mutual problem-solving produces better outcomes than avoidance, creating structured forums for addressing disagreements before they become entrenched, and establishing that professional disagreement expressed respectfully is a valued team behavior rather than a disruptive one — while acknowledging that some situations may genuinely warrant avoidance or accommodation as tactical choices rather than default behaviors

B. Implement a formal conflict resolution process that requires staff to document and address disagreements through a structured mediation process

C. Train staff in all five conflict management styles so they can select the most appropriate style for each situation

D. Identify and address the root cause of avoidance — typically fear of retaliation, cultural norms against confrontation, or past negative experiences with conflict — before teaching alternative approaches

59. A nurse manager is applying French and Raven's five bases of power — legitimate (positional), reward, coercive, expert, and referent (personal) — to analyze the power dynamics on the unit.

Assessment reveals that the nurse manager relies heavily on legitimate and coercive power (formal authority and consequences), while the unit's most influential informal leader derives power primarily from expert and referent sources (clinical expertise and interpersonal respect). Staff comply with the nurse manager's directives but are INSPIRED by the informal leader. Which leadership development priority is MOST important?

A. Develop the nurse manager's legitimate and reward power to strengthen the formal authority base

B. Develop the nurse manager's expert and referent power bases — building clinical credibility through visible expertise and developing interpersonal relationships that generate personal respect — since expert and referent power produce internal motivation and genuine commitment, while legitimate and coercive power produce compliance that disappears when monitoring stops

C. Leverage the informal leader's influence by formally involving them in leadership activities

D. Accept that the nurse manager and informal leader occupy complementary power roles and focus on ensuring their influence is directionally aligned

60. A nurse manager is evaluating the unit's span of control — the number of direct reports a single manager supervises. The current span of control is forty-two FTEs. Research on effective span of control in nursing management suggests that optimal spans range from twenty to forty, depending on factors including the geographic dispersion of the team, the complexity of the work, the experience level of staff, and the availability of intermediate leadership positions such as charge nurses. Which consequence of the excessive span of control is MOST likely to manifest first?

A. Decreased quality outcomes as the manager's attention is spread too thin across too many staff members

B. Increased staff turnover as individual nurses feel unseen and unsupported by a manager who cannot provide adequate individual attention — since the first consequence of excessive span of control is relationship deterioration, and nurses who do not feel personally known and valued by their manager develop weaker organizational attachment, making them more vulnerable to recruitment by competitors or burnout-driven departure

C. Decreased manager effectiveness as the administrative burden of managing forty-two FTEs consumes time that should be devoted to strategic leadership

D. Increased staff conflict as interpersonal issues that would normally be mediated by the manager escalate without intervention

61. A nurse manager is applying emotional intelligence competencies to leadership practice. Daniel Goleman's emotional intelligence framework identifies four domains: self-awareness (recognizing one's

own emotions), self-management (controlling one's emotional responses), social awareness (recognizing others' emotions), and relationship management (using emotional awareness to manage interactions). The nurse manager receives feedback that she is perceived as empathetic and socially aware but ineffective at managing difficult conversations — she accurately reads others' emotions but avoids delivering difficult feedback because she does not want to cause emotional distress. Which emotional intelligence gap is MOST evident?

A. The gap between self-awareness and self-management — the nurse manager recognizes her own discomfort with causing distress but cannot manage that discomfort sufficiently to act on it

B. The gap between social awareness and relationship management — she accurately reads emotional situations but lacks the relational skill to navigate them productively

C. The gap is in relationship management specifically — the ability to use emotional awareness to guide interactions toward productive outcomes, including the ability to deliver difficult feedback in a way that is honest AND compassionate, recognizing that avoiding difficult conversations is not empathy but rather self-protection disguised as concern for others, since genuine empathy includes caring enough about someone's growth to provide feedback they need

D. The gap is in self-awareness — she does not recognize that her avoidance of difficult conversations is driven by her own emotional discomfort rather than genuine concern for the other person

62. A nurse manager is developing a delegation framework for the unit's registered nurses. Research on delegation effectiveness identifies that the most common delegation error is "under-delegation" — RNs performing tasks that could be safely delegated to UAPs, consuming RN time that should be devoted to activities requiring nursing judgment. Staff report that they do not delegate because "it takes longer to explain what I need than to do it myself" and "I can't trust that it will be done right." Which leadership intervention MOST effectively increases appropriate delegation?

A. Provide education on the five rights of delegation — right task, right circumstance, right person, right direction, right supervision — and the legal framework for delegation

B. Address the underlying barriers by providing nurses with efficient delegation communication tools such as standardized task cards that eliminate the need to explain routine delegated tasks each time, implementing UAP competency verification that builds RN confidence in UAP capability, and reframing delegation from "giving away my work" to "managing my practice to focus on what only an RN can do" — making delegation easier, safer, and professionally valued rather than teaching it as a concept that remains difficult to practice

C. Assign specific tasks to UAPs through standing protocols so delegation decisions do not need to be made individually by each RN

D. Implement a delegation audit that tracks RN delegation patterns and provides feedback to nurses who under-delegate

63. A nurse manager is developing a progressive discipline framework for managing staff performance. Progressive discipline follows a structured sequence — verbal counseling, written warning, final written warning, and termination — with each step providing clear expectations and consequences. A nurse has received a verbal counseling for a medication error that resulted from failure to follow the barcode medication administration protocol. Three weeks later, the same nurse makes another medication error involving a different protocol violation — failure to perform an independent double-check for a high-alert medication. Which progressive discipline analysis is MOST appropriate?

A. The second error is a separate, unrelated event that warrants a new verbal counseling specific to the independent double-check failure

B. The second error escalates to a written warning based on the timeline — two medication errors within three weeks demonstrates a pattern regardless of the specific protocol violated

C. Both errors share a common root cause — the nurse's pattern of bypassing medication safety verification steps — making the second error an escalation of the same behavioral pattern rather than an unrelated event, warranting progression to a written warning that addresses the underlying pattern of safety protocol non-compliance rather than the specific protocol violated in each individual event

D. The second error requires investigation before any disciplinary decision — determining whether system factors contributed to both errors before attributing the pattern to individual behavior

64. A nurse manager is applying root cause analysis methodology to investigate a sentinel event — a patient fall with traumatic brain injury. RCA requires identifying ALL contributing factors — not just the proximate cause — and developing system-level solutions. The investigation reveals: the patient's fall risk assessment was not updated after a sedating medication was administered, the bed alarm was turned off by a float nurse who was unfamiliar with the unit's alarm protocol, the patient's call light was out of reach, and the unit's staffing on the shift was two nurses below target. Which RCA finding is MOST important for system-level prevention?

A. The failure to update the fall risk assessment after sedating medication administration, since medication-related fall risk changes occur frequently and a system is needed to trigger reassessment automatically

B. The float nurse's unfamiliarity with the alarm protocol, since orientation gaps for float staff create predictable safety vulnerabilities

C. The staffing deficit that reduced the nursing team's capacity for patient surveillance

D. All four findings are equally important and must be addressed as an integrated system failure — the RCA methodology requires that system-level solutions address EVERY contributing factor identified, since removing any single factor may not have prevented the event given the presence of the other three, and the system's vulnerability lies in the convergence of multiple failures rather than any individual factor

65. A nurse manager is implementing a Plan-Do-Study-Act improvement cycle to reduce the unit's medication administration time. The current average time from medication order to administration is fifty-eight minutes. The target is thirty minutes. The first PDSA cycle tested a new workflow for ten patients and reduced the time to forty-two minutes. Which next step is MOST consistent with PDSA methodology?

A. Implement the new workflow for all patients since it produced a significant improvement

B. Repeat the test with the same intervention on a larger sample to verify the improvement before wider implementation

C. Analyze what specifically produced the sixteen-minute improvement, identify which elements of the new workflow contributed most, refine the intervention based on the analysis, and test the refined intervention in a second PDSA cycle with a slightly larger sample — recognizing that PDSA is an iterative methodology where each cycle builds on the learning of the previous one, refining the intervention through sequential testing rather than implementing after a single successful test

D. Accept the forty-two-minute result and adjust the target to forty minutes since it may be more realistic than the original thirty-minute goal

66. A nurse manager is evaluating the application of Lean methodology principles to the unit's discharge process. Lean methodology, adapted from Toyota manufacturing, focuses on eliminating waste — defined as any activity that does not add value from the customer's perspective. The eight types of waste in Lean are: defects, overproduction, waiting, non-utilized talent, transportation, inventory, motion, and extra processing. Analysis of the discharge process reveals that the average discharge takes four point two hours from physician order to patient departure. Which waste type is MOST commonly found in hospital discharge processes?

A. Waiting — the patient and family waiting for prescriptions to be filled, transportation to arrive, discharge paperwork to be completed, physician signatures, and nursing education to be scheduled — since the majority of the four-point-two-hour discharge time consists of sequential waiting periods between value-added activities rather than the activities themselves, and compressing waiting time through parallel processing produces the largest time reduction

B. Defects — errors in discharge paperwork, prescriptions, and instructions that require rework and delay the process

C. Extra processing — redundant documentation requirements and unnecessary steps in the discharge workflow

D. Motion — nurses traveling between the patient room, nursing station, pharmacy, and other locations to complete discharge activities

67. A nurse manager is applying the Baldrige Performance Excellence Framework to evaluate the unit's overall performance. The Baldrige framework evaluates seven categories: Leadership, Strategy, Customers, Measurement/Analysis/Knowledge Management, Workforce, Operations, and Results. The framework emphasizes ALIGNMENT — the degree to which plans, processes, and measures are consistent across all categories. Assessment reveals strong individual category performance but poor alignment — the unit's stated strategy emphasizes patient-centered care, but the measurement system tracks primarily clinical process metrics, the workforce evaluation system rewards efficiency, and the operational processes are designed for throughput. Which misalignment is MOST damaging?

A. The strategy-measurement misalignment — an organization cannot achieve what it does not measure, and measuring process compliance while pursuing patient-centeredness means the data cannot tell leadership whether the strategy is succeeding

B. The strategy-workforce misalignment — rewarding efficiency while pursuing patient-centeredness creates behavioral incentives that directly conflict with the stated strategic direction

C. The measurement-to-workforce-to-operations misalignment collectively — the system measures process metrics, rewards efficiency, and designs for throughput, creating a reinforcing cycle that drives behavior AWAY from the patient-centered strategy regardless of the strategy's quality, making the misalignment a self-defeating system rather than a collection of individual gaps

D. The strategy-operations misalignment — processes designed for throughput cannot deliver patient-centered care regardless of the strategy, measurement, or workforce alignment

68. A nurse manager is implementing TeamSTEPPS — Team Strategies and Tools to Enhance Performance and Patient Safety — to improve teamwork on the unit. TeamSTEPPS provides an evidence-based framework organized around four core competencies: communication, leadership, situation monitoring, and mutual support. After training, the nurse manager observes that staff consistently use TeamSTEPPS communication tools such as SBAR and CUS but rarely demonstrate mutual support behaviors such as task assistance and feedback. Which barrier MOST likely explains the selective adoption?

A. Communication tools are easier to implement because they provide scripts and structure, while mutual support requires interpersonal risk

B. The TeamSTEPPS training may have emphasized communication tools more than mutual support behaviors

C. Staff may not perceive mutual support as a safety behavior and instead view it as "being nice" rather than a clinical imperative

D. Mutual support behaviors require a foundation of psychological safety that the unit has not yet developed — offering to help a colleague requires vulnerability (admitting you have capacity while they are struggling), and providing feedback requires interpersonal risk (the colleague may react negatively), meaning mutual support adoption depends on a trust environment that communication tools do not require, since using SBAR or CUS follows a protocol while offering help or feedback requires personal judgment and relationship risk

69. A nurse manager is applying Everett Rogers' Diffusion of Innovations theory to understand why a new evidence-based wound care protocol has been adopted by only thirty-eight percent of nursing staff after six months. Rogers identifies five adopter categories: innovators (2.5%), early adopters (13.5%), early majority (34%), late majority (34%), and laggards (16%). The thirty-eight percent adoption rate suggests that the innovation has captured innovators, early adopters, and part of the early majority but has not yet "crossed the chasm" to widespread adoption. Which factor MOST commonly prevents innovations from reaching the early majority?

A. The innovation lacks visible results that demonstrate its superiority over the previous practice

B. The early majority needs time to observe the innovation working successfully before they adopt it

C. The innovation may be too complex to integrate into existing nursing workflow

D. The early majority makes adoption decisions based on peer influence and practical experience rather than evidence or leadership endorsement — they need to see respected colleagues (not innovators, who are seen as risk-takers, but practical, trusted peers) using the innovation successfully in their daily practice before they will adopt it themselves, meaning the nurse manager must identify and support credible peer champions from within the early majority rather than relying on innovators or evidence alone to drive adoption

70. A nurse manager is developing a mentoring program for newly promoted charge nurses. The literature distinguishes between mentoring and coaching: mentoring involves a more experienced person sharing wisdom, career guidance, and professional development support over an extended relationship, while coaching focuses on specific skill development and performance improvement within a defined timeframe. The charge nurses need BOTH — long-term career guidance AND immediate skill development. Which program design is MOST effective?

A. Assign each charge nurse a mentor from the experienced nurse manager pool who provides both mentoring and coaching

B. Implement a dual-support model — pairing each charge nurse with a mentor (an experienced nurse leader outside the unit who provides career guidance, emotional support, and professional perspective) AND a coach (the nurse manager or an experienced charge nurse who provides specific skill development in scheduling, conflict resolution, and clinical leadership through structured practice and feedback) — recognizing that the mentor relationship requires psychological safety that the direct supervisory relationship cannot provide, while coaching requires content expertise and frequent interaction that an external mentor cannot deliver

C. Implement a group mentoring model where newly promoted charge nurses support each other through peer learning

D. Focus exclusively on coaching during the first six months since immediate skill development is more urgent than long-term career guidance

71. A nurse manager is evaluating the unit's organizational culture using Edgar Schein's three levels of culture model: artifacts (visible structures, processes, and behaviors), espoused values (stated beliefs, norms, and strategies), and basic underlying assumptions (deeply embedded, unconscious beliefs that drive behavior). Assessment reveals a significant gap between espoused values and artifacts — the unit espouses "teamwork" as a core value, but observable behaviors include nurses working independently, avoiding collaboration, and expressing frustration when asked to help colleagues. Which level of culture must be addressed to close the gap?

A. Address the artifact level by implementing visible teamwork structures such as team-based assignments and collaborative workflows

B. Reinforce the espoused values through repeated communication, signage, and recognition of teamwork behaviors

C. The gap suggests that the unit's basic underlying assumptions are inconsistent with the espoused teamwork value — staff may hold deep unconscious beliefs such as "I am responsible only for my own patients," "helping others means my own patients suffer," or "asking for help is a sign of weakness" that drive individualistic behavior regardless of what is officially valued, and meaningful culture change requires surfacing and challenging these assumptions rather than working at the artifact or espoused values level

D. Address all three levels simultaneously through a comprehensive culture change initiative

72. A nurse manager is developing a strategy for leading a virtual nursing team — nurses who work remotely and provide care through telehealth platforms, remote patient monitoring, and virtual admission assessments. Virtual team leadership presents unique challenges: leaders cannot observe work

behavior directly, communication is mediated by technology, team cohesion is difficult to build without face-to-face interaction, and social isolation increases burnout risk. Which leadership adaptation is MOST critical?

A. Implement more frequent communication touchpoints than would be needed for an in-person team

B. Establish clear performance metrics and accountability structures for remote work

C. Create virtual social interaction opportunities to build team cohesion

D. Shift from presence-based leadership to outcome-based leadership — replacing physical observation of work behavior with clearly defined performance metrics, outcome measurement, and regular one-on-one check-ins that assess both work quality and personal well-being — while intentionally creating connection through virtual team rituals, recognizing that virtual teams require MORE intentional relationship investment, not less, since the informal relationship-building that occurs naturally in physical proximity must be deliberately designed into the virtual environment

73. A nurse manager is developing a comprehensive approach to managing the unit through a period of organizational restructuring. The organization is eliminating a management layer, which means the nurse manager will absorb responsibility for an additional unit — doubling the number of direct reports from thirty-five to seventy. Research on organizational restructuring shows that middle managers are simultaneously the most affected by restructuring and the most critical to its success, since they translate organizational decisions into operational reality. Which personal leadership action is MOST important?

A. Negotiate for additional support resources such as assistant nurse managers or administrative staff to manage the expanded span of control

B. Develop efficient systems for managing two units simultaneously, such as shared meeting schedules and standardized communication protocols

C. Communicate transparently with both teams about the restructuring timeline and its implications for their daily experience

D. Assess honestly whether the expanded role is sustainable and negotiate the structural support needed to be effective — determining whether adequate intermediate leadership exists on both units, whether the manager's physical presence can be distributed effectively, and whether the organizational support infrastructure will prevent the expanded span from degrading the leadership quality that both teams need — before committing to absorb the additional responsibility without the resources to succeed

74. A nurse manager is applying the concept of "collective bargaining" in a unionized nursing environment. The unit's nurses are represented by a collective bargaining agreement that defines wages, hours, working conditions, and the grievance process. A nurse files a formal grievance stating that the

nurse manager violated the contract by changing the shift rotation schedule without consulting the union representative. The nurse manager was unaware that the specific schedule change required union consultation. Which response is MOST appropriate?

A. Defend the schedule change as a management decision within the nurse manager's operational authority

B. Consult with human resources to determine whether the schedule change violated the contract before responding

C. Acknowledge the potential contract violation, meet with the union representative to discuss the schedule change, and work collaboratively to reach a resolution that satisfies both the contractual obligation and the operational need — demonstrating that the nurse manager respects the collective bargaining process even when the violation was unintentional, since labor-management relationships are built on trust and responsiveness rather than positional defense

D. Reverse the schedule change immediately to demonstrate respect for the collective bargaining agreement

75. A nurse manager is developing a crisis leadership plan for managing the unit during a mass casualty event. Crisis leadership differs from routine leadership in several ways: decisions must be made rapidly with incomplete information, communication must be clear and directive rather than collaborative, and the leader must project calm authority while managing their own stress response. The nurse manager has never managed a mass casualty event. Which preparation activity is MOST valuable?

A. Participating in realistic simulation exercises that place the nurse manager in crisis decision-making scenarios — making rapid decisions with incomplete information, communicating under pressure, managing conflicting priorities, and experiencing the physiological stress response that crisis produces — because crisis leadership competency develops through experiential practice rather than cognitive preparation, and the manager's performance during an actual crisis will rely on behavioral responses developed through simulation rather than knowledge gained through education

B. Reviewing the organization's emergency management plan and the nurse manager's specific role within it

C. Attending a crisis leadership educational program that covers the principles of incident command and emergency management

D. Building relationships with emergency management personnel who will be partners during a crisis event

76. A nurse manager is developing an approach to managing the unit's relationship with a physician who consistently demonstrates disruptive behavior — including demeaning language toward nurses, throwing instruments during procedures, and refusing to respond to nursing calls. Despite multiple incident reports, the physician has not been disciplined because of high revenue generation. Staff are reluctant to work with the physician and several have requested transfers. Which action is MOST appropriate?

A. Document the pattern of disruptive behavior comprehensively and escalate to the chief nursing officer and chief medical officer simultaneously

B. Present the cumulative cost of the physician's behavior — turnover costs for departing nurses, recruitment costs for replacements, agency costs during vacancies, risk management costs for hostile work environment claims, and patient safety event costs attributed to communication breakdown — framing the disruptive behavior as a business liability that exceeds the physician's revenue contribution, since financial arguments often succeed where professional conduct arguments have failed in physician-protected organizational cultures

C. Implement a structured communication protocol that minimizes direct nurse-physician interaction with the disruptive physician

D. Support staff who wish to transfer and recruit replacements who may be more tolerant of the physician's behavior

77. A nurse manager is developing an innovation strategy for the unit. Rogers' Diffusion of Innovations identifies five characteristics that determine whether an innovation will be adopted: relative advantage (better than current practice), compatibility (fits existing values and workflow), complexity (ease of understanding), trialability (can be tested before full commitment), and observability (results are visible). A proposed bedside medication verification system scores high on relative advantage and observability but low on compatibility — it requires significant workflow changes. Which adoption strategy is MOST effective?

A. Redesign the medication verification system to improve compatibility with existing workflow, even if this reduces its relative advantage — since compatibility is the strongest predictor of adoption speed, and a less effective innovation that is actually adopted produces better outcomes than a more effective innovation that is resisted

B. Implement the system as designed and provide intensive training to overcome the compatibility barrier

C. Allow a trial period where nurses can choose between the new system and the current process

D. Mandate the new system and enforce compliance through monitoring and accountability

78. A nurse manager is evaluating the effectiveness of the unit's shared governance program after three years of operation. The program has four councils: Practice, Quality, Education, and Professional Development. Participation data:

Council	Active Members	Attendance	Projects Completed (Year 3)
Practice	12	85%	6
Quality	8	78%	4
Education	6	62%	2
Professional Development	4	48%	1

Which pattern is MOST concerning?

A. The declining participation and productivity across councils from Practice to Professional Development suggests declining organizational commitment

B. The Education Council's low project completion may indicate inadequate scope of authority or resource allocation

C. The Quality Council's eight members may be insufficient for the scope of quality improvement activities needed

D. The Professional Development Council's four members and forty-eight percent attendance indicates the council has lost relevance and may be operating without a clear purpose or meaningful authority — and this decline likely foreshadows a risk to the other councils since shared governance programs that allow individual councils to become performative create precedent for disengagement that spreads across the governance structure

79. A nurse manager is applying the concept of "psychological safety" — defined by Amy Edmondson as the shared belief that the team is safe for interpersonal risk-taking. Psychologically safe teams are more likely to report errors, offer ideas, ask questions, and challenge authority when patient safety requires it. The nurse manager administers a psychological safety survey and discovers that the unit scores in the thirty-second percentile. Which leadership behavior has the GREATEST impact on improving psychological safety?

A. Implement a formal no-retaliation policy for staff who report errors or raise concerns

B. The nurse manager's personal response to vulnerability — specifically, how the manager reacts when a staff member reports an error, asks a "dumb" question, challenges a decision, or admits they do not know something — since psychological safety is built or destroyed in these micro-moments of interpersonal risk, and if the manager responds with curiosity, gratitude, and support, staff learn that vulnerability is safe, while if the manager responds with criticism, dismissal, or punishment, staff learn that vulnerability is dangerous regardless of what any formal policy states

C. Create regular forums such as safety huddles where staff are invited to share concerns and observations

D. Share the psychological safety survey results with the team and collaboratively develop improvement strategies

80. A nurse manager is developing a professional portfolio program for the unit's nursing staff. A professional portfolio documents the nurse's educational background, certifications, continuing education, clinical competencies, leadership activities, professional organization involvement, quality improvement contributions, and career development goals. Unlike a resume which summarizes, a portfolio provides evidence. Which benefit of professional portfolio development is MOST significant for the nurse manager?

A. Professional portfolios shift the responsibility for competency documentation from the manager to the individual nurse — making each nurse accountable for demonstrating their own professional growth, creating a continuous self-assessment habit that identifies development needs before they manifest as performance gaps, and providing objective evidence for performance evaluations, promotion decisions, and credential verification that reduces the subjectivity and potential bias in manager-dependent assessment

B. Professional portfolios provide documentation that can be used during regulatory surveys to demonstrate staff competency

C. Professional portfolios increase nurses' awareness of their professional achievements, building confidence and satisfaction

D. Professional portfolios create a standardized competency documentation format across the unit

81. A nurse manager is implementing a formal nursing peer review process. Peer review is a process by which nurses evaluate the quality of nursing care provided by their peers against established standards of practice. The American Nurses Association endorses peer review as an essential component of professional self-regulation. However, nurses on the unit resist participating in peer review because they "don't want to judge their colleagues" and fear damaging relationships. Which implementation approach MOST effectively addresses the resistance?

A. Mandate peer review participation as a condition of employment and provide training on objective evaluation techniques

B. Implement peer review anonymously so reviewers do not face interpersonal consequences

C. Frame peer review as a LEARNING activity rather than a JUDGMENT activity — emphasizing that peer review's purpose is collective professional growth through structured reflection on practice, that findings are used for system improvement rather than individual discipline, and that the review focuses on practice patterns rather than individual errors — creating a model where being reviewed is a professional development opportunity rather than a threat, and reviewing is an act of professional responsibility rather than an act of judgment

D. Begin with positive peer review where only exemplary practice is reviewed before introducing constructive review

82. A nurse manager is navigating a scope of practice question. An experienced nurse has been performing a clinical procedure that is within the scope of practice in the state where she previously practiced but is NOT explicitly listed in the scope of practice in the current state. The procedure is also not explicitly prohibited. The nurse argues that if it is not prohibited, it is permitted. Which analysis is MOST accurate?

A. The nurse's interpretation is correct — if the procedure is not explicitly prohibited by the state Nurse Practice Act, it is within the scope of practice by default

B. The nurse's interpretation is incorrect — if the procedure is not explicitly authorized by the state Nurse Practice Act, it falls outside the scope of practice and should not be performed

C. The scope of practice question requires formal clarification — the nurse manager should consult the state board of nursing for an advisory opinion on whether the procedure falls within the scope of practice, since the absence of explicit authorization or prohibition creates ambiguity that cannot be resolved by individual interpretation, and practicing outside the defined scope based on personal interpretation exposes both the nurse and the organization to regulatory and liability risk

D. The procedure should be evaluated by the organization's credentialing committee to determine whether it can be authorized through institutional privileging regardless of the state scope of practice question

83. A nurse manager is developing an ethical decision-making framework for the unit. Multiple ethical frameworks exist, including: principlism (applying autonomy, beneficence, non-maleficence, and justice), utilitarianism (maximizing overall good), deontology (following moral rules regardless of consequences), virtue ethics (asking what a virtuous person would do), and care ethics (prioritizing relationships and responsiveness). The nurse manager needs a practical framework staff can apply during clinical ethical dilemmas. Which approach is MOST effective?

A. Select principlism as the unit's standard ethical framework since it is the most widely used in healthcare ethics

B. Train staff in all five ethical frameworks and allow them to select the most appropriate framework for each situation

C. Develop a simple ethical decision-making algorithm that guides staff through identification of the ethical issue, gathering of relevant facts, consideration of stakeholders, application of ethical principles, evaluation of options, and selection and justification of the chosen action

D. Implement a structured ethical reasoning process that teaches staff to apply multiple ethical lenses to the same dilemma — asking "which principles apply?" (principlism), "which option produces the most good?" (utilitarianism), "what duties do we have?" (deontology), "what would a morally exemplary nurse do?" (virtue), and "what does the relationship require?" (care) — recognizing that complex ethical dilemmas rarely yield to a single framework, and the quality of ethical reasoning depends on examining the situation from multiple perspectives before reaching a decision

84. A nurse manager is addressing the professional implications of a nurse who has been identified as an "impaired practitioner" — a nurse who is unable to practice safely due to substance use disorder. The nurse's performance has deteriorated over several months: increased absenteeism, medication documentation discrepancies, patient complaints about reduced attentiveness, and a recent event where a colleague noted that the nurse appeared physically impaired during a shift. The state has an alternative-to-discipline program that allows impaired nurses to receive treatment while retaining their license under monitored conditions. Which action sequence is MOST appropriate?

A. Confront the nurse directly about the suspected impairment and offer to help her access treatment resources

B. Document the performance concerns, meet with the nurse privately to discuss the observed behaviors using specific factual examples rather than accusations, communicate the organizational resources available including the state's alternative-to-discipline program, ensure the nurse is removed from patient care immediately if impairment is suspected during a shift, and follow organizational policy for reporting to the state board while supporting the nurse's access to treatment — balancing the immediate patient safety obligation with the professional and humane obligation to support a colleague through a medical condition

C. Report the nurse to the state board of nursing immediately since impaired practice is a mandatory reporting obligation

D. Conduct an investigation to confirm the impairment before taking any action, since premature intervention based on suspicion could damage the nurse's career if the suspicion is unfounded

85. A nurse manager is developing a professional development strategy for promoting lifelong learning on the unit. Assessment reveals that nurses who have been in practice for more than ten years are significantly less likely to pursue continuing education beyond the minimum required for licensure renewal. These experienced nurses report that continuing education offerings are "too basic," "don't teach me anything new," and "aren't worth my time." Which strategy MOST effectively re-engages experienced nurses in lifelong learning?

A. Provide experienced nurses with advanced learning opportunities matched to their expertise level — clinical specialty conferences, leadership development programs, evidence-based practice research participation, teaching and mentoring roles, and scholarly writing opportunities — recognizing that the barrier is not resistance to learning but resistance to learning experiences designed for a lower expertise level, and that experienced nurses re-engage when the learning challenges them at their current capability rather than reviewing foundational content they mastered years ago

B. Implement a mandatory annual competency assessment that identifies knowledge gaps experienced nurses may not recognize

C. Create a financial incentive program that rewards continuing education beyond the licensure minimum

D. Assign experienced nurses as preceptors for new staff, leveraging their expertise to benefit others while indirectly promoting their own learning through the teaching process

86. A nurse manager is developing guidelines for managing the professional implications of interprofessional conflict. A physician and a nurse disagree about a patient's plan of care — the physician has ordered aggressive treatment for a patient the nurse believes should transition to comfort care based on the patient's previously expressed wishes. The nurse has communicated her concern through appropriate channels and the physician has acknowledged the concern but maintained the treatment plan. The patient's family supports the physician's aggressive approach. Which professional action is MOST appropriate for the nurse?

A. Accept the physician's decision since the physician has final medical decision-making authority and the family concurs

B. Escalate through the chain of command — notifying the nurse manager and requesting an ethics consultation — since the nurse has a professional obligation to advocate for the patient's expressed wishes even when the physician and family disagree, recognizing that the patient's previously expressed wishes are the primary ethical consideration and that the nurse's advocacy responsibility does not end when the initial communication is acknowledged but unresolved

C. Document the disagreement in the medical record and continue providing care as ordered

D. Discuss the situation with the patient's previously designated healthcare decision-maker if different from the current family spokesperson

87. A nurse manager is addressing a professional ethics situation involving a nurse who has discovered that a colleague has been falsifying medication administration documentation — charting that medications were administered when they were not. The nurse is reluctant to report the colleague because they are close friends and the nurse fears destroying the relationship. The nurse asks the manager for advice on how to handle the situation. Which guidance is MOST appropriate?

A. Advise the nurse that reporting is optional and suggest she speak with the colleague directly before deciding whether to report

B. Explain that the professional obligation to report is non-negotiable — the ANA Code of Ethics requires nurses to take action when a colleague's practice places patients at risk, and falsifying medication documentation represents both a patient safety risk and a professional conduct violation that the nurse has an ethical duty to report regardless of the personal relationship, while acknowledging that the situation is personally painful and offering support for the nurse's emotional response to the reporting obligation

C. Report the falsification herself as the nurse manager so the reporting nurse does not have to bear the personal consequences

D. Investigate the alleged falsification independently before requiring the nurse to report, to verify the claim before acting on it

88. A nurse manager is developing a unit-level approach to addressing social determinants of health in nursing practice. Social determinants — including income, education, housing, food access, transportation, and social support — significantly affect patient health outcomes and readmission risk. Nursing assessment traditionally focuses on clinical factors, but research shows that unaddressed social determinants are the primary driver of preventable readmissions for many patient populations. Which integration approach is MOST practical?

A. Train nursing staff to conduct comprehensive social determinants assessments for all patients

B. Hire a dedicated social worker for the unit to manage all social determinants screening and intervention

C. Integrate brief, validated social determinants screening questions into the nursing admission assessment — asking targeted questions about food security, housing stability, transportation access, and social support — with defined referral pathways that connect positive screens to community resources, making social determinants assessment a standard nursing function that identifies vulnerability early

enough for intervention rather than discovering social barriers at discharge when they become readmission drivers

D. Focus nursing assessment on clinical factors and defer social determinants assessment to case management and social work

89. A nurse manager is developing a professional approach to managing the intersection of personal religious beliefs and professional nursing practice. A nurse requests an accommodation to avoid caring for patients undergoing elective pregnancy termination procedures, citing religious beliefs that conflict with the procedure. The state has a conscience clause that permits healthcare providers to refuse participation in certain procedures based on religious or moral objections. However, the unit routinely admits patients recovering from these procedures. Which approach MOST appropriately balances the competing interests?

A. Grant the accommodation without restriction since the conscience clause legally protects the nurse's right to refuse

B. Deny the accommodation since the nurse accepted a position on a unit that admits these patients and should have anticipated the conflict

C. Grant the accommodation with defined parameters — ensuring that the nurse's religious beliefs are respected while the accommodation does not create an undue burden on colleagues who must assume additional assignments, does not delay or compromise patient care, and is documented through a formal accommodation process — establishing that professional obligation and personal conviction can be balanced through structured accommodation rather than forced choice

D. Transfer the nurse to a unit where the conflict does not arise

90. A nurse manager is developing a comprehensive approach to promoting cultural humility rather than cultural competence in nursing practice. Cultural competence implies achieving mastery of cultural knowledge, while cultural humility recognizes that cultural understanding is an ongoing, never-completed process of self-reflection, learning, and openness. Assessment reveals that nurses who attended cultural competence training sometimes apply cultural generalizations stereotypically — assuming that all members of a cultural group share the same beliefs and practices. Which approach MOST effectively promotes cultural humility?

A. Provide more detailed cultural competence training that addresses intra-cultural variation and the danger of cultural stereotyping

B. Replace cultural knowledge education with a reflective practice approach that focuses on self-awareness — helping nurses recognize their own cultural assumptions, understand how their cultural

lens shapes clinical assessment, develop comfort with cultural uncertainty, and approach each patient as a cultural individual rather than a cultural representative — building the habit of asking "what is important to YOU?" rather than assuming cultural norms based on demographic category

C. Assign culturally concordant nursing staff whenever possible to reduce the need for cross-cultural clinical interactions

D. Implement a cultural liaison program where designated nurses serve as cultural resources for specific patient populations

91. A nurse manager is addressing a situation where a nurse has been offered a financial incentive by a medical device company to recommend their product to colleagues and patients. The nurse reports the offer to the nurse manager because she is "not sure if it's okay." The device is clinically effective and used on the unit. Which professional analysis is MOST important?

A. Determine whether the organization has a conflict-of-interest policy that addresses vendor relationships with clinical staff

B. Evaluate whether the device is clinically effective and whether the nurse's recommendation would benefit patients regardless of the incentive

C. Report the vendor's offer to the organization's compliance department

D. The financial incentive creates a conflict of interest that compromises the nurse's professional objectivity — even if the device is clinically excellent, accepting payment to recommend it transforms the recommendation from a professional clinical judgment to a commercial endorsement, violating the professional obligation to act in the patient's interest rather than personal financial interest, and the offer itself should be reported to compliance regardless of whether the nurse intends to accept it

92. A nurse manager is developing guidelines for managing nurses who wish to participate in professional advocacy activities — such as lobbying legislators, participating in public demonstrations, writing opinion articles, or testifying before legislative committees — on issues that may be controversial. Some nurses want to advocate for healthcare policy positions that align with their professional values but conflict with the organization's political stance. Which guidance is MOST appropriate?

A. Prohibit nurses from engaging in political advocacy that conflicts with the organization's position

B. Allow nurses to participate in advocacy activities only during non-work hours and without identifying their organizational affiliation

C. Support nurses' professional advocacy as a component of nursing's professional obligation to influence health policy — providing guidance on distinguishing between personal advocacy (where the nurse speaks as an individual citizen) and organizational representation (where the nurse speaks on behalf of the organization), clarifying that nurses have the right to advocate for health policy positions even when those positions differ from the organization's stance, as long as they do not misrepresent their advocacy as the organization's position

D. Defer to the organization's government relations department for all political advocacy activities

93. A nurse manager is developing a comprehensive approach to managing professional development for a nurse who has expressed interest in pursuing advanced practice education. The nurse is an excellent bedside clinician with five years of experience. The organization offers tuition assistance for advanced education. However, completing an advanced practice program means the nurse will likely leave the bedside role — either leaving the organization for an NP position elsewhere or transitioning to a different role within the organization. Which strategic calculation should guide the nurse manager's recommendation?

A. Recommend against organizational tuition support since the investment will not benefit the current unit

B. Support the nurse's advanced practice education through organizational tuition assistance — recognizing that developing an excellent bedside nurse into an advanced practice provider benefits the profession, the organization (if the NP remains), and the nurse's career development, and that managers who are known for supporting professional growth attract and retain stronger candidates than managers who prioritize unit-level retention over individual development — accepting the potential loss of a strong bedside nurse as the cost of being a development-oriented leader

C. Support the education if the nurse signs a retention commitment to remain with the organization for a defined period after completing the program

D. Recommend the nurse pursue the education independently and reapply for organizational tuition support when advanced practice positions are available within the organization

94. A nurse manager is addressing a professional development situation where a nurse has achieved clinical expertise in a narrow specialty area but has limited knowledge outside that specialty. The nurse is recognized as the unit's expert in cardiac rhythm interpretation but demonstrates knowledge gaps in wound care, diabetes management, and respiratory assessment — areas that are within the expected competency of all nurses on the medical-surgical unit. When assigned patients outside her specialty, the nurse's care quality declines measurably. Which professional development approach is MOST appropriate?

A. Allow the nurse to specialize by assigning her primarily cardiac patients and distributing non-cardiac patients to other staff

B. Provide targeted competency development in the identified gap areas while acknowledging and leveraging the nurse's cardiac expertise

C. Implement a formal competency remediation plan that addresses the knowledge gaps as a performance deficiency

D. Develop a comprehensive plan that addresses both the specialty depth and the generalist breadth — expanding the nurse's competency in wound care, diabetes, and respiratory assessment through targeted education and mentored practice while structuring her cardiac expertise as a unit resource through peer education, protocol development, and consultation, so that her specialty strength is leveraged rather than isolated and her generalist gaps are closed through development rather than accommodation or remediation

95. A nurse manager is evaluating the professional implications of a nurse who has been identified as a whistleblower — reporting patient safety concerns to an external regulatory agency after internal reporting channels failed to produce action. The nurse reported persistent staffing inadequacies and their impact on patient safety to the state health department after six months of internal reports to the nurse manager, director, and chief nursing officer produced no change. The state health department has initiated a facility investigation. Organizational leadership is angry about the external report. Which professional principle is MOST important?

A. The nurse followed the appropriate escalation sequence and is protected by whistleblower statutes

B. Organizational leadership's anger is understandable but should not result in retaliation against the nurse

C. The investigation may identify legitimate concerns that benefit the organization's improvement despite the uncomfortable process

D. The nurse exercised professional advocacy when internal channels failed — the ANA Code of Ethics establishes the nurse's obligation to advocate for patient safety, and when organizational channels are exhausted without resolution, external reporting becomes not just a right but a professional obligation, and any retaliatory action against the nurse would violate both legal whistleblower protections and the professional principle that safety advocacy must be supported even when organizationally uncomfortable

96. A nurse manager is developing the unit's annual operating budget. The operating budget consists of two major components: revenue projections and expense projections. On the expense side, labor costs typically represent sixty to seventy percent of total operating expenses for a nursing unit. The nurse manager must calculate the labor budget based on projected patient volume, target HPPD, and staffing

mix. Projected average daily census: 24. Target HPPD: 8.2. Skill mix: 70% RN, 30% ancillary. Average RN hourly rate (loaded): $52. Average ancillary hourly rate (loaded): $28. Which calculation produces the annual RN labor budget?

A. 24 patients × 8.2 HPPD × 365 days = 71,832 total care hours × 0.70 RN mix = 50,282 RN hours × $52/hr = $2,614,664 — but this represents PRODUCTIVE hours only and must be adjusted upward by approximately 1.14 (non-productive time factor for PTO, sick, education) to determine total PAID hours

B. 24 × 8.2 × 365 × 0.70 × $52 = $2,614,664 with no further adjustment needed

C. Calculate RN FTEs first (50,282 hours ÷ 2,080 hours/FTE = 24.2 RN FTEs), then multiply by average annual RN salary including benefits

D. 24 × 8.2 × 0.70 × $52 × 365 = $2,614,664, then divide by 2,080 to determine the number of FTEs required

97. A nurse manager is developing a capital budget request for new cardiac monitors. Capital expenditures are defined as purchases that exceed a defined dollar threshold (typically $5,000-$10,000), have a useful life exceeding one year, and are not consumable supplies. The current cardiac monitors are eight years old, have a projected remaining useful life of two years, and experience increasing maintenance costs. Replacement monitors cost $12,000 each. The unit needs sixteen monitors. Total capital request: $192,000. Which capital budget justification element is MOST persuasive to the finance committee?

A. The clinical superiority of the new monitors compared to the aging current equipment

B. The total cost of ownership comparison — demonstrating that the current monitors' escalating maintenance costs ($38,000 last year, projected $52,000 next year, projected $68,000 in year two) combined with the risk of complete failure requiring emergency replacement at premium pricing makes planned replacement at $192,000 less expensive than continuing to maintain aging equipment that will need replacement within two years regardless, framing the capital investment as cost avoidance rather than new spending

C. The patient safety risk created by aging monitors with declining reliability and outdated alarm algorithms

D. The opportunity to standardize monitoring equipment across units, reducing training complexity and improving interoperability

98. A nurse manager is analyzing the unit's productivity using HPPD as the primary metric. Monthly data:

| Month | ADC | Actual HPPD | Target HPPD | Variance |

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

| Jan | 26 | 8.8 | 8.2 | +0.6 |

| Feb | 22 | 9.4 | 8.2 | +1.2 |

| Mar | 28 | 8.1 | 8.2 | -0.1 |

| Apr | 24 | 8.5 | 8.2 | +0.3 |

| May | 20 | 10.2 | 8.2 | +2.0 |

| Jun | 27 | 8.3 | 8.2 | +0.1 |

Which pattern is MOST actionable?

A. The overall trend of consistently exceeding HPPD targets suggests systematic overstaffing

B. The inverse relationship between ADC and HPPD variance — February (ADC 22, +1.2 variance) and May (ADC 20, +2.0 variance) versus March (ADC 28, -0.1 variance) and June (ADC 27, +0.1 variance) — reveals that the staffing model does not flex effectively with census changes, maintaining relatively fixed staffing levels regardless of patient volume, and the largest productivity losses occur during low-census periods where staff are not being flexed proportionally

C. March shows a negative variance suggesting potential understaffing that should be investigated for quality impact

D. The data requires acuity-adjusted analysis before any conclusions can be drawn since HPPD alone does not account for patient complexity variations

99. A nurse manager is evaluating the financial impact of implementing a nurse-driven early mobility program. The program requires additional physical therapy consultation ($35,000/year), mobility equipment ($18,000 initial investment), and nursing education time ($8,000). Expected benefits based on published evidence:

| Benefit | Projected Impact |

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

| LOS reduction | 0.4 days average |

| ICU transfer prevention | 6 patients/year |

| Fall rate | No significant change expected |

| VTE prevention | 4 events/year |

| Patient satisfaction | 3-5 percentile improvement |

Annual patient volume: 1,800. Average cost per patient day: $1,850. Average ICU day cost: $4,200. Average VTE treatment cost: $18,500.

Which ROI calculation is MOST comprehensive?

A. LOS reduction savings: 1,800 × 0.4 days × $1,850 = $1,332,000 annually — a figure so large it alone justifies the program

B. LOS reduction savings need adjustment — the $1,850/day represents average cost, but marginal cost of the last day is typically thirty to forty percent of average cost since fixed overhead is already absorbed

C. ICU transfer prevention: 6 × ($4,200 - $1,850) × average ICU LOS = substantial savings

D. The comprehensive calculation must use MARGINAL cost for LOS reduction (approximately $555-$740 per avoided day rather than the full $1,850 average, producing $399,600-$532,800 in LOS savings), PLUS ICU transfer prevention savings (6 patients × differential cost × average ICU stay), PLUS VTE prevention savings (4 × $18,500 = $74,000), against total program cost ($35,000 + $8,000 annual + amortized equipment) — and the marginal cost adjustment is the critical analytical distinction that determines whether the ROI projection is credible or inflated

100. A nurse manager is developing a supply chain cost management strategy. The unit's supply costs have increased fourteen percent year-over-year while patient volume increased only three percent. Analysis reveals:

| Supply Category | Cost Increase | Volume-Adjusted Increase |

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

| Wound care supplies | 22% | 19% |

| IV supplies | 8% | 5% |

| Personal protective equipment | 18% | 15% |

| Medications (unit stock) | 11% | 8% |

| General medical supplies | 9% | 6% |

Which cost management strategy is MOST appropriate?

A. Implement across-the-board supply reduction targets for all categories

B. Focus cost reduction efforts on the two highest-volume categories since they likely represent the largest absolute dollar amounts

C. Prioritize investigation of wound care supplies (19% volume-adjusted increase) and PPE (15% volume-adjusted increase) since their cost increases significantly exceed volume-driven growth, suggesting either price increases, utilization changes, waste, or practice variation that can be managed — while accepting that some IV and medication cost growth reflects market pricing trends beyond the unit's control

D. Request pharmacy review of the medication cost increase since drug pricing trends may offer formulary optimization opportunities

101. A nurse manager is developing a revenue cycle management improvement project. Revenue cycle management encompasses all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue. Charge capture audits reveal that the unit consistently fails to capture charges for:

| Service | Missed Charge Rate | Estimated Annual Revenue Loss |

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

| Wound VAC changes | 34% | $68,000 |

| Blood glucose monitoring | 28% | $22,000 |

| Specimen collection | 42% | $31,000 |

| Patient education sessions | 56% | $45,000 |

Which root cause is MOST likely driving the overall charge capture deficit?

A. Nurses view charge capture as a billing function rather than a clinical documentation responsibility — they do not connect their clinical activities to revenue generation and do not perceive charge capture

as part of their professional role, creating a systematic gap between services provided and services billed that represents lost revenue the unit has already earned through clinical care delivery

B. The EHR charge capture interface may be cumbersome, creating workflow barriers that discourage compliance

C. Staffing levels may not allow adequate time for charge capture documentation

D. Nurses may not know which services are billable and which are bundled into the room rate

102. A nurse manager is analyzing the impact of case mix index on the unit's financial performance. Case mix index is a measure of the average complexity of patients treated, with higher CMI indicating more complex patients who generate higher DRG reimbursement but also consume more resources. The unit's CMI has increased from 1.42 to 1.68 over two years. Which financial implication is MOST important?

A. Higher CMI generates proportionally higher DRG reimbursement that should improve the unit's revenue position

B. Higher CMI may indicate more accurate documentation and coding rather than a genuine increase in patient complexity

C. Higher CMI increases the unit's eligibility for additional resource allocation in the budget process

D. The nurse manager must determine whether the increased revenue from higher CMI is being offset by proportionally higher costs — since more complex patients require more nursing hours, more supplies, longer lengths of stay, and more ancillary services, and the unit's financial performance depends on whether the higher reimbursement exceeds the higher costs, not simply on the direction of the CMI change

103. A nurse manager is developing a cost-benefit analysis for implementing a patient rounding technology — a mobile application that prompts and tracks intentional hourly rounding. The technology costs $24,000 annually. Expected benefits include fall reduction, call light reduction, and patient satisfaction improvement. Which analytical approach MOST credibly demonstrates value?

A. Project the financial benefit of preventing falls using the average cost per fall with injury ($14,000) and the expected fall reduction percentage

B. Calculate the total value of all expected benefits including fall reduction, call light reduction (nurse time savings), and patient satisfaction improvement (VBP revenue impact)

C. Present a conservative analysis using ONLY the most quantifiable benefit — fall reduction — calculating the break-even point (number of prevented falls needed to offset $24,000 cost = 1.7 falls with injury annually) and comparing to the current fall rate to determine the required percentage reduction, then adding call light reduction and satisfaction improvement as supplementary but unquantified benefits — since a credible business case rests on conservative projections of the most measurable outcome rather than optimistic projections across multiple uncertain variables

D. Benchmark against facilities that have implemented similar technology and use their published outcome data as the projected benefit

104. A nurse manager is developing a strategic plan for the unit using SWOT analysis — identifying Strengths, Weaknesses, Opportunities, and Threats. The completed SWOT reveals:

Strengths: High clinical expertise, strong team cohesion, excellent patient satisfaction

Weaknesses: Aging physical plant, limited technology adoption, high overtime usage

Opportunities: New physician group joining, value-based payment expansion, community health partnership

Threats: Competing facility opened nearby, nursing workforce shortage, declining reimbursement rates

Which strategic insight from the SWOT is MOST actionable?

A. The combination of the strength (high clinical expertise, excellent satisfaction) with the opportunity (new physician group joining) creates a growth strategy — the unit's clinical reputation and patient experience quality can attract the new physician group's patient volume, leveraging existing strength to capture new revenue, while the weakness (aging physical plant) combined with the threat (competing facility) creates an urgent improvement priority since the new competitor likely offers a modern environment that the unit's aging facility cannot match

B. The weakness of high overtime usage should be addressed immediately since it affects both expenses and staff well-being

C. The threat of a competing facility should be the primary strategic focus since market share loss directly impacts financial viability

D. The opportunity for value-based payment expansion should drive the strategic plan since it represents the future of healthcare reimbursement

105. A nurse manager is developing a marketing strategy for the unit's clinical services. Healthcare marketing differs from consumer marketing in several ways: the "customer" includes patients, families, physicians, and insurers; the "product" is a clinical service that patients cannot evaluate before experiencing; and trust is the primary purchase driver. The unit has developed a specialized heart failure management program that significantly reduces readmission rates. Which marketing approach is MOST effective?

A. Advertise the program directly to consumers through community health education events and digital marketing

B. Focus marketing on referring physicians since they are the primary referral source for heart failure patients

C. Market the program to payers and insurers first — demonstrating the readmission reduction data and total cost of care impact — since payers influence patient volume through network design, preferred provider designations, and value-based referral incentives, and a program that demonstrably reduces total cost of care can attract contractual volume from payers seeking to manage their heart failure population costs, generating a more sustainable patient pipeline than consumer advertising

D. Publish the program's outcomes in peer-reviewed literature to build evidence-based credibility that attracts both referrals and payer interest

106. A nurse manager is evaluating the financial impact of the unit's workers' compensation claims. Over the past three years:

Year	Claims	Total Cost	Lost Work Days
Year 1	8	$124,000	186
Year 2	11	$168,000	244
Year 3	14	$215,000	318

The worsening trend represents both a financial and operational concern. The most common injury types are patient handling (58%), slips/trips/falls (22%), and needle sticks (12%). Which financial analysis provides the STRONGEST justification for a prevention investment?

A. Project the Year 4 trajectory at the current growth rate and demonstrate the escalating financial burden

B. Calculate the fully loaded cost of the lost work days including replacement staffing (agency and overtime costs), productivity loss during return-to-work transitions, and the insurance premium increases triggered by the worsening experience modification rate

C. The total direct cost ($215,000 in Year 3) represents only a fraction of the true financial impact — adding indirect costs including replacement staffing for 318 lost work days (approximately $127,200 at agency rates), administrative time for claims management, modified duty productivity loss, insurance premium increases (typically 25-40% of direct costs), and staff morale/retention impact estimates the true cost at $430,000-$520,000, making a $75,000-$100,000 safe patient handling equipment investment easily justifiable against the annualized total cost trend

D. Compare the unit's workers' compensation costs per FTE to organizational and industry benchmarks to demonstrate the severity of the problem

107. A nurse manager is developing a patient throughput optimization strategy. Current throughput data:

| Metric | Current | Benchmark |

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

| Admission time (ED order to floor) | 78 min | 45 min |

| Discharge time (order to departure) | 4.2 hrs | 2.5 hrs |

| Transfer time (order to receiving unit) | 52 min | 30 min |

| Bed turnaround (departure to next admission) | 88 min | 45 min |

Which throughput bottleneck has the GREATEST financial impact?

A. The discharge time gap (4.2 hours vs. 2.5 hours benchmark) has the greatest financial impact because delayed discharges hold beds that could admit revenue-generating patients, and the 1.7-hour excess multiplied across the unit's daily discharge volume creates cumulative bed-hours of lost capacity that directly translates to deferred admissions and lost revenue — making discharge optimization the highest-value throughput intervention

B. The admission time gap directly affects ED boarding costs and patient safety

C. The bed turnaround time affects the unit's ability to accept new patients throughout the day

D. All four metrics should be addressed simultaneously through a comprehensive throughput improvement initiative

108. A nurse manager is analyzing the unit's overtime utilization patterns:

Overtime Category	Percentage	Annual Cost
Planned overtime (known vacancies)	42%	$148,000
Unplanned overtime (call-ins, census surges)	35%	$123,000
Incidental overtime (shift extension)	23%	$81,000

Total annual overtime: $352,000. Overtime as percentage of total labor budget: 11.2% (benchmark: 4-6%).

Which overtime category offers the MOST manageable reduction opportunity?

A. Unplanned overtime through improved staffing contingency planning

B. Incidental overtime through workflow optimization and on-time shift completion initiatives

C. Planned overtime through vacancy management — accelerated recruitment, improved retention, and float pool utilization

D. Planned overtime at forty-two percent of total overtime ($148,000) represents the most manageable reduction opportunity because it results from known vacancies — a predictable, chronic condition that can be addressed through structural solutions including accelerated recruitment timelines, improved retention strategies to reduce vacancy creation, expanded float pool access, and strategic use of per diem staff — since planned overtime is the only category where the cause is known in advance and can be systematically eliminated rather than reactively managed

109. A nurse manager is developing a financial dashboard for the unit. An effective financial dashboard displays the most critical financial metrics in a format that enables rapid assessment of financial performance and early identification of trends requiring intervention. The nurse manager must select six to eight metrics from a list of twenty available financial indicators. Which selection principle is MOST important?

A. Select metrics that represent the key financial drivers the nurse manager can directly influence — including labor productivity (HPPD), labor cost per patient day, overtime percentage, agency utilization, supply cost per patient day, and revenue per patient day — creating a dashboard where every metric

connects to a specific management action the nurse manager can take, since metrics the manager cannot influence provide information without actionability

B. Select metrics that align with the organization's strategic financial priorities

C. Select metrics that represent a balanced view across revenue, expense, productivity, and quality dimensions

D. Select metrics that the nursing staff can understand and relate to their daily practice

110. A nurse manager is evaluating two competing proposals for reducing the unit's agency staffing costs. Agency costs have been $420,000 annually — significantly above the organizational benchmark. Proposal A: Implement a premium pay internal staffing program that offers existing staff time-and-a-half rates for picking up additional shifts. Estimated cost: $280,000 (represents a $140,000 savings over agency costs). Proposal B: Create four new permanent FTE positions to eliminate the need for agency staff. Estimated cost: $340,000 annually (represents an $80,000 savings over agency costs). Which analysis provides the MOST complete comparison?

A. Proposal A provides greater immediate cost savings ($140,000 vs. $80,000) and should be selected

B. Proposal B provides greater long-term stability but costs more than Proposal A

C. Both proposals reduce costs compared to agency, but the premium pay model (Proposal A) risks creating staff dependency on premium rates, burnout from excessive hours, and a culture where picking up extra shifts becomes an expected income source — while the permanent FTE model (Proposal B) provides stable coverage, consistent care quality, and reduced overtime/burnout risk despite the smaller direct savings, meaning the decision requires evaluating total organizational impact beyond the direct cost comparison

D. Neither proposal adequately addresses the root cause of the agency dependency, which should be investigated before either solution is implemented

111. A nurse manager is developing a financial justification for a new clinical program — a nurse-led heart failure disease management clinic. The clinic would provide post-discharge follow-up, medication management, symptom monitoring, and self-management education for heart failure patients. Program costs:

| Component | Annual Cost |

|---|---|

| NP salary and benefits | $135,000 |

| RN coordinator | $85,000 |

| Space and equipment | $25,000 |

| Supplies and education materials | $15,000 |

| Total | $260,000 |

Current heart failure 30-day readmission rate: 24%

National benchmark: 18%

Annual heart failure discharges: 340

Average readmission cost: $14,200

CMS readmission penalty (current): $62,000 annually

Which financial model provides the MOST compelling justification?

A. If the clinic reduces readmissions from 24% to 18% (6 percentage points), prevented readmissions = 340 × 6% = 20.4 readmissions × $14,200 = $289,680 in avoided readmission costs, exceeding the $260,000 program cost in the first year

B. The readmission cost savings ($289,680) plus the CMS penalty reduction (portion of $62,000) against the $260,000 program cost produces a strong first-year ROI

C. The program's value must be evaluated differently depending on the organization's payment model — under fee-for-service, prevented readmissions actually reduce revenue (each readmission generates reimbursement), making the CMS penalty reduction the primary financial benefit; under value-based payment, prevented readmissions reduce total cost of care and improve quality metrics, making the readmission cost avoidance the primary benefit — and the financial model must align with the organization's current and transitional payment environment

D. Compare the program's cost-effectiveness to alternative readmission reduction strategies before committing to the full clinic model

112. A nurse manager is analyzing the financial implications of the unit's patient acuity distribution. The patient classification system categorizes patients into four acuity levels:

| Acuity Level | % of Patients | Required HPPD | Actual HPPD | Staffing Match |

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

| Level 1 (lowest) | 15% | 5.0 | 7.2 | Overstaffed |

| Level 2 | 40% | 7.5 | 7.8 | Matched |

| Level 3 | 30% | 9.5 | 9.0 | Understaffed |

| Level 4 (highest) | 15% | 12.0 | 10.5 | Understaffed |

Which finding is MOST financially and clinically significant?

A. The Level 2 patients are appropriately staffed, confirming the staffing model works for the largest patient group

B. The Level 1 overstaffing represents wasted labor resources that could be redistributed

C. The Level 3 and Level 4 understaffing creates patient safety risk that may generate adverse event costs

D. The staffing model is allocating excess resources to the lowest-acuity patients while under-resourcing the highest-acuity patients — Level 1 patients receive 2.2 HPPD above their need while Level 4 patients receive 1.5 HPPD below their need, suggesting that the staffing model uses a flat allocation approach rather than acuity-adjusted deployment, creating both financial waste (overstaffing low-acuity) and clinical risk (understaffing high-acuity) that a single acuity-based staffing adjustment could address simultaneously

113. A nurse manager is developing a break-even analysis for extending the unit's operating hours. The unit currently operates twelve beds for twelve hours daily (7AM-7PM) and is considering expanding to twenty-four-hour operation. Additional costs for the night operation:

| Cost Component | Annual Cost |

|---|---|

| Night shift nursing staff (6 FTEs) | $468,000 |

| Night support staff (2 FTEs) | $112,000 |

| Night shift differential premium | $42,000 |

| Utilities and overhead | $38,000 |

| Total additional cost | $660,000 |

Average revenue per patient day: $2,400. Average cost per patient day (variable costs only): $850.

Which break-even calculation is MOST accurate?

A. Break-even requires $660,000 ÷ $2,400 per patient day = 275 patient days annually, or approximately 0.75 patients per night

B. Break-even requires $660,000 ÷ ($2,400 - $850) = $660,000 ÷ $1,550 contribution margin per patient day = 426 patient days annually, or approximately 1.17 patients per night — using the contribution margin (revenue minus variable costs) rather than total revenue, since the fixed costs of night operation must be covered by the margin remaining after variable patient care costs are deducted

C. The break-even analysis should be based on the number of admissions rather than patient days since admissions drive DRG reimbursement

D. The analysis should include the opportunity cost of NOT operating at night — patients diverted to competitors during night hours who may not return for future daytime care

114. A nurse manager is developing a comprehensive approach to managing the unit's financial performance during a period of declining reimbursement. The organization's payer mix is shifting toward government payers (Medicare and Medicaid) who reimburse below the cost of care, while commercial insurance volume is declining due to a competing facility that opened nearby. The unit's current payer mix:

| Payer | % of Volume | Reimbursement vs. Cost |

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

| Medicare | 48% | -8% (below cost) |

| Medicaid | 14% | -22% (below cost) |

| Commercial | 32% | +18% (above cost) |

| Self-pay | 6% | -45% (below cost) |

Which financial strategy is MOST sustainable?

A. Reduce costs across all categories to achieve profitability at lower reimbursement rates

B. Focus on increasing commercial insurance volume since it is the only payer category generating positive margins

C. Develop a multi-dimensional strategy that simultaneously manages costs to narrow the Medicare/Medicaid loss margin, protects and grows the commercial volume through service differentiation and quality positioning, reduces self-pay bad debt through financial counseling and insurance enrollment assistance, and develops new revenue sources such as specialty programs that attract commercially insured patients — recognizing that sustainable financial performance in a shifting payer environment requires action across all payer categories rather than dependence on any single strategy

D. Negotiate higher reimbursement rates with Medicare and Medicaid through quality-based payment programs

115. A nurse manager is presenting a comprehensive unit financial performance summary to organizational leadership. The presentation must connect financial performance to clinical quality, patient experience, and workforce outcomes to demonstrate integrated management. Which presentation approach is MOST effective?

A. Present financial metrics first since organizational leadership prioritizes financial performance

B. Present quality metrics first since quality drives financial performance through value-based payment

C. Present an integrated narrative that demonstrates the connections between the financial, quality, experience, and workforce domains — for example, showing how investment in nurse retention ($X) reduced turnover costs ($Y) AND improved quality metrics (Z%) which generated additional VBP revenue ($W), creating a virtuous cycle where workforce investment produces quality improvement that generates financial return — demonstrating that the nurse manager manages an integrated system rather than isolated metrics, and that financial performance is the OUTCOME of clinical, experiential, and workforce excellence rather than an independent objective

D. Present each domain separately with detailed supporting data and allow leadership to draw the connections

Answer Key – Exam 18 (with Full Answer Explanations)

1. D — AIDET is a delivery framework that structures what the nurse communicates TO the patient but includes no listening component where the nurse receives information FROM the patient. Staff can execute AIDET perfectly while still failing to demonstrate the receptive listening behaviors patients evaluate when responding to "listened carefully." The framework improves information delivery but does not address information reception.

2. C — De-escalation is a probabilistic skill that increases the likelihood of successful resolution but cannot guarantee it in every encounter. Some patients are in agitation states that exceed the threshold where verbal techniques are effective. The measure of competence is correct technique application rather than guaranteed patient response, and understanding this distinction prevents the nurse from abandoning a valuable skill after a single unsuccessful encounter.

3. B — Proposing a structured trial with efficiency metrics demonstrates that interdisciplinary rounding actually reduces the physician's total communication burden by consolidating fragmented phone calls, pages, and clarification conversations into a single coordinated interaction. Measuring actual time expenditure during the trial versus the current model provides data that addresses the physician's specific concern about workflow efficiency.

4. D — Developing a transparent recording policy that acknowledges families' desire to document care, establishes reasonable guidelines, and coaches nurses to view recording as quality documentation reframes the dynamic from surveillance to partnership. Nurses who provide excellent care have nothing to fear from documentation of that care, and the reframing transforms a threat perception into a quality reinforcement.

5. B — Modifying the format to include a dedicated "clinical priority" section preserves the structure ensuring essential data transfer while creating space for the clinical judgment experienced nurses need to express. Effective handoff requires both standardized data transfer AND clinical narrative, and the modification honors both elements rather than sacrificing one for the other.

6. A — Reframing goals-of-care conversations as exploring what the patient values most at EVERY stage of illness, not only at the end, removes the association with "taking away hope." Research consistently shows patients who have these conversations experience less anxiety because uncertainty about the future is more distressing than honest conversation about preferences.

7. C — Facilitating a structured joint meeting where each shift describes their workflow reality — staffing levels, acuity patterns, available resources, and task feasibility — builds mutual understanding of the different operational environments. Collaborative development of realistic cross-shift expectations that acknowledge legitimate constraints transforms blame into shared problem-solving.

8. B — Implementing system-level interventions that make prohibited abbreviations difficult to use — EHR blocks, pharmacy verification flags, and nursing clarification authority — addresses the error at the design level rather than relying on individual memory. System barriers are more reliable than education and acknowledgment forms for preventing habitual behaviors.

9. B — Scripted assertive communication tools like CUS give nurses standardized, organizationally endorsed language for raising concerns, removing the interpersonal risk by making the challenge a system protocol rather than a personal confrontation. Combined with physician education that these phrases are safety signals requiring a clinical pause, the tool transforms individual courage into systematic safety communication.

10. A — Communicating with radical transparency — narrating every action, explaining clinical purposes, offering choices about timing and sequence, and maintaining an unhurried presence — reduces the threat perception that fuels paranoid interpretation. Paranoia is driven by perceived loss of control and unpredictability, and maximizing patient control and predictability directly addresses the underlying mechanism.

11. A — Nurses define "explaining medications" as providing drug identification data while patients define it as understanding WHY they take each medication, what it will DO, how they will FEEL, and what to WATCH FOR. This definitional gap means both parties believe communication occurred but evaluated different content, explaining why nurses report compliance while patients report dissatisfaction.

12. B — Coaching nurses to acknowledge the family member's healthcare expertise while clearly delineating their role validates their knowledge without conceding clinical authority. The framework "your role right now is as the loved one, our role is the clinical team" establishes boundaries respectfully while recognizing the unique emotional burden of the clinician-as-family-member experience.

13. A — Validating the patient's fear as legitimate, explaining the transition is motivated by improving pain management rather than reducing it, describing the multimodal approach specifically, providing incremental steps rather than abrupt changes, and ensuring continuous assessment communicates that the change comes from caring. Opioid transition conversations succeed or fail based on whether the patient perceives the motivation as compassionate or punitive.

14. B — Distinguishing between routine care interactions where bilingual communication builds rapport and clinical decisions where professional interpretation ensures accuracy and documentation integrity balances therapeutic benefit with safety. Eliminating all bilingual nurse communication sacrifices the relationship-building value, while allowing unrestricted interpretation creates accuracy and liability risk.

15. C — Restructuring the care conference format to include a designated "nursing assessment" agenda segment with defined time allocation creates a structural expectation for nursing contribution. This

eliminates dependence on the nurse competing for floor time against physician-dominated discussion and makes nursing voice a designed feature of the conference rather than an optional addition.

16. A — Acknowledging proactive health monitoring, documenting the data as patient-reported information, communicating its availability to the clinical team, and explaining the difference between consumer and clinical-grade data incorporates the information as contextual enrichment without substituting it for validated clinical assessment. This approach respects the patient's engagement while maintaining clinical standards.

17. D — Training nurses in trajectory-based communication — reporting findings as "improved from," "unchanged from," or "worsened from" the previous assessment — makes the rate and direction of clinical change the primary communication rather than a static snapshot. Clinical trajectory often has greater significance than the current value alone, and trajectory reporting captures the information that drives clinical decision-making.

18. C — Supporting real-time access as legally required while implementing proactive communication — informing patients of access, explaining documentation language context, offering to review results together, and training nurses to write notes as concurrent readers — transforms mandated transparency into a communication quality driver. Proactive support prevents the anxiety that unsupported access creates.

19. C — Training nurses to lead every interaction with an open-ended assessment question before providing information makes the asking phase the mandatory starting point that shapes what the nurse subsequently tells. This ensures information delivery is responsive to the patient's actual knowledge state and concerns rather than a standardized information dump.

20. A — Training nurses to redirect from "what would I do?" to "what do you think the patient would want?" applies the substituted judgment standard that asks the decision-maker to consider the patient's known values and preferences. The nurse provides factual clinical information that helps the decision-maker apply those values to the specific situation without substituting the nurse's personal preferences.

21. D — A unified communication model where the team aligns messaging during rounds, each discipline limits communication to their domain, a designated communication lead coordinates messages, and parents have a single point of contact structures information flow so consistency is designed into the system. Consistency dependent on individual coordination will always fail in a multi-provider environment.

22. C — Educating staff that eye contact norms vary significantly across cultures and that averted gaze can signify respect rather than disengagement corrects the assessment error at its source. Assessment accuracy depends on identifying culturally appropriate behavioral indicators for each patient rather than applying a single communication standard to all populations.

23. D — Empowering nurses to engage in respectful clinical inquiry when a lab order appears routine — framing the question as collaborative assessment rather than questioning authority — provides data on patient-level impact including pain, anemia, and sleep disruption. This positions nursing as a clinical partner in appropriate utilization rather than a passive order executor.

24. B — Addressing the patient directly by calmly stating that discriminatory language is unacceptable while immediately supporting the affected nurse through acknowledgment, emotional validation, and incident documentation upholds both the zero-tolerance policy and the staff member's dignity. Reassignment based on discriminatory requests reinforces the discriminatory behavior.

25. A — Adding a phonetic spelling requirement for medication names during telephone orders inserts verification at the point where the error actually occurs — initial hearing — rather than at the read-back stage where the original misperception has already been incorporated. The current read-back process accurately confirms an inaccurately heard order; phonetic spelling prevents the initial mishearing.

26. C — Gradually shifting the primary communication target from the parent to the adolescent develops the self-advocacy skills needed when parental presence is no longer the default. Beginning with the nurse addressing questions to the adolescent, coaching symptom description, and progressively reducing parental intermediation builds communication independence through practice rather than abrupt transition.

27. A — A standardized critical alarm notification protocol with direct electronic notification to the assigned nurse's device, mandatory acknowledgment within sixty seconds, and automatic escalation compresses the communication chain from technician-to-nurse-to-patient into a direct system-to-nurse-to-patient pathway. This eliminates the information degradation that occurs through verbal relay in the multi-step chain.

28. D — Training nurses to offer choice, control, and predictability in every interaction — asking permission before touching, explaining what will happen, offering sequence options, and pausing during distress — prevents trauma activation regardless of whether the patient has disclosed a trauma history. These behaviors are universally therapeutic and do not require screening to be effective.

29. B — Meeting with the concerned family member to correct misinformation, then meeting with the decision-maker to clarify the misunderstood information and offer written summaries for accurate sharing addresses both the immediate misinformation and the systemic communication pathway. The approach improves the information quality without attempting to control the family's internal communication choices.

30. A — The simultaneous worsening of falls with injury and declining RN satisfaction suggests a common underlying cause such as staffing inadequacy, moral distress, or workload burden degrading both the work environment and patient safety. Research demonstrates a direct relationship between nurse engagement and patient safety outcomes, making the co-occurrence more concerning than either trend in isolation.

31. A — A proactive toileting schedule based on each patient's elimination patterns, fluid intake timing, and diuretic administration anticipates toileting needs before the patient attempts independent ambulation. Forty-eight percent of falls are toileting-related and most occur when patients cannot wait for call light response, making proactive toileting the highest-impact single intervention.

32. D — Hub disinfection at seventy-one percent means true all-or-none bundle compliance is significantly lower than the eighty-seven percent average, since at least twenty-nine percent of central line accesses involve a broken bundle regardless of other element performance. Bundle effectiveness depends on all elements performed together, and the weakest element determines the actual bundle compliance rate.

33. B — An inaccurate admission medication list becomes the foundation for every subsequent clinical decision — doses ordered, interactions checked, and discharge medications reconciled all reference the admission list. A twenty-two percent error rate at admission creates cascading effects through every care decision and transition, making it the most consequential accuracy gap despite not being the lowest completion rate.

34. A — A standardized sedation assessment scale with defined frequency, clear escalation thresholds, and nursing authority to pause the PCA when sedation exceeds defined levels enables early detection and intervention for escalating sedation. Since seventy-eight percent of PCA adverse events involve over-sedation, systematic sedation monitoring is the most direct prevention of PCA-related respiratory depression.

35. A — Enhanced two-nurse independent bedside verification where each nurse independently compares the patient's armband to the blood product tag addresses the most dangerous error category.

Wrong-patient transfusion can cause fatal hemolytic reactions, and independent verification — where neither nurse relies on the other's confirmation — provides the strongest safeguard against identification error.

36. C — Research consistently shows that restraint use does NOT significantly reduce unplanned device removal — restrained patients remove devices at similar or higher rates because agitation increases with restraint. Alternative interventions including meaningful activity, family presence, re-orientation, and mitts are equally or more effective at preventing device removal while reducing the physical and psychological harm of restraint.

37. B — A nurse-driven catheter removal protocol shifting the default from "stays until someone orders removal" to "removed unless continuation criteria are actively documented" addresses catheter duration — the primary remaining risk factor. Every additional catheter day increases CAUTI risk regardless of maintenance quality, and the 5.8-day average versus 3.2-day benchmark represents the most actionable gap.

38. B — A daily sedation vacation protocol combined with nurse-driven spontaneous breathing trials targets the two largest contributing factors — excessive sedation (35%) and delayed breathing trials (25%). Both are mechanistically linked: excessive sedation prevents assessment for breathing trial readiness, and delayed trials extend the ventilator duration that creates the VAE risk window.

39. C — The forty-two percent non-intervention rate represents the necessary trade-off of a sensitive early warning system — catching the fifty-eight percent who DO require intervention outweighs the resource cost of evaluating those who do not. Raising the trigger threshold would reduce false activations but risk missing genuinely deteriorating patients, which defeats the system's primary purpose.

40. A — A nurse-driven INR monitoring protocol with standardized assessment frequency, dose-holding thresholds, physician notification criteria, dietary education, and pre-discharge verification targets both the largest category (supratherapeutic INR, 22 events) and the discharge safety gap (subtherapeutic INR, 11 events). Both reflect inadequate ongoing monitoring that systematic protocol-driven surveillance addresses.

41. A — The Sign Out occurs when the brain perceives the primary task as complete, reducing attention to post-task verification. Combined with time pressure for the next case and physical fatigue, task completion psychology makes the Sign Out the most psychologically vulnerable checklist phase despite its equal importance for instrument counts, specimen labeling, and post-operative care planning.

42. B — Mandating that specimen containers may only be labeled at the point of collection — at the bedside, immediately after obtaining the specimen — prohibits the pre-labeling that creates the error mechanism. The error occurs specifically when labeling is temporally or spatially separated from collection, and making them an inseparable paired action is the only reliable prevention.

43. B — Concentrated electrolytes convert sixty-seven percent of errors to harm events and neuromuscular blocking agents convert one hundred percent, compared to twenty-nine percent for insulin. The error-to-harm ratio indicates that errors with these medications are disproportionately likely to cause harm when they occur, making them the highest-risk categories per error event despite lower absolute counts.

44. A — Integrating patient identification into the emergency response as a parallel task — assigning a specific team member the verification role during the first thirty seconds — makes identification simultaneous with treatment rather than sequential. This prevents the "everyone knows who the patient is" assumption without creating treatment delays.

45. A — The Infection Control Risk Assessment evaluates construction infection risk based on activity type, proximity to patient care, and patient population vulnerability, using the ICRA matrix to determine required containment measures. Matching containment level to risk level ensures that the highest-risk combination — construction near immunocompromised patients — receives the most intensive protection.

46. D — A comprehensive safe patient handling program combining mechanical equipment, mobility assessment algorithms, zero-lift policies, and a culture change component addresses both the equipment and behavioral dimensions. Equipment availability alone does not change behavior without the cultural shift that makes using equipment the expected professional norm rather than an optional convenience.

47. C — Recognizing and managing shivering using the Bedside Shivering Assessment Scale is the most critical competency because uncontrolled shivering increases metabolic demand, raises intracranial pressure, generates heat that counteracts cooling, and causes discomfort. Shivering management is the difference between therapeutic temperature maintenance and treatment failure during TTM.

48. A — Eleven cardiac arrests not preceded by rapid response activation represent failure-to-rescue events where deterioration progressed to arrest without early warning system detection. This is the most concerning metric because intercepting deterioration before cardiac arrest is the rapid response system's primary purpose, and these events indicate the system is failing its core mission.

49. D — An automated INR result notification system sending critical values directly to assigned clinicians with defined response timeframes and automatic escalation targets the most frequently occurring contributing factor (4 events). This system-level intervention removes reliance on manual result checking, addressing the root cause with a reliable automated process.

50. A — Continuous assessment of consciousness level with the ability to recognize the transition from moderate to deep sedation is the primary safety competency. The main risk of moderate sedation is unintended progression to deeper levels where airway protective reflexes are lost, and the nurse's ability to detect this transition determines whether rescue occurs before respiratory compromise develops.

51. D — Effective leadership requires BOTH transformational and transactional elements. Transformational leadership inspires discretionary effort, innovation, and growth, while transactional leadership provides clear expectations, accountability, and operational consistency. The most effective leaders integrate both approaches, using transformational leadership to inspire and transactional leadership to stabilize.

52. D — Kotter's Step 5 specifically requires leaders to remove systemic obstacles blocking the change rather than asking people to change behavior within a system designed for the old way. Securing approval process streamlining and scheduling system modification BEFORE asking staff to implement the new model prevents the frustration and failure that occur when structural barriers contradict behavioral expectations.

53. B — Presenting contamination evidence, sharing a compelling patient story, and facilitating discussion about the disconnect between professional infection prevention commitment and personal nursing station behavior creates cognitive dissonance. This dissonance destabilizes comfort with the current behavior and opens readiness for change — the essential "unfreezing" that Lewin's model requires before change can occur.

54. D — In complex adaptive systems, leaders should shift from controlling outcomes through linear planning to creating conditions enabling emergence — fostering relationships, information flows, and shared mental models that allow self-organization toward better outcomes. The leader's role is influencing conditions from which solutions emerge rather than designing and imposing solutions.

55. D — Just culture analysis evaluates the nurse's specific behavioral choices: if she used the barcode system and it failed, the event is human error; if she chose to skip verification due to time pressure, it is at-risk behavior; if she knowingly bypassed multiple safety checks despite risk awareness, it approaches reckless behavior. The classification depends on behavioral choices made, not outcome severity.

56. C — Developing New Knowledge/Innovation/Improvements through a unit-level nursing research and EBP program supports staff in conducting inquiries, implementing changes, presenting findings, and publishing results. This builds the scholarly practice infrastructure Magnet requires while leveraging the existing Exemplary Professional Practice strength as the clinical foundation for inquiry.

57. A — Clinical practice, professional development, and quality improvement decisions should be governed by staff councils, while budget, personnel actions, and regulatory compliance remain management decisions. Shared governance distributes authority over professional practice to the professionals delivering care while operational decisions require management accountability structures.

58. A — Modeling and teaching collaborative conflict resolution as the preferred approach demonstrates that direct conflict addressed through mutual problem-solving produces better outcomes than avoidance. Establishing that respectful professional disagreement is valued team behavior creates the cultural permission that an avoidance-dominant unit lacks, while acknowledging that avoidance may occasionally be an appropriate tactical choice.

59. B — Developing expert and referent power bases — clinical credibility through visible expertise and interpersonal relationships generating personal respect — produces internal motivation and genuine commitment. Legitimate and coercive power produce compliance that disappears when monitoring stops, while expert and referent power generate influence that persists independent of formal authority.

60. B — The first consequence of excessive span of control is relationship deterioration — nurses who do not feel personally known and valued by their manager develop weaker organizational attachment. Individual attention is the foundation of the manager-staff relationship, and when forty-two FTEs compete for one manager's attention, the resulting anonymity drives turnover before quality metrics or administrative burden become visible problems.

61. C — The gap is in relationship management — using emotional awareness to guide interactions toward productive outcomes. Avoiding difficult conversations is not empathy but self-protection disguised as concern for others. Genuine empathy includes caring enough about someone's growth to provide needed feedback, and the relationship management skill integrates social awareness with the courage to act on it.

62. B — Addressing underlying barriers through standardized task cards eliminating repetitive explanation, UAP competency verification building confidence, and reframing delegation as "managing my practice to focus on what only an RN can do" makes delegation easier, safer, and professionally

valued. Overcoming practical barriers produces more delegation behavior than teaching delegation as a concept that remains difficult to practice.

63. C — Both errors share a common root cause — the nurse's pattern of bypassing medication safety verification steps. The second error escalates the same behavioral pattern rather than representing an unrelated event, warranting a written warning addressing the underlying pattern of safety protocol non-compliance rather than treating each protocol violation as an independent incident.

64. D — RCA methodology requires system-level solutions addressing EVERY contributing factor since removing any single factor may not have prevented the event given the other three. The system's vulnerability lies in the convergence of multiple simultaneous failures, and comprehensive prevention requires addressing all identified factors as an integrated system rather than selecting one as primary.

65. C — PDSA is iterative: analyze what specifically produced the improvement, identify which workflow elements contributed most, refine the intervention, and test the refined version in a second cycle with a slightly larger sample. Each cycle builds on the previous one's learning, refining through sequential testing rather than implementing after a single successful small-scale test.

66. A — Waiting is the most common waste in hospital discharge — patients waiting for prescriptions, transportation, paperwork, signatures, and education scheduling. The majority of discharge time consists of sequential waiting periods between value-added activities, and compressing waiting through parallel processing produces the largest time reduction.

67. C — The measurement-to-workforce-to-operations misalignment creates a reinforcing cycle driving behavior AWAY from the patient-centered strategy: the system measures process metrics, rewards efficiency, and designs for throughput, creating a self-defeating system regardless of the strategy's quality. The misalignment is systemic rather than a collection of individual gaps.

68. D — Mutual support behaviors require psychological safety that the unit has not yet developed. Offering help requires vulnerability (admitting capacity while a colleague struggles), and providing feedback requires interpersonal risk (potential negative reaction). Communication tools follow protocols requiring no personal risk, while mutual support requires trust that the unit environment has not yet established.

69. D — The early majority makes adoption decisions based on peer influence from respected, practical colleagues — not innovators (seen as risk-takers) or evidence alone. The nurse manager must identify

and support credible peer champions from within the early majority who can demonstrate the innovation working in daily practice, since this population trusts peer experience over leadership endorsement or published evidence.

70. B — A dual-support model pairing each charge nurse with an external mentor for career guidance and emotional support AND an internal coach for specific skill development recognizes that the mentor relationship requires psychological safety the supervisory relationship cannot provide, while coaching requires content expertise and frequent interaction an external mentor cannot deliver. Each relationship serves a different developmental need.

71. B — The unit's basic underlying assumptions — deeply held unconscious beliefs such as "I am responsible only for my own patients" or "asking for help signals weakness" — drive individualistic behavior regardless of espoused teamwork values. Meaningful culture change requires surfacing and challenging these assumptions rather than working at the visible artifact or espoused values level.

72. D — Shifting from presence-based to outcome-based leadership replaces physical observation with performance metrics and regular check-ins assessing both work quality and well-being, while intentionally creating connection through virtual team rituals. Virtual teams require MORE intentional relationship investment since the informal relationship-building of physical proximity must be deliberately designed into the virtual environment.

73. D — Honestly assessing whether the expanded role is sustainable and negotiating necessary structural support — intermediate leadership, adequate physical presence distribution, and organizational infrastructure — before committing prevents the manager from absorbing additional responsibility without resources to succeed. Accepting an unsustainable scope harms both teams rather than serving either effectively.

74. C — Acknowledging the potential contract violation, meeting with the union representative, and working collaboratively toward resolution demonstrates respect for the collective bargaining process even when the violation was unintentional. Labor-management relationships are built on trust and responsiveness, and collaborative resolution strengthens the relationship more than positional defense.

75. A — Realistic simulation exercises placing the nurse manager in crisis decision-making scenarios develop crisis competency through experiential practice. Performance during an actual crisis relies on behavioral responses developed through simulation rather than knowledge from education, because crisis leadership involves physiological stress responses that only simulation can approximate.

76. B — Presenting the cumulative cost of the physician's behavior — turnover, recruitment, agency, risk management, and safety event costs — frames disruptive behavior as a business liability exceeding the physician's revenue contribution. Financial arguments often succeed where professional conduct arguments have failed in physician-protected organizational cultures because they speak the language leadership prioritizes.

77. A — Redesigning the system to improve compatibility with existing workflow, even if this reduces relative advantage, produces better outcomes than a superior innovation that is resisted. Compatibility is the strongest predictor of adoption speed, and a less effective innovation that is actually adopted produces better results than a more effective one that remains unused.

78. D — The Professional Development Council's four members and forty-eight percent attendance indicates lost relevance and meaningful authority. This decline foreshadows risk to the other councils since shared governance programs that allow individual councils to become performative create precedent for disengagement that spreads across the governance structure if not addressed.

79. B — The nurse manager's personal response to vulnerability — how she reacts when staff report errors, ask questions, challenge decisions, or admit uncertainty — builds or destroys psychological safety in these micro-moments. If the manager responds with curiosity and support, staff learn vulnerability is safe; if with criticism or dismissal, staff learn it is dangerous regardless of formal policies.

80. A — Professional portfolios shift competency documentation responsibility from manager to individual nurse, creating continuous self-assessment that identifies development needs before they manifest as performance gaps. The portfolio provides objective evidence for evaluations and promotions that reduces subjectivity and potential bias in manager-dependent assessment.

81. C — Framing peer review as a learning activity rather than a judgment activity — emphasizing collective professional growth, system improvement rather than individual discipline, and practice patterns rather than individual errors — transforms the experience from threatening to developmental. Being reviewed becomes a development opportunity, and reviewing becomes professional responsibility rather than judgment.

82. C — The absence of explicit authorization or prohibition creates ambiguity that cannot be resolved by individual interpretation. Consulting the state board of nursing for an advisory opinion addresses the scope question through the authoritative body, since practicing based on personal interpretation exposes both the nurse and organization to regulatory and liability risk.

83. D — A structured ethical reasoning process applying multiple lenses — principlism, utilitarianism, deontology, virtue ethics, and care ethics — to the same dilemma recognizes that complex ethical situations rarely yield to a single framework. The quality of ethical reasoning depends on examining the situation from multiple perspectives before reaching a decision.

84. B — Documenting concerns, meeting privately using specific factual examples rather than accusations, communicating available resources including the alternative-to-discipline program, ensuring immediate removal from patient care if impairment is suspected during a shift, and following reporting policy while supporting treatment access balances immediate patient safety with the professional obligation to support a colleague through a medical condition.

85. A — Providing experienced nurses with advanced learning opportunities matched to their expertise level — specialty conferences, leadership development, research participation, teaching roles, and scholarly writing — addresses the actual barrier. The resistance is not to learning but to learning experiences designed for a lower expertise level, and experienced nurses re-engage when challenged at their current capability.

86. B — Escalating through the chain of command and requesting ethics consultation fulfills the nurse's professional obligation to advocate for the patient's expressed wishes even when the physician and family disagree. The nurse's advocacy responsibility does not end when the initial communication is acknowledged but unresolved, since the patient's previously expressed wishes are the primary ethical consideration.

87. B — The professional obligation to report is non-negotiable — the ANA Code of Ethics requires action when a colleague's practice places patients at risk. Falsifying medication documentation is both a patient safety risk and a professional conduct violation requiring reporting regardless of personal relationship, while acknowledging the emotional difficulty and offering support for the reporting nurse.

88. C — Integrating brief validated social determinants screening questions into the nursing admission assessment with defined referral pathways makes social determinants assessment a standard nursing function. This identifies vulnerability early enough for intervention rather than discovering social barriers at discharge when they become readmission drivers.

89. C — Granting the accommodation with defined parameters ensures religious beliefs are respected while the accommodation does not burden colleagues, delay patient care, or compromise professional obligations. Structured accommodation demonstrates that professional obligation and personal conviction can be balanced through process rather than forced choice.

90. B — Replacing cultural knowledge education with a reflective practice approach focusing on self-awareness — recognizing personal cultural assumptions, understanding how cultural lens shapes assessment, developing comfort with cultural uncertainty, and asking "what is important to YOU?" rather than assuming cultural norms — builds the habit of approaching each patient as a cultural individual rather than a cultural representative.

91. D — The financial incentive creates a conflict of interest compromising professional objectivity regardless of the device's clinical merit. Accepting payment transforms a professional clinical judgment into a commercial endorsement, violating the obligation to act in the patient's interest rather than personal financial interest. The offer should be reported to compliance regardless of acceptance intent.

92. C — Supporting professional advocacy as a component of nursing's obligation to influence health policy, while providing guidance on distinguishing personal advocacy from organizational representation, clarifies that nurses have the right to advocate for health policy positions even when they differ from the organization's stance. The key distinction is not misrepresenting personal advocacy as the organization's position.

93. B — Supporting advanced practice education through tuition assistance recognizes that developing an excellent bedside nurse into an advanced practice provider benefits the profession and potentially the organization. Managers known for supporting professional growth attract and retain stronger candidates, and accepting the potential loss is the cost of being a development-oriented leader.

94. D — A comprehensive plan expanding generalist competency through targeted education while structuring the cardiac expertise as a unit resource through peer education, protocol development, and consultation leverages specialty strength rather than isolating it. This closes generalist gaps through development rather than accommodation while making the nurse's unique expertise benefit the entire team.

95. D — The nurse exercised professional advocacy when internal channels failed. The ANA Code of Ethics establishes the obligation to advocate for patient safety, and when organizational channels are exhausted without resolution, external reporting becomes a professional obligation. Retaliatory action would violate both legal whistleblower protections and the professional principle that safety advocacy must be supported.

96. C — The calculation produces 50,282 RN productive hours at $2,614,664, but this represents productive hours only. The figure must be adjusted upward by approximately 1.14 (the non-productive

time factor for PTO, sick leave, and education) to determine total paid hours, since the budget must fund the hours nurses are paid but not working alongside the hours they deliver direct care.

97. B — The total cost of ownership comparison demonstrates that current monitors' escalating maintenance costs ($38,000 last year, projected $52,000 and $68,000 in subsequent years) plus emergency replacement risk makes planned replacement at $192,000 less expensive than continued maintenance of equipment needing replacement within two years regardless. Framing capital investment as cost avoidance is more persuasive than clinical or standardization arguments.

98. B — The inverse relationship between ADC and HPPD variance reveals the staffing model does not flex effectively with census — maintaining relatively fixed levels regardless of volume. The largest productivity losses occur during low-census periods where staff are not flexed proportionally, indicating the flexing mechanism rather than the baseline staffing level is the primary management target.

99. D — The comprehensive calculation must use marginal cost for LOS reduction (approximately $555-$740 per avoided day rather than the $1,850 average), plus ICU transfer prevention savings, plus VTE prevention savings ($74,000), against total program cost. The marginal cost adjustment is the critical analytical distinction determining whether the ROI projection is credible or inflated by a factor of three.

100. C — Wound care supplies (19% volume-adjusted increase) and PPE (15% volume-adjusted increase) significantly exceed volume-driven growth, suggesting price increases, utilization changes, waste, or practice variation that can be managed. Some IV and medication cost growth reflects market pricing beyond the unit's control, making targeted investigation of the highest-variance categories more productive than across-the-board cuts.

101. A — Nurses view charge capture as a billing function rather than a clinical documentation responsibility, creating a systematic disconnect between services provided and services billed. The perception gap is the root cause driving all four service categories' missed charges, and reframing charge capture as a clinical documentation responsibility addresses the underlying cultural barrier.

102. D — The nurse manager must determine whether increased CMI revenue is offset by proportionally higher costs — more nursing hours, supplies, longer stays, and ancillary services. The unit's financial performance depends on whether higher reimbursement exceeds higher costs, not simply on CMI direction, since a higher CMI with disproportionately higher costs can worsen financial performance despite increased revenue.

103. C — A conservative analysis using only the most quantifiable benefit — fall reduction — calculates the break-even point (1.7 prevented falls with injury annually against $24,000 cost) and compares to the current rate. Adding satisfaction and call light benefits as supplementary but unquantified improvements builds a credible business case resting on conservative projections rather than optimistic multi-variable estimates.

104. A — The strength-opportunity combination creates a growth strategy: clinical reputation and patient experience quality can attract the new physician group's volume. Simultaneously, the weakness-threat combination (aging plant plus new competitor) creates urgent improvement priority since the competitor likely offers a modern environment. SWOT's strategic value lies in identifying these cross-category intersections.

105. C — Marketing to payers first demonstrates readmission reduction and total cost of care impact, influencing patient volume through network design, preferred provider designations, and value-based referral incentives. A program demonstrably reducing total cost of care attracts contractual volume from payers managing their heart failure population, generating more sustainable patient flow than consumer advertising.

106. C — The $215,000 direct cost represents only a fraction of total impact. Adding indirect costs — replacement staffing for 318 lost days ($127,200 at agency rates), administrative time, modified duty productivity loss, insurance premium increases (25-40% of direct costs), and retention impact — estimates true cost at $430,000-$520,000, making a $75,000-$100,000 equipment investment easily justifiable.

107. A — The discharge time gap (4.2 vs. 2.5 hours) has the greatest financial impact because delayed discharges hold beds that could admit revenue-generating patients. The 1.7-hour excess multiplied across daily discharge volume creates cumulative lost capacity directly translating to deferred admissions and lost revenue, making discharge optimization the highest-value throughput intervention.

108. D — Planned overtime at forty-two percent ($148,000) results from known vacancies — a predictable, chronic condition addressable through accelerated recruitment, improved retention, float pool expansion, and per diem staffing. Planned overtime is the only category where the cause is known in advance and can be systematically eliminated through structural solutions rather than reactively managed.

109. A — Selecting metrics the nurse manager can directly influence — HPPD, labor cost per patient day, overtime percentage, agency utilization, supply cost, and revenue per patient day — creates a

dashboard where every metric connects to a specific management action. Metrics the manager cannot influence provide information without actionability, reducing the dashboard's utility as a management tool.

110. C — The premium pay model risks creating staff dependency on premium rates, burnout from excessive hours, and a culture where extra shifts become expected income, while the permanent FTE model provides stable coverage, consistent quality, and reduced burnout risk despite smaller direct savings. The decision requires evaluating total organizational impact beyond the direct cost comparison.

111. D — Under fee-for-service, prevented readmissions reduce revenue since each generates reimbursement, making CMS penalty reduction the primary benefit; under value-based payment, prevention reduces total cost and improves quality metrics. The financial model must align with the organization's current and transitional payment environment since the same clinical outcome produces different financial impact depending on the payment model.

112. D — The staffing model allocates excess resources to lowest-acuity patients (Level 1 receives 2.2 HPPD above need) while under-resourcing highest-acuity patients (Level 4 receives 1.5 HPPD below need). This flat allocation creates both financial waste and clinical risk that a single acuity-based deployment adjustment could address simultaneously.

113. B — Break-even requires $660,000 divided by $1,550 contribution margin per patient day (revenue $2,400 minus variable costs $850) = 426 patient days annually, or approximately 1.17 patients per night. Using contribution margin rather than total revenue is essential since fixed night operation costs must be covered by the margin remaining after variable patient care costs are deducted.

114. C — A multi-dimensional strategy simultaneously managing costs to narrow the Medicare/Medicaid loss margin, protecting commercial volume through differentiation, reducing self-pay bad debt through enrollment assistance, and developing new revenue sources recognizes that sustainable performance in a shifting payer environment requires action across all categories rather than dependence on any single strategy.

115. C — An integrated narrative demonstrating connections between financial, quality, experience, and workforce domains — showing how workforce investment reduced turnover AND improved quality which generated VBP revenue — demonstrates that the nurse manager manages an integrated system rather than isolated metrics. Financial performance is the outcome of clinical, experiential, and workforce excellence rather than an independent objective.