

PRACTICE EXAM 16: NURSE EXECUTIVE ADVANCED MIRROR EXAM (150 QUESTIONS)

This 150-question practice simulation is modeled on the ANCC Nurse Executive, Advanced Board Certification Examination. The current certification examination allows 3 hours for 150 questions, including 125 scored questions and 25 pretest questions. Answer every practice question. This independent study aid is not affiliated with or endorsed by the American Nurses Credentialing Center (ANCC).

1. A newly merged health system has different cultures, workflows, and priorities. Which leadership response is most appropriate first?

- A. Impose the larger system's practices immediately
- B. Wait for the cultures to blend without structured work
- C. Frame the shared purpose, surface competing assumptions, and support joint problem solving
- D. Let each campus pursue separate priorities indefinitely

2. During a difficult capital discussion, which behavior best demonstrates executive presence?

- A. Speak with certainty even when key assumptions are untested
- B. Acknowledge uncertainty, state the evidence, and recommend a decision with contingencies
- C. Present only favorable projections to maintain enthusiasm
- D. Defer every question to the finance department

3. A nurse executive is entering a partnership with a skeptical community organization. What should happen before proposing a solution?

- A. Learn the partner's priorities, history, constraints, and definition of success
- B. Send a finished proposal and request endorsement
- C. Ask the partner to adopt the health system's measures

D. Limit contact to the legal teams until agreement is signed

4. Which activity provides the strongest starting point for a strategic plan addressing declining rural access?

A. Choose the service line with the loudest internal advocate

B. Copy a neighboring system's access plan

C. Set a budget target before understanding the access problem

D. Combine internal performance data with external demographic, economic, and community information

5. A board asks whether to expand a service line into a new market. Which planning method best exposes uncertainty?

A. Use one optimistic forecast as the official plan

B. Delay the decision until uncertainty disappears

C. Model several plausible scenarios with explicit assumptions and trigger points

D. Rely on a competitor's public announcement

6. Which board action represents appropriate governance of an enterprise cybersecurity program?

A. Approve individual password resets for clinical units

B. Set risk appetite, require meaningful reporting, and monitor management's response

C. Direct the analyst's daily investigation steps

D. Replace the security team after every reported vulnerability

7. A committee has repeatedly revisited the same strategic decision because members are unclear about authority. What should the executive sponsor do?

A. Add more meetings without changing the charter

B. Clarify the committee's purpose, decision rights, membership, and escalation path

- C. Ask the chair to decide privately for the group
- D. Move the issue to the board without defining the question

8. A proposed electronic medication project affects pharmacy, nursing, physicians, IT, and patients. Which action should precede launch?

- A. Map stakeholders, dependencies, decisions, and measures in a shared project charter
- B. Assign the project to IT because it involves software
- C. Begin configuration before identifying workflow owners
- D. Ask each department to define success independently

9. Frontline leaders report that a new discharge process is not feasible on night shift. What change-management action is best?

- A. Require all shifts to use the process unchanged
- B. Postpone the project until every concern is resolved
- C. Assess readiness, test the workflow with night-shift users, and adapt before scaling
- D. Ask day-shift leaders to explain the process to nights

10. A major initiative has several respected sponsors who disagree about priorities. Which action is most likely to create alignment?

- A. Allow each sponsor to communicate a separate priority
- B. Select the sponsor with the highest title as the sole voice
- C. Avoid discussing disagreement in front of the project team
- D. Build a sponsor coalition around shared outcomes, decision rules, and visible commitments

11. A project is on schedule, but a vendor dependency may delay a critical interface. What should the sponsor request?

- A. A dependency analysis with owners, dates, contingencies, and escalation thresholds

- B. Wait for the vendor to solve the issue informally
- C. Add staff to unrelated tasks to show progress
- D. Remove the interface from the scope without evaluating impact

12. A project team wants to add a reporting module after requirements have been approved. What is the sponsor's best response?

- A. Approve the module because stakeholders are enthusiastic
- B. Reject it automatically to protect the original plan
- C. Let the vendor decide whether the addition is worthwhile
- D. Use change control to examine value, cost, timing, risk, and effect on approved scope

13. A strategic project has missed two milestones, and the team has stopped reporting bad news. Which action should the executive sponsor take?

- A. Demand optimistic updates until morale improves
- B. Reestablish transparent status reporting, identify root barriers, and reset the recovery plan
- C. Replace the entire team without reviewing the barriers
- D. Stop the project immediately without assessing its value

14. A nurse manager repeatedly interrupts staff during huddles. Which coaching response is most effective?

- A. Give a general lecture about respectful communication
- B. Interrupt the manager in the next huddle to demonstrate the point
- C. Describe the observed behavior, explore its impact, and agree on a practice goal
- D. Wait for the annual evaluation to discuss the issue

15. Which feedback approach is most useful after a leader gives unclear instructions?

- A. Label the leader as a poor communicator

- B. Discuss the issue only with peers
- C. Describe the situation, behavior, and effect, then invite the leader's perspective
- D. Send a vague message asking the leader to improve

16. A talented manager wants broader career guidance, while a senior executive has limited time. Which relationship is most accurately described as mentoring?

- A. A single conversation correcting a missed deadline
- B. A formal performance action with required milestones
- C. A sponsor making promotion decisions for the manager
- D. An ongoing developmental relationship that offers perspective, support, and role modeling

17. A high-potential director has strong technical skills but limited enterprise experience. What is the best succession-development step?

- A. Create stretch assignments, mentoring, feedback, and readiness milestones tied to the future role
- B. Promote immediately to accelerate learning
- C. Keep the director in the current role until a vacancy occurs
- D. Select a successor based only on tenure

18. A talent review shows that managers rate similar performance differently across units. What should the executive do?

- A. Average all ratings without discussing differences
- B. Calibrate criteria with examples and review ratings for consistency and bias
- C. Accept each manager's rating as inherently subjective
- D. Remove performance ratings from succession decisions

19. Two service-line leaders have a recurring conflict over shared procedural capacity. What should the nurse executive do first?

- A. Award capacity to the service with higher revenue
- B. Ask both leaders to compromise without examining data
- C. Facilitate a conversation about interests, constraints, shared outcomes, and objective allocation criteria
- D. Make a private decision and announce it later

20. A physician group and nursing council disagree about a rapid-response policy. Which negotiation tactic is most constructive?

- A. Separate positions from interests and compare alternatives against agreed safety criteria
- B. Repeat the executive's preferred policy until the group accepts it
- C. Trade unrelated concessions to end the meeting
- D. Ask the legal office to choose between the groups

21. A committee supports a strategic direction but cannot agree on every implementation detail. What should the executive promote?

- A. Require unanimous agreement before any work begins
- B. Allow each member to implement a personal version
- C. Close the committee because consensus is incomplete
- D. Document the areas of agreement, unresolved choices, owners, and a decision timeline

22. A nurse executive must announce a temporary unit closure during a severe staffing disruption. Which communication is best?

- A. Release a brief statement that says only that leaders are monitoring the issue
- B. State what is known, what is changing, why, what patients should expect, and when updates will occur
- C. Wait until every operational detail is final
- D. Share different explanations with different stakeholder groups

23. Staff members say they do not report near misses because managers react defensively. What should the executive do?

- A. Require reports while keeping the resulting actions confidential
- B. Model curiosity, protect respectful reporting, and share visible learning from reports
- C. Ask staff to report only events that caused harm
- D. Discipline the manager publicly before reviewing the pattern

24. An executive receives an angry email criticizing a decision made in public. What is the strongest first response?

- A. Reply immediately with a detailed defense
- B. Forward the message to peers for informal judgment
- C. Ignore the message because the tone was disrespectful
- D. Pause, verify the concern, and respond to the substance without retaliating

25. An organization claims that collaboration is a core value, but senior leaders hoard information. What should change first?

- A. Align leader routines, incentives, and consequences with the value being promoted
- B. Publish a more inspiring values poster
- C. Ask staff to collaborate more without changing leader behavior
- D. Measure collaboration only through attendance at meetings

26. Which objective is most useful for a strategic initiative to improve nurse retention?

- A. Improve retention as much as possible across the organization
- B. Create a positive culture for all employees over time
- C. Reduce regrettable turnover by a defined amount within a defined period while monitoring equity
- D. Encourage managers to retain more nurses whenever possible

27. A system's vision is inspiring but disconnected from current decisions. Which leadership action best restores alignment?

- A. Rewrite the vision with more ambitious language
- B. Let each department interpret the vision independently
- C. Set financial targets without linking them to the vision
- D. Translate the vision into strategic priorities, measures, resource choices, and leader behaviors

28. A health system's enterprise goal is to improve access. How should the nurse executive cascade it to service lines?

- A. Define aligned local outcomes, owners, measures, and actions that contribute to the enterprise goal
- B. Send the goal to managers without further guidance
- C. Allow each unit to select unrelated access activities
- D. Count planning meetings as evidence of access improvement

29. A board dashboard contains many measures but does not show whether strategy is working. What should the executive recommend?

- A. Add more measures from every department
- B. Report only the latest financial result
- C. Link leading and lagging indicators to strategic objectives
- D. Remove all measures that are not perfect

30. A proposal for an outpatient expansion has a favorable projected margin. Which business-case question is most important next?

- A. Can the proposal be announced before validation is complete
- B. What assumptions, incremental costs, capacity needs, risks, and outcomes support the projection?
- C. Does the vendor describe the market as rapidly growing
- D. Will the expansion make the organization appear innovative

31. A technology vendor offers a low purchase price but requires substantial training and maintenance. Which analysis is most appropriate?

- A. Choose the lowest purchase price automatically
- B. Exclude training because it is a temporary cost
- C. Compare total cost of ownership with expected benefits, risks, and implementation capacity
- D. Select the vendor with the longest feature list

32. A staffing innovation appears financially attractive, but the projected benefit depends on several uncertain assumptions. What should the executive request?

- A. Use the most favorable estimate for the final recommendation
- B. Sensitivity analysis showing how the conclusion changes when key assumptions vary
- C. Avoid presenting assumptions so the proposal looks simpler
- D. Reject the idea because no forecast is certain

33. A nursing division is over budget for agency labor. What should the executive examine before reducing hours?

- A. Analyze volume, acuity, vacancies, overtime, scheduling, and agency drivers
- B. Cut every unit's staffing by the same percentage
- C. Assume managers are overspending without reviewing workload
- D. Freeze recruitment regardless of the vacancy pattern

34. A service line is evaluated under value-oriented reimbursement. Which measure set best supports executive decision making?

- A. Encounter volume alone
- B. Departmental revenue without outcome data
- C. Cost reduction without reviewing access or safety
- D. Outcomes, patient experience, access, total cost, and coordination across settings

35. Two strategic initiatives compete for the same implementation team. Which prioritization method is strongest?

- A. Fund the project with the most polished presentation
- B. Choose the project requested first
- C. Split resources evenly without defining a viable outcome
- D. Compare strategic fit, expected value, risk, equity, capacity, and opportunity cost

36. A hospital is considering a partnership with a community clinic. Which executive action best protects the relationship and the mission?

- A. Leave responsibilities informal to preserve flexibility
- B. Define shared outcomes, responsibilities, data expectations, resources, and a joint review process
- C. Require the clinic to adopt the hospital's workflow
- D. Measure success only by referrals sent to the hospital

37. An innovation team wants to scale a promising pilot after favorable early feedback. What should the executive require?

- A. Define stage-gate criteria for safety, outcomes, adoption, equity, cost, and readiness
- B. Scale immediately because users like the pilot
- C. Continue piloting without a decision date
- D. Scale only after every possible user approves

38. A strategic initiative has met its activity targets but not its intended patient outcome. What should the executive do?

- A. Declare success because the activities were completed
- B. Increase activity volume without examining the mechanism
- C. Test the change assumptions and redirect resources using outcome evidence
- D. Stop measuring outcomes because they are difficult

39. After a complex implementation, which review is most likely to produce transferable learning?

- A. Compare expected and actual results, explain variation, and assign follow-up owners
- B. Celebrate completion without reviewing the process
- C. Archive the project files without discussing lessons
- D. Ask the sponsor to remember the main problems

40. A new executive wants leaders to model a change before asking staff to adopt it. Which action is most credible?

- A. Announce that leaders support the change but keep their old workflow
- B. Ask staff to pilot the change without executive participation
- C. Use the new workflow visibly, discuss lessons learned, and invite practical feedback
- D. Wait for perfect results before leaders use it

41. A cross-functional project has many contributors but no clear final decision maker. Which tool should the sponsor use?

- A. Ask everyone to vote on every decision
- B. Define decision rights, accountable ownership, consultation, and information roles
- C. Allow the most senior participant to decide informally
- D. Add a second project manager without clarifying authority

42. During executive rounding, a nurse reports that a policy is creating workarounds. What should the executive do?

- A. Ask the nurse to follow the policy until the next survey
- B. Tell the nurse that workarounds are a local management issue
- C. Promise an immediate policy change without assessment
- D. Thank the nurse, explore the workflow, verify the risk, and close the feedback loop

43. A nurse executive represents the health system in a public forum where stakeholders disagree about access. Which approach is best?

- A. Defend the organization by dismissing criticism
- B. Describe the system's position accurately, acknowledge legitimate concerns, and identify areas for collaboration
- C. Promise a solution that has not been approved
- D. Avoid discussing tradeoffs to protect the brand

44. A strategic plan contains ten priorities, each labeled urgent. What should the executive team do?

- A. Ask departments to work on all priorities simultaneously
- B. Rank priorities by which leader speaks first
- C. Use explicit criteria to narrow the portfolio to priorities the organization can resource
- D. Rename the priorities as goals without changing the workload

45. A regional service strategy has many activities but no clear link between work and intended outcomes. What should the executive add?

- A. More activities so every stakeholder has a task
- B. A communications plan that avoids discussing assumptions
- C. A deadline for completion without defining the intended result
- D. A logic model connecting resources, activities, outputs, outcomes, assumptions, and measures

46. A health system is considering centralizing transfer coordination. Which leadership question should come first?

- A. What problem, decision rights, service standards, and patient outcomes would centralization improve?
- B. Which department currently has the most staff
- C. Can the change be announced before workflow design
- D. Would centralization make the organization look more modern

47. A board member asks why a strategic target was missed. Which response best supports accountable leadership?

- A. Blame the department that owned the measure
- B. Describe only the factors outside the organization's control
- C. Promise that the target will be met without changing the plan
- D. Separate facts from assumptions, explain contributing factors, and recommend a corrective decision

48. A payer contract rewards lower utilization but may create barriers for patients who need complex care. What should the executive negotiate?

- A. Accept the contract because lower utilization always means better value
- B. Reject any financial incentive without examining its design
- C. Align incentives with access, outcomes, coordination, equity, and appropriate use of resources
- D. Track only the contract's savings report

49. A capital proposal has a positive projected return but would delay another initiative with a stronger safety benefit. What should the executive present?

- A. Only the positive return to speed approval
- B. The proposal's return, risk, opportunity cost, and comparison with alternative investments
- C. The proposal first because it was submitted earlier
- D. A promise to fund the safety initiative later without analysis

50. A department meets a volume target by shifting difficult cases to another service. What should the executive do?

- A. Review the measure's incentives, examine system outcomes, and redesign accountability across services
- B. Reward the department because its dashboard improved

- C. Add an even higher volume target
- D. Ignore the shift because each service manages its own results

51. A hospital is preparing for multiple oversight reviews. Which action best supports reliable readiness?

- A. Map each requirement to its authority, evidence, owner, and monitoring process
- B. Treat every oversight requirement as interchangeable
- C. Prepare only materials requested during the last review
- D. Let each unit interpret requirements independently

52. A clinical policy conflicts with current evidence and local workflow. What should the nurse executive do?

- A. Wait until the next survey to update the policy
- B. Tell staff to use the newer practice informally
- C. Replace the policy immediately without review
- D. Verify the evidence, assess implementation risk, and revise the policy through governance

53. Which planning activity should precede an emergency operations update?

- A. Copy a neighboring hospital's emergency plan
- B. Conduct a local hazard vulnerability analysis and identify capability gaps
- C. Schedule a drill before identifying priority hazards
- D. Write one generic response for every possible event

54. During a regional disaster involving several agencies, which structure best supports coordinated authority?

- A. Rotate command among department directors each hour
- B. Let every agency operate under a separate command structure
- C. Use incident command roles, common terminology, and defined reporting lines

D. Place all decisions with one clinical leader

55. An electronic health record outage lasts through a medication-administration period. What should the executive team prioritize?

- A. Tell staff to recreate the entire record from memory
- B. Delay all care until the system returns
- C. Activate downtime procedures, protect critical information, and coordinate safe restoration
- D. Allow each unit to invent its own documentation method

56. Which behavior best reflects preoccupation with failure in a high-reliability organization?

- A. Review only events that caused permanent injury
- B. Assume a period without harm proves the process is safe
- C. Discourage reporting so the unit's results look better
- D. Investigate a small recurring anomaly before it produces serious harm

57. A team proposes a simplified explanation for a complex medication error. Which high-reliability response is strongest?

- A. Ask what assumptions, conditions, and system interactions may have contributed
- B. Accept the simplest explanation because it is easiest to communicate
- C. Focus only on the last person who touched the medication
- D. Close the review if the policy was technically available

58. A rapid response nurse identifies a deteriorating patient before the primary team arrives. Which high-reliability principle is illustrated?

- A. Deference to the highest-ranking person regardless of expertise
- B. Deference to expertise at the point of greatest relevant knowledge
- C. Strict hierarchy that prevents independent escalation

D. Reliance on the most familiar routine rather than current assessment

59. A near miss was reported, but staff worry it will be used for punishment. What should the executive emphasize?

- A. Promise that no report will ever lead to review
- B. Punish the person closest to the event to demonstrate seriousness
- C. Use a fair accountability approach that separates human error, risky choice, and reckless conduct
- D. Stop accepting anonymous reports

60. A root-cause review finds that a policy was not followed during a serious event. What question should come next?

- A. Which employee should receive the strongest punishment
- B. Why did the work system make the unsafe action more likely or the safe action harder?
- C. How can the policy be rewritten with more pages
- D. Can the review be closed because training was completed

61. Which corrective action is strongest after repeated specimen-labeling errors?

- A. Redesign the labeling process to make the correct action easy and verify effectiveness
- B. Send another reminder email about careful labeling
- C. Ask staff to sign a statement promising attention
- D. Add a warning sign without changing the workflow

62. A hospital wants to assess the safety of a new infusion pump before implementation. Which method is most appropriate?

- A. Wait for an adverse event before assessing risk
- B. Review only the vendor's marketing summary
- C. Ask one experienced nurse to approve the device

D. Use failure mode and effects analysis to identify possible failures and mitigations prospectively

63. A risk register contains twenty hazards with no prioritization. What should the quality leader request?

- A. Rate likelihood, impact, detectability, and mitigation status using agreed criteria
- B. List hazards alphabetically for easier reading
- C. Remove low-frequency hazards regardless of severity
- D. Assign every hazard to the same manager

64. A plan of correction has been implemented for a documentation deficiency. Which evidence best demonstrates effectiveness?

- A. A signed memo stating that education was completed
- B. Sustained performance data showing the corrective process works across relevant settings
- C. One favorable audit immediately after training
- D. A policy revision without practice data

65. A hospital compares falls rates across units with very different patient volumes. What is essential for interpretation?

- A. Rank units by raw event count
- B. Exclude units with small volumes
- C. Use comparable denominators and examine acuity, exposure, and case mix
- D. Use the unit with the lowest rate as the universal target

66. Which measure would best show whether a new bedside handoff process was performed reliably?

- A. The number of staff meetings about handoff
- B. The annual patient-satisfaction score alone
- C. The total number of handoff policies printed

D. The proportion of observed handoffs meeting the defined process elements

67. A new discharge process reduces length of stay but increases return calls from confused patients. Which additional measure is most important?

- A. The number of project meetings held
- B. Measure unintended burden or harm from the change
- C. The number of staff who attended training
- D. The number of discharge forms available

68. A run chart shows several consecutive points above the prior median after a process change. What should the team do?

- A. Ignore the pattern until a full year of data is available
- B. Declare causation from the pattern alone
- C. Investigate whether the pattern represents a meaningful shift and relate it to the intervention
- D. Replace the measure because the chart is inconvenient

69. A control chart shows a point beyond the established control limits. What is the best initial response?

- A. Verify the data and investigate a possible special cause
- B. Adjust the limits immediately so the point fits
- C. Average the point away
- D. Redesign the entire process without investigating

70. A team wants to test a new rounding script on one unit before systemwide adoption. Which improvement approach is most appropriate?

- A. Implement the script everywhere before learning from use
- B. Study the idea only through a literature search
- C. Wait for a perfect protocol before testing it

D. Run a small plan-do-study-act cycle with a defined prediction and measures

71. A process map reveals that patients repeat the same information at four registration points. What should the improvement team ask next?

- A. Ask which steps add value and which duplicate work
- B. How can each registration point collect more information
- C. Which department should be blamed for the duplication
- D. Whether the map should be hidden from patients

72. A nurse executive is asked to adopt a published delirium intervention. What should the team do before implementation?

- A. Copy the intervention exactly without local assessment
- B. Appraise the evidence, assess local fit, and plan implementation and outcome evaluation
- C. Use the article's conclusion as proof of local success
- D. Distribute the citation and wait for spontaneous adoption

73. A quality project might become a publication using identifiable patient data. Which action is most appropriate?

- A. Assume all improvement work is automatically exempt
- B. Publish first and ask about oversight later
- C. Clarify whether the activity is research or improvement and obtain review
- D. Avoid documenting the project to keep it operational

74. An observation audit shows perfect hand hygiene, but observers announced their presence in advance. How should the result be interpreted?

- A. Declare the process reliable based on the perfect result
- B. Discard all hand-hygiene measurement permanently

- C. Increase the target to make the result more challenging
- D. Consider observation bias and repeat measurement using a credible sampling approach

75. Medication reconciliation errors continue during transitions between units. Which intervention is most likely to address the process?

- A. Ask each unit to reconcile medications independently
- B. Send a reminder about careful documentation
- C. Add more medication lists without assigning responsibility
- D. Define ownership, use a shared reconciliation workflow, and verify discrepancies at handoffs

76. A hospital sees a cluster of infections on one unit. What should the quality leader do first?

- A. Announce a systemwide outbreak before reviewing the data
- B. Confirm the signal, define the cases and time period, and begin a focused investigation
- C. Close the unit permanently without assessing the pattern
- D. Assume all cases have the same cause

77. A safety-culture survey shows that staff feel unable to challenge senior clinicians. Which response is best?

- A. Share the findings, engage staff in causes, and track specific leadership and speaking-up actions
- B. Repeat the survey until the score improves
- C. Publish the score without discussing it
- D. Tell staff to be more courageous in future surveys

78. A dashboard shows fewer pressure injuries, but the denominator changed after a documentation update. What should the executive do?

- A. Report the improvement immediately because the rate is lower
- B. Ignore the documentation change

- C. Reconcile definitions and denominators before concluding that performance improved
- D. Replace the outcome with a more favorable measure

79. A quality team wants to understand whether a discharge disparity affects specific populations. Which analysis is most useful?

- A. Use the overall average to represent every patient
- B. Remove demographic data to avoid comparison
- C. Compare only the highest-performing group
- D. Stratify outcomes and investigate pathways causing the difference

80. A chart review team has limited capacity to examine a large set of records. Which method improves credibility?

- A. Select the easiest records to retrieve
- B. Review only records with favorable outcomes
- C. Use a defined sampling plan and consistent inclusion criteria
- D. Change inclusion criteria as reviewers encounter difficulty

81. After an emergency drill, participants report that radios failed in several locations. What should happen next?

- A. Thank participants and wait for the next drill
- B. Document the gap, assign an owner, and test mitigation
- C. Purchase equipment without confirming the communication need
- D. Remove the radio step from the emergency plan

82. An emergency plan relies on one person to authorize all supply movement. Which improvement is most important?

- A. Define delegated authority and backup roles for essential decisions

- B. Add more supplies without clarifying authority
- C. Ask the single person to remain available indefinitely
- D. Delay movement until the person can be reached

83. A plan of correction has improved one unit's audit results, but other units show the same risk. What should the executive do?

- A. Declare the issue resolved because one unit improved
- B. Test whether the corrective process can be standardized and spread with local adaptation
- C. Require every unit to copy the intervention without assessment
- D. Close the project and stop monitoring

84. A nurse notices a mislabeled specimen before it leaves the unit. Which quality response is most appropriate?

- A. Discard the specimen and avoid documenting the event
- B. Praise the nurse and take no further action
- C. Wait to see whether the laboratory detects the error
- D. Protect the patient, report the near miss, and examine the labeling process for system defenses

85. A hospital must prioritize limited emergency supplies during a prolonged disruption. Which process is most reliable?

- A. Distribute supplies to the loudest requesting unit
- B. Let each unit keep its usual allocation regardless of demand
- C. Use an incident structure, defined clinical priorities, inventory data, and escalation rules
- D. Wait for a single executive to approve every item

86. A medication process has repeated selection errors between look-alike products. Which intervention is strongest?

- A. Redesign storage and verification steps, then measure whether selection errors decline
- B. Add a reminder sign above the storage area
- C. Ask staff to slow down without changing the process
- D. Send a message describing the last error

87. A benchmark shows that a hospital performs below a peer group, but the populations and definitions differ. What should the quality leader do?

- A. Adopt the peer's rate as the immediate target
- B. Exclude the hospital's highest-risk patients
- C. Confirm definitions, denominators, case mix, and collection methods first
- D. Stop benchmarking because comparisons are imperfect

88. A team reports that a new checklist is complete, but observations show critical steps are skipped. What should the executive examine?

- A. Count additional checklist signatures as proof of reliability
- B. The checklist's usability, workflow integration, training, and fidelity of actual use
- C. Blame staff for not valuing the checklist
- D. Remove the checklist because compliance is imperfect

89. A corrective-action plan improves one audit result, but leaders are unsure whether gains will last. Which follow-up is best?

- A. Define sustained measures, review trends, and assign an owner for ongoing monitoring
- B. Close the plan after the first favorable audit
- C. Repeat education every month without measuring performance
- D. Transfer monitoring to an unassigned committee

90. An employee tells a manager that a medical condition is making a work task difficult. What should the manager do first?

- A. Ask coworkers to decide whether the condition is serious
- B. Tell the employee to take unpaid leave immediately
- C. Require the employee to disclose details to the whole team
- D. Engage the appropriate accommodation process and focus on job functions and possible solutions

91. A supervisor wants to remove a worker from a role because of an assumption about what the worker can physically do. What should the executive emphasize?

- A. Use the supervisor's assumption as a safety rule
- B. Assess essential functions and actual capability rather than relying on stereotype
- C. Move the worker without discussing the job requirements
- D. Ask the worker to prove capability publicly

92. A unit has repeated exposure incidents involving sharps. Which workforce-safety response is strongest?

- A. Analyze the work system, provide appropriate controls and training, and monitor implementation
- B. Tell staff to be more careful without changing equipment
- C. Discipline the last employee involved
- D. Stop collecting exposure reports to reduce anxiety

93. An employee reports a safety concern and then receives an unexplained negative schedule change. What should the executive ensure?

- A. Tell the employee that scheduling is entirely discretionary
- B. Ask the employee to stop raising concerns
- C. Wait until the annual review to examine the pattern
- D. Review the action promptly for possible retaliation and apply consistent employment criteria

94. A manager says an experienced older nurse cannot learn a new technology. What should the executive address?

- A. Move older nurses away from technology-dependent roles
- B. Accept the manager's judgment because it is based on experience
- C. Require objective competency support and prohibit age-based assumptions about capability
- D. Ask the nurse to train alone to disprove the concern

95. An applicant pool narrows sharply after a screening test is introduced. What should the human-resources leader examine?

- A. Keep the test because fewer applicants make hiring faster
- B. Remove all screening from the process
- C. Choose the applicants with the most familiar backgrounds
- D. Review the test's job relevance, validity, impact, and alternatives

96. A hiring panel wants to select a candidate based on an informal conversation rather than scored interviews. What should the executive recommend?

- A. Allow each interviewer to use personal intuition
- B. Use structured questions, defined criteria, and documented evidence for each candidate
- C. Select the candidate who seems most like the current team
- D. Ask the panel chair to choose without discussion

97. A newly hired nurse completed orientation but has not demonstrated independent performance on a high-risk procedure. What is the best next step?

- A. Assign the nurse independently because orientation is complete
- B. Remove the procedure from the nurse's role permanently
- C. Use direct competency validation and provide supervised development before independent assignment
- D. Ask a coworker to sign off without observing performance

98. A manager wants to use an annual in-service attendance list as proof of competency. What should the executive explain?

- A. Education exposure is different from demonstrating knowledge, skill, judgment, and reliable performance
- B. Attendance always proves competency
- C. Competency can be assumed for experienced staff
- D. Competency should be assessed only after an event occurs

99. A staff member asks to perform a task that is not included in the organization's approved role expectations. What should the manager verify?

- A. Whether the staff member feels confident
- B. Whether another unit allows the task
- C. Applicable law, organizational policy, education, demonstrated competence, and supervision requirements
- D. Whether the task would save time today

100. A charge nurse plans to delegate a complex assessment to a novice staff member. What should guide the decision?

- A. The charge nurse's desire to finish rounds quickly
- B. Patient needs, task complexity, the staff member's competence, and available supervision
- C. Whether the novice has completed any orientation
- D. The task's usual assignment regardless of patient condition

101. A nurse manager and employee agree that conflict-management skills need development. Which plan is strongest?

- A. Assign a general leadership module with no follow-up
- B. Wait for the next annual review
- C. Move the employee away from conflict-prone work
- D. Set a specific goal, practice the skill, provide feedback, and review progress

102. A promotion process favors employees who have informal access to senior leaders. What should the executive do?

- A. Use transparent criteria, broaden development access, and review promotion patterns for equity
- B. Accept informal sponsorship as a normal leadership privilege
- C. Stop offering mentorship to avoid favoritism
- D. Promote the most visible employee regardless of criteria

103. Employees from a marginalized group say that meetings feel unsafe but cannot identify one single incident. What should the executive do?

- A. Dismiss the concern because no formal complaint was filed
- B. Listen without demanding a single proof point, examine patterns, and address the environment
- C. Ask employees to solve the issue privately
- D. Wait for a survey score before responding

104. A hospital's patient education materials are translated, but staff rarely use interpreter services. What should the executive review?

- A. Assume translated materials solve communication barriers
- B. Tell patients to bring family members to interpret
- C. Measure only the number of translated brochures
- D. Workflow access, expectations, competency, documentation, and patient experience data

105. A nurse reports repeated humiliating comments from a senior colleague. Which response is best?

- A. Tell the nurse to avoid the colleague
- B. Ask the nurse to confront the colleague alone
- C. Ensure safety, document the concern, investigate fairly, and address conduct through policy
- D. Ignore the behavior if no patient was harmed

106. A staffing plan treats every shift as needing the same number of nurses despite changing acuity. What should the executive introduce?

- A. A workload model that considers patient needs, skill mix, support, and escalation capacity
- B. Use a fixed ratio without examining patient needs
- C. Let each shift negotiate staffing informally
- D. Measure adequacy only by whether beds are open

107. A unit has frequent overtime and errors near the end of long shifts. Which workforce response should be prioritized?

- A. Examine workload and scheduling patterns, strengthen fatigue safeguards, and monitor outcomes
- B. Tell staff to manage fatigue individually
- C. Offer overtime to the same high performers
- D. Ignore the pattern because overtime fills shifts

108. Staff engagement scores have fallen after a reorganization. Which first step is most useful?

- A. Launch a morale campaign without reviewing the findings
- B. Blame managers for the score
- C. Share the results, listen for local drivers, and select a few accountable improvement actions
- D. Repeat the survey until leaders like the result

109. A nurse manager wants to retain experienced staff but has no budget for raises. Which action should come first?

- A. Offer a generic appreciation email to everyone
- B. Assume salary is the only retention driver
- C. Ask staff to make retention their personal responsibility
- D. Conduct stay interviews to learn what supports commitment and what creates avoidable frustration

110. An employee's performance has declined after role expectations changed. What is the fairest management response?

- A. Begin discipline without explaining the new expectations
- B. Clarify expectations, assess support and competence, and create a documented improvement plan
- C. Ignore the decline until a serious event occurs
- D. Compare the employee publicly with a high performer

111. Two employees commit the same documentation error, but only one receives discipline because the other is favored. What should the executive do?

- A. Apply consistent, proportionate standards after reviewing the facts
- B. Protect the favored employee to preserve retention
- C. Discipline both without reviewing context
- D. Avoid documenting the inconsistency

112. A department wants to use a bonus to improve reporting of safety concerns. What should the human-capital leader consider?

- A. Reward units with the fewest reported events
- B. Pay staff for reporting any event without review
- C. Make reporting optional for high performers
- D. Ensure incentives do not suppress honest safety reporting

113. A manager proposes paying new hires more than experienced nurses in the same role. What should the executive examine?

- A. Approve the difference because recruitment is difficult
- B. Ignore current staff concerns as a morale issue
- C. Internal equity, market factors, experience, role requirements, and a transparent compensation rationale
- D. Reduce experienced staff pay to restore uniformity

114. A shared-governance council recommends changing a clinical practice, but its authority is unclear. What should the executive do?

- A. Approve every council recommendation automatically
- B. Define the council's scope, decision rights, consultation route, and executive accountability
- C. Reject the recommendation because executives retain accountability
- D. Ask the council to implement the change without review

115. A professional practice council has members who rarely attend and decisions are dominated by two voices. Which improvement is best?

- A. Clarify membership expectations, use inclusive facilitation, and make participation meaningful
- B. Remove absent members without examining barriers
- C. Let the dominant voices make decisions faster
- D. Cancel the council and collect anonymous suggestions only

116. A union campaign begins in a hospital. What is the most appropriate leadership stance?

- A. Ask managers to persuade staff to oppose organizing
- B. Promise benefits in exchange for a vote
- C. Remain neutral, provide accurate information, and avoid coercion or retaliation
- D. Monitor which employees attend organizing meetings

117. A succession plan identifies no ready successor for a critical nursing role. What should the executive do?

- A. Name the longest-tenured employee immediately
- B. Wait until the vacancy occurs before acting
- C. Keep the gap confidential so the role appears stable
- D. Create interim coverage and targeted development while broadening the talent pipeline

118. A nurse manager wants to improve inclusion after a staff survey shows that some voices are routinely interrupted. Which action is best?

- A. Ask quieter staff to speak louder
- B. Set meeting norms, facilitate equitable participation, and monitor whether behavior changes
- C. Ban disagreement during meetings
- D. Use attendance as the only inclusion measure

119. A unit has rising workplace-violence reports. Which workforce strategy should be prioritized?

- A. Tell staff to avoid isolated areas without changing the environment
- B. Stop reporting to protect the unit's reputation
- C. Use incident data and staff input to strengthen prevention, response, and post-event support
- D. Rely only on a single annual training session

120. An employee requests a schedule adjustment for a sincerely held religious practice. What should the manager do first?

- A. Use the established accommodation process and assess options against essential operations and consistent criteria
- B. Deny the request because schedules must never change
- C. Ask coworkers to vote on whether the practice is valid
- D. Require the employee to explain personal beliefs to the whole unit

121. A primary-care network wants to redesign services around people with multiple chronic conditions. Which model element is most important?

- A. Specialty visits without primary-care coordination
- B. A portal that replaces all human care coordination
- C. Separate programs that optimize each department independently

D. Coordinated, comprehensive care with access, continuity, and patient partnership

122. A telehealth program serves patients who may be located in different jurisdictions. What should leaders verify before expansion?

- A. Assume the clinician's home location answers every requirement
- B. Patient location, clinician requirements, privacy safeguards, competence, and escalation pathways
- C. Treat remote care as risk-free because no facility is used
- D. Use one workflow without considering technology limits

123. A virtual-care service has low use among patients with limited broadband and language barriers. What should the executive prioritize?

- A. Assess digital access, language, disability, affordability, and non-digital alternatives
- B. Require every patient to use the same video platform
- C. Measure success only by virtual-visit volume
- D. Assume low use means patients do not value care

124. A health system wants durable access in an underserved region. Which workforce strategy is strongest?

- A. Open a clinic without a staffing or retention plan
- B. Build education, residency, preceptor, and community-partner pathways tied to local needs
- C. Rely on temporary clinicians for long-term access
- D. Copy urban workflows without local assessment

125. A hospital is choosing between a fixed staffing model and a flexible model for seasonal demand. What should the executive compare?

- A. Choose the model with the lowest scheduled hours
- B. Use the same model because another hospital uses it

- C. Decide from staff preference without outcome data
- D. Demand variability, skill mix, continuity, cost, quality, and the safeguards of each model

126. A competent adult declines a recommended procedure after receiving understandable information. Which ethical principle is most directly involved?

- A. Beneficence through overriding the refusal
- B. Justice through requiring equal treatment
- C. Respect for autonomy through informed and voluntary decision making
- D. Fidelity through withholding risk information

127. A patient lacks capacity and has not documented preferences. Which approach should guide a surrogate decision?

- A. Allow the most vocal relative to decide without verifying authority
- B. Use known values when available and best-interest reasoning when preferences are unknown
- C. Choose the least expensive treatment automatically
- D. Delay all care until every relative agrees

128. A limited therapy must be allocated among eligible patients. Which process is most ethically defensible?

- A. Give priority to patients who can pay the most
- B. Allow each clinician to use hidden personal judgment
- C. Allocate the therapy to the first family that calls
- D. Apply transparent, relevant criteria consistently and provide review or appeal mechanisms

129. A manager asks for a patient's diagnosis to be shared with staff who are not involved in the patient's care. What should the executive reinforce?

- A. Share the full record so everyone is informed

- B. Permit discussion in public areas if names are omitted
- C. Share only information needed for an authorized care or operational purpose
- D. Use the patient's story for education without checking authorization

130. A goals-of-care dispute persists after clinicians and family review the medical facts. Which role should an ethics consultant take?

- A. Facilitate deliberation about facts, values, responsibilities, and patient-centered options
- B. Replace the attending clinician's decision
- C. Choose the option favored by the most vocal relative
- D. Issue a legal ruling without hearing stakeholders

131. Nurses report moral distress because they repeatedly provide care they believe conflicts with patient goals. What should leaders do?

- A. Tell nurses that professional duty requires silence
- B. Offer counseling without examining the care system
- C. Move distressed nurses without reviewing the recurring pattern
- D. Provide ethics support and address organizational conditions that constrain appropriate care

132. A new evidence-based mobility intervention is being considered for systemwide adoption. Which sequence is most appropriate?

- A. Adopt the article's intervention without local assessment
- B. Wait until every organization uses it
- C. Appraise the evidence, assess local fit, engage users, implement, and evaluate outcomes
- D. Distribute the citation and assume practice will change

133. A project intends to publish findings from an intervention using identifiable patient data. What should the executive ensure?

- A. Clarify the project's purpose and obtain the appropriate research or improvement review
- B. Assume operational work never needs oversight
- C. Publish the findings and address review later
- D. Avoid documenting the project to reduce administrative burden

134. A bedside nurse asks why medication delays occur at discharge. Which response best supports a spirit of inquiry?

- A. Say that discharge delays are unavoidable
- B. Frame a focused question and examine workflow data with the people doing the work
- C. Ask the nurse to collect data alone without support
- D. Change the process immediately without defining the problem

135. A health system compares outcomes across services with different levels of patient complexity. What should leaders do before ranking performance?

- A. Rank services by unadjusted outcomes alone
- B. Review case mix and use appropriate risk adjustment while examining possible inequity
- C. Exclude the service caring for the sickest patients
- D. Replace the outcome with a measure that is easier to compare

136. Overall readmissions improve, but the rate worsens for patients who need language assistance. What should the executive do?

- A. Report only the improved overall average
- B. Assume the subgroup result is random variation
- C. Stratify results, investigate communication barriers, and target transition support
- D. Stop collecting language information

137. A patient-experience score declines after a new scheduling process begins. Which evaluation is most useful?

- A. Combine survey results, patient narratives, access data, and staff observations
- B. Use the score alone to identify the cause
- C. Dismiss the result because clinical outcomes improved
- D. Ask leaders to interpret comments without reviewing workflow

138. A hospital's readmissions rise after earlier discharge. Which response should be examined first?

- A. Reverse every discharge regardless of patient need
- B. Increase inpatient testing without reviewing the transition
- C. Ask patients to call only if they become confused
- D. Strengthen transition planning, medication understanding, follow-up, and cross-setting communication

139. A clinic redesign is intended to improve access for patients with transportation barriers. Which design method is best?

- A. Design the clinic solely from executive assumptions
- B. Ask one patient to approve a finished plan
- C. Co-design the workflow with patients, caregivers, staff, and community partners
- D. Use access data only after implementation

140. Which factors should guide selection of a systemwide clinical technology?

- A. The number of vendor features
- B. The lowest purchase price without lifecycle analysis
- C. The preference of the most senior clinician
- D. Clinical fit, usability, interoperability, safety, equity, total cost, and implementation capability

141. A health system is considering an artificial-intelligence model to predict deterioration. Which governance requirement is essential?

- A. Validate locally, monitor bias and drift, and retain accountable human oversight
- B. Deploy because the vendor's validation was favorable
- C. Allow the model to make irreversible decisions without review
- D. Judge success only by alert volume

142. A predictive model identifies many patients as high risk, but few experience the predicted event. What should be examined?

- A. Increase alerts so no patient is missed
- B. Calibration, threshold selection, false positives, workflow burden, and subgroup performance
- C. Assume accuracy because the model is mathematically complex
- D. Remove clinical review to preserve automation

143. Which cybersecurity practice best limits the effect of a compromised clinical account?

- A. Give every employee broad access to avoid delays
- B. Share a department password during shortages
- C. Rely only on an annual security lecture
- D. Use least-privilege access, strong authentication, monitoring, and timely revocation

144. Two hospitals use different definitions for the same quality outcome. What should the executive sponsor?

- A. A larger report containing both definitions without reconciliation
- B. A shared data model with common definitions, interfaces, ownership, and validation
- C. A manual spreadsheet maintained by one analyst
- D. Separate dashboards that avoid comparison

145. Clinicians report that an electronic alert system produces too many low-value warnings. What should leaders do?

- A. Prioritize alerts by clinical value, test changes with users, and monitor missed-risk tradeoffs
- B. Add more alerts so important warnings are not overlooked
- C. Turn off the system without reviewing performance
- D. Require identical acknowledgment for every alert

146. After a clinical information system goes live, frontline adoption remains poor despite technical reliability. Which implementation action should the executive prioritize?

- A. Declare success because the system went live on schedule
- B. Add a policy requiring use without observing workflow
- C. Use workflow-based training, local champions, feedback, and iterative improvement
- D. Replace users who report usability problems

147. A remote-monitoring program receives an alert for a patient whose condition is worsening. What design element is essential?

- A. A dashboard that displays alerts without assigning ownership
- B. Defined thresholds, responsible reviewers, response times, escalation routes, and patient communication
- C. A policy asking patients to decide whether staff respond
- D. One daily review regardless of clinical urgency

148. A community assessment links poor chronic-disease outcomes with transportation and food insecurity. Which delivery strategy is strongest?

- A. Tell clinicians to provide advice without referral capacity
- B. Measure only clinic visits because social needs are external
- C. Partner with community organizations and integrate social-needs support into care planning
- D. Build a separate program without affected residents

149. A health system evaluates a patient-facing technology after six months. Which evaluation is most complete?

- A. Count downloads and declare success
- B. Use only the vendor's satisfaction report
- C. Evaluate only whether staff time decreased
- D. Examine outcomes, safety, equity, usability, adoption, experience, and total cost

150. A virtual-care service works well for English-speaking patients but has poor follow-up among patients with limited English proficiency. What should leaders do?

- A. Review language access, interpreter workflow, usability, and outcome differences before scaling
- B. Scale the service because overall satisfaction is high
- C. Ask patients to use family members as interpreters
- D. Remove language data from the evaluation

Practice Exam 16: Answer Key and Explanations

- 1. C** — Complex integration requires leaders to help people learn together while preserving attention to mission and outcomes. Immediate imposition, passive waiting, and permanent separation avoid the relational work that makes integration sustainable. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 2. B** — Executive presence combines composure, candor, accountability, and a clear recommendation grounded in evidence. False certainty, selective reporting, and deflection reduce confidence because decision makers cannot see the real risk. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 3. A** — Relationship building begins with curiosity about the other party's experience, interests, and capacity rather than with a finished answer. A finished proposal, imposed measures, or legal-only contact can signal that the relationship is transactional. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 4. D** — Strategic assessment should connect organizational capability with external conditions and the needs of the population served. Advocacy, imitation, and premature budgeting can produce priorities that do not fit the local problem or available capability. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 5. C** — Scenario planning helps leaders examine how different assumptions could affect demand, capacity, finances, and strategic risk. Optimism, indefinite delay, and competitor reaction do not provide

a disciplined way to prepare for multiple futures. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

6. B — Governance establishes direction, risk tolerance, oversight, and accountability while management operates the program. Daily technical control, transaction-level direction, and reflexive replacement blur oversight with execution. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

7. B — A useful committee charter makes its role and boundaries explicit so deliberation can lead to accountable action. More meetings, private decisions, and escalation without a clear question preserve the ambiguity that caused the delay. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

8. A — Complex projects need a shared frame that identifies affected groups, dependencies, authority, scope, and intended outcomes. Single-department ownership, early configuration, and separate success definitions invite gaps and competing expectations. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

9. C — Readiness assessment and representative testing reveal practical barriers and allow the intervention to improve before wider adoption. Forced use, indefinite postponement, and secondhand explanation either ignore operational knowledge or prevent learning. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

10. D — A sponsor coalition makes the purpose and decisions coherent so the project team receives consistent direction. Multiple messages, title-based control, and hidden disagreement increase confusion and weaken implementation credibility. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

11. A — Explicit dependency management makes hidden constraints visible and supports timely mitigation before the critical path fails. Informal waiting, unrelated staffing, and silent scope reduction do not manage the consequence of the dependency. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

12. D — Change control makes tradeoffs visible and preserves accountability for changes to an approved project baseline. Automatic approval, automatic rejection, and vendor-only judgment each bypass informed governance of consequences. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

13. B — Sponsors must make accurate information safe to share and use it to address scope, capacity, dependencies, and leadership barriers. Optimism demands, indiscriminate replacement, and abrupt cancellation can hide or discard the information needed to recover. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

14. C — Specific observation, reflection, and a practice goal connect coaching to behavior the learner can change. A lecture, public demonstration, or delayed feedback is less likely to produce insight and deliberate practice. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

15. C — Behavior-focused feedback reduces defensiveness and creates a shared basis for understanding and improvement. Labels, indirect discussion, and vague requests do not identify what should change or why it matters. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

16. D — Mentoring supports longer-term growth and perspective while complementing, rather than replacing, coaching, evaluation, and sponsorship. A single correction, formal performance action, or promotion authority represents a different leadership process. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

17. A — Succession planning builds readiness deliberately by connecting capability gaps with experiences, support, and evidence of progress. Immediate promotion, passive waiting, and tenure-only selection do not demonstrate readiness for enterprise responsibility. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

18. B — Calibration makes expectations explicit and helps leaders identify inconsistent standards or bias before talent decisions are made. Averaging, unchecked subjectivity, and abandoning ratings avoid rather than improve decision quality. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

19. C — Interest-based facilitation exposes the operational needs behind positions and creates criteria that can guide a fair decision. Revenue alone, undefined compromise, and private decisions can leave the underlying conflict and perceived unfairness intact. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

20. A — Negotiation improves when parties identify the needs behind positions and use shared criteria to evaluate options. Repetition, unrelated trades, and outsourcing the decision do not create a durable operational agreement. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

21. D — Practical consensus clarifies what is shared and how remaining choices will be resolved without confusing unanimity with progress. Unanimity, personal versions, and premature closure can delay action or create uncoordinated implementation. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

22. B — Crisis communication reduces uncertainty by separating known facts from open questions and giving stakeholders an actionable next step. Vague monitoring, perfectionistic delay, and inconsistent messages invite rumor and weaken trust. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

- 23. B** — Leaders shape speaking-up behavior through their response to information, especially when reports reveal system vulnerability. Compulsion without trust, harm-only reporting, and public blame may suppress the very learning the organization needs. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 24. D** — Self-regulation protects judgment and allows the leader to distinguish a valid concern from the emotional delivery. Immediate defense, gossip-based review, and dismissal can escalate conflict or conceal useful information. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 25. A** — Values become credible when daily leader behavior and organizational consequences reinforce the stated expectation. Posters, staff-only responsibility, and meeting attendance do not correct contradictory signals from senior leadership. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 26. C** — A measurable objective defines the outcome, time frame, and an equity lens for accountability and evaluation. Aspirations and encouragement do not establish a testable standard or show whether improvement is distributed fairly. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 27. D** — Strategy gives a future aspiration practical meaning through choices about priorities, resources, behaviors, and measures. New wording, independent interpretations, and unlinked financial targets leave the aspiration disconnected from execution. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 28. A** — Cascading strategy preserves enterprise intent while translating it into actionable accountability at each operational level. Untranslated goals, unrelated activity, and meeting counts do not show contribution to access outcomes. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 29. C** — A useful dashboard connects indicators to decisions and balances early signals with results that confirm strategic impact. More data, a single financial result, and perfectionism can obscure rather than improve executive oversight. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 30. B** — A business case is credible when its assumptions and consequences are explicit enough for leaders to test and compare. Early announcement, marketing language, and appearance do not establish operational or financial feasibility. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 31. C** — Total-cost analysis includes the resources required to operate and sustain a solution, not merely the acquisition price. Purchase price, omitted training, and feature count can all misrepresent the actual value of the investment. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.
- 32. B** — Sensitivity analysis helps decision makers distinguish robust value from a conclusion that depends on one fragile assumption. Optimism, hidden assumptions, and automatic rejection are poor

substitutes for understanding uncertainty. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

33. A — Driver-based variance analysis identifies why spending changed and helps leaders protect care while addressing the actual cause. Equal cuts, blame, and recruitment freezes may worsen workload and fail to correct the spending driver. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

34. D — Value-oriented management considers the result and the resources used to achieve it across the patient's care journey. Volume, revenue alone, and isolated cost reduction can reward activity while worsening outcomes or access. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

35. D — Portfolio prioritization makes tradeoffs visible so limited capacity is directed toward the most defensible combination of value and feasibility. Presentation quality, request order, and equal splitting do not reveal which initiative can actually succeed. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

36. B — Partnership governance turns goodwill into a shared operating model with accountability and reciprocal value. Informality, one-sided workflow, and referral volume alone can create burden without improving community outcomes. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

37. A — Stage-gate decisions protect the organization from scaling an appealing idea before evidence and implementation capacity are adequate. Popularity, indefinite piloting, and universal approval are incomplete criteria for responsible scale. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

38. C — Benefits realization asks whether completed work produced the value that justified the investment and what assumptions failed. Activity completion, more volume, and abandoned measurement confuse effort with impact. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

39. A — A structured after-action review converts experience into organizational knowledge and connects lessons to future ownership. Celebration, archiving, and memory do not reliably change the next project or preserve learning. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

40. C — Visible modeling demonstrates commitment and helps leaders discover implementation barriers alongside the people doing the work. Statements without behavior, staff-only piloting, and delayed use weaken the change message. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

41. B — Clear decision rights prevent diffusion of accountability while preserving appropriate consultation and subject-matter input. Universal voting, informal hierarchy, and added titles can slow decisions without clarifying responsibility. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

42. D — Rounding is valuable when leaders listen, investigate, and communicate what was learned and what will happen next. Deferral, dismissal, and unassessed promises either ignore the signal or create expectations without evidence. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

43. B — External representation requires candor, respect for stakeholders, and disciplined communication about what the organization can responsibly do. Dismissal, unauthorized promises, and hidden tradeoffs may protect a momentary image while damaging long-term trust. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

44. C — Strategy requires choice; narrowing the portfolio protects capacity and gives the organization a credible path to execution. Simultaneous work, speaking order, and relabeling do not resolve resource constraints or improve focus. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

45. D — A logic model makes the strategy testable by showing how work is expected to create value and where assumptions could fail. More activity, hidden assumptions, and completion dates do not show whether the strategy can produce its intended result. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up.

46. A — Operating-model choices should begin with purpose, accountability, workflow, and outcomes rather than organizational fashion. Staff count, early announcement, and appearance do not establish that centralization solves the actual problem. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

47. D — Accountability combines ownership with an honest explanation and a decision about how the organization will learn or adapt. Blame, externalization, and unsupported promises do not help the board evaluate stewardship or next steps. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

48. C — Business acumen includes examining how reimbursement incentives shape care, access, behavior, and unintended consequences. Automatic acceptance, automatic rejection, and savings alone can miss patient and system effects. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

49. B — Capital stewardship compares investments in context, including what the organization gives up by choosing one option. Selective return, submission order, and unsupported promises hide the portfolio tradeoff. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

50. A — Executive oversight should detect when local measures encourage behavior that worsens the broader care system. Dashboard reward, higher pressure, and siloed ownership can reinforce gaming rather than improvement. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

51. A — A requirements map helps leaders distinguish purposes and evidence while assigning accountability for sustained compliance. Interchangeability, historical preparation, and independent interpretation can leave important obligations misunderstood or unsupported. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

52. D — Policy revision should be evidence-informed, governed, and translated into practice so expectations remain clear and reliable. Waiting, informal workarounds, and unreviewed replacement create inconsistent practice and avoidable risk. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

53. B — Local hazard analysis connects likely threats with impact, existing capability, and gaps that the plan must address. Copied plans, premature drills, and generic responses may miss the risks most relevant to the organization. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

54. C — A common incident structure supports coordination, resource management, and clear authority while allowing expertise to inform decisions. Rotation, isolated command, and one-person control increase confusion and exceed individual management capacity. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

55. C — Downtime management protects patient care by using prepared workflows, preserving essential information, and coordinating recovery. Memory-based reconstruction, blanket delay, and unit-specific improvisation increase error and fragmentation. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

56. D — High reliability treats weak signals and near misses as opportunities to detect system vulnerability early. Harm-only review, complacency, and reporting suppression remove the information needed for prevention. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

57. A — High-reliability thinking resists oversimplification and examines how work conditions shape behavior and outcomes. Easy narratives, last-person blame, and policy availability alone can hide latent system conditions. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

58. B — Deference to expertise allows the person with the most relevant knowledge to influence urgent decisions. Rank, rigid hierarchy, and routine familiarity can delay recognition when the situation changes. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

59. C — Fair accountability supports learning while preserving a response to intentional or unjustifiable risk-taking. Blanket immunity, proximity-based punishment, and reduced reporting undermine trust and

learning. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

60. B — Systems analysis looks at conditions, design, workload, resources, and feedback rather than treating policy existence as prevention. Punishment, policy length, and training completion alone do not explain why behavior occurred in context. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

61. A — Strong actions change the system and include measurement to determine whether the hazard has actually decreased. Reminders, promises, and warning signs rely mainly on memory and may leave the error pathway intact. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

62. D — Prospective risk assessment identifies how a process could fail before patients are exposed and supports planned mitigation. Waiting for harm, marketing material, and one-person approval are incomplete protections. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

63. A — Prioritization criteria help leaders direct attention and resources to risks that warrant action first. Alphabetical order, frequency alone, and uniform assignment do not reflect meaningful risk differences. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

64. B — Effectiveness requires evidence that the changed process is reliable over time, not merely that a response was announced. A memo, one early audit, and a policy revision cannot demonstrate sustained performance. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

65. C — Rates become meaningful when numerator and denominator definitions and relevant population differences are understood. Raw counts, exclusion, and uncritical target copying can produce misleading conclusions. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

66. D — A process measure evaluates whether the intended behavior occurred and can be linked to later outcome analysis. Meetings, a broad satisfaction result, and printed policies do not show process reliability. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

67. B — Balancing measures reveal whether improvement in one outcome creates harm, burden, or delay elsewhere in the system. Activities and materials do not show the unintended effect suggested by the return calls. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

68. C — Run-chart signals prompt disciplined review of change over time while avoiding claims that exceed the available evidence. Waiting, overclaiming, and discarding the measure each weaken useful

learning. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

69. A — A special-cause signal calls for verification and investigation before leaders make broader process changes. Changing limits, averaging away the signal, and redesigning blindly can conceal the cause. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

70. D — Small tests allow teams to learn quickly, compare results with a prediction, and adapt before scaling. Systemwide launch, literature alone, and perfectionistic delay do not generate local implementation learning. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

71. A — Process mapping supports improvement when teams distinguish value, waste, handoffs, and information flow. More collection, blame, and concealment increase burden or suppress learning instead of improving flow. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

72. B — Evidence-based practice connects credible findings with local context, implementation support, and evaluation of results. Copying, assuming transferability, and distributing information alone do not produce reliable practice change. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

73. C — Early classification and appropriate oversight protect participants and support ethical use of data. Automatic exemption, delayed review, and undocumented work create avoidable governance risk. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

74. D — Measurement design affects validity; leaders should examine whether observation changed behavior or excluded ordinary conditions. Celebration, permanent abandonment, and arbitrary targets do not address the validity concern. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

75. D — Reliable reconciliation requires clear ownership, common information, and verification where responsibility changes. Independent work, reminders, and additional lists can preserve the handoff gap. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

76. B — Early surveillance work establishes whether the pattern is real and defines the problem before interventions are selected. Premature announcement, irreversible closure, and assumed causation can create harm without improving control. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

77. A — Culture data become useful when leaders make the results visible and act on the conditions that shape behavior. Repeated measurement, publication alone, and staff blame do not change the underlying environment. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

78. C — Trend interpretation depends on stable definitions and denominators so apparent improvement reflects real performance. Immediate reporting, ignored data changes, and measure substitution can create a false success signal. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

79. D — Stratification reveals whether an average conceals unequal experience or outcome and points toward targeted improvement. Averages, data removal, and selective comparison hide rather than address disparities. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

80. C — A transparent sampling plan reduces selection bias and makes findings more interpretable and reproducible. Convenience, favorable-only review, and changing criteria weaken confidence in the result. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

81. B — Exercises are valuable when findings become assigned, tested corrective actions rather than observations that disappear. Waiting, unassessed purchasing, and deleting the step leave the communication vulnerability unresolved. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

82. A — Continuity depends on role clarity and redundancy so essential decisions continue when one leader is unavailable. More supplies, heroic availability, and delay do not correct a single point of failure. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

83. B — Spread requires evidence that the change works and attention to how context affects adoption across settings. One-unit success, rigid copying, and stopped monitoring cannot establish reliable system performance. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

84. D — Near-miss reporting creates an opportunity to prevent harm by learning from a failure intercepted in time. Nonreporting, praise without learning, and waiting for detection squander the safety signal. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

85. C — Scarce-resource management needs transparent priorities, current information, and delegated authority so decisions remain coordinated. Loudness, routine allocation, and one-person approval can create inequity and delay during a changing event. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

86. A — A reliable intervention changes the conditions that produce error and checks whether the redesign works in practice. Signs, exhortations, and retrospective messages rely mainly on memory and leave the selection pathway unchanged. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

87. C — Benchmarking supports learning only when leaders understand whether differences reflect performance, population, or measurement. Automatic targets, exclusions, and abandonment can produce unfair conclusions or discard useful information. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

88. B — Implementation quality depends on whether the tool fits work and is used as intended, not simply whether it exists or is signed. Signatures, blame, and removal do not reveal why the process is unreliable. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

89. A — Sustainment requires continued measurement, ownership, and a response plan when performance begins to drift. Early closure, education without data, and unassigned monitoring do not protect against recurrence. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

90. D — A structured accommodation process protects privacy while examining essential work and reasonable ways to support performance. Coworker judgment, automatic leave, and broad disclosure can be unfair, intrusive, or unrelated to the job requirement. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

91. B — Fair workforce decisions compare actual job requirements with evidence and available support rather than assumptions about disability. Stereotype, unilateral movement, and public proof can create discrimination and reduce trust. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

92. A — Workplace safety improves when leaders address hazards through system controls, education, and feedback rather than blame alone. Caution messages, individual punishment, and suppressed reporting leave the hazard pathway intact. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

93. D — Retaliation concerns require prompt, impartial review of timing, rationale, and consistency with how others are treated. Discretion claims, silencing, and delayed review can permit unfair treatment to continue. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

94. C — Development and assignment decisions should rely on observed competency and support needs, not age stereotypes. Role removal, deference to stereotype, and solo proof are not fair or effective development practices. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

95. D — Selection tools should be related to the work and reviewed for unintended exclusion and consistent application. Speed, no screening, and familiarity do not establish a fair or job-related selection process. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

96. B — Structured selection improves consistency, job relevance, and the ability to review how decisions were made. Intuition, similarity preference, and unilateral choice increase bias and reduce accountability. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

97. C — Orientation introduces role expectations; competency validation confirms performance in the actual task before independent practice. Completion, permanent exclusion, and unobserved sign-off do not establish safe competence. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

98. A — Competency requires evidence that the person can perform the role safely and consistently, not merely that education was offered. Attendance, experience assumptions, and event-triggered assessment leave performance unverified. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

99. C — Scope decisions depend on governing requirements and demonstrated competence, not confidence, custom, or convenience alone. Confidence, another unit's practice, and immediate efficiency are insufficient safeguards for role decisions. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

100. B — Delegation is a clinical and leadership judgment that matches the task and patient with capability and oversight. Convenience, partial orientation, and routine assignment do not account for patient-specific risk. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

101. D — Development is more effective when it connects an identified gap with practice, feedback, support, and a time to reassess. A module alone, delayed review, and avoidance do not build or verify the skill. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

102. A — Equitable talent systems make opportunity and criteria visible while examining whether access patterns distort advancement. Unexamined privilege, ending mentorship, and visibility alone do not create fair advancement. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

103. B — Psychological safety concerns can emerge from cumulative patterns that require listening, data, and visible leadership action. No single incident, private burden, and delayed response can allow harmful conditions to persist. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

104. D — Language access depends on reliable workflows and staff capability as well as written materials. Brochures, family interpretation, and material counts do not demonstrate understandable communication. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

105. C — Incivility can harm staff safety, retention, and patient care, so leaders must respond through fair and protective processes. Avoidance, unsupported confrontation, and patient-harm-only thresholds do not address the workplace risk. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

106. A — Workload-based planning aligns staffing resources with the complexity and support required for safe care. Fixed numbers, informal negotiation, and open beds alone do not demonstrate adequate capacity. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

107. A — Fatigue risk is influenced by system design, workload, scheduling, and recovery opportunities, not only personal choice. Individual blame, repeated reliance on a few staff, and filled shifts can leave risk unchanged. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

108. C — Engagement improves when leaders treat feedback as information about work conditions and respond visibly. Campaigns, blame, and repeated measurement without action do not address the conditions staff experience. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

109. D — Stay interviews identify local, actionable retention factors that may include workload, growth, recognition, scheduling, and leadership. Generic praise, salary-only assumptions, and personal responsibility do not reveal the specific retention problem. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

110. B — Fair performance management gives the employee clear expectations, a chance to improve, and consistent support and follow-up. Immediate discipline, delayed response, and public comparison undermine fairness and learning. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

111. A — Consistent standards require leaders to examine context while avoiding favoritism and arbitrary differences in consequence. Protection, automatic equal punishment, and concealment each weaken trust and procedural fairness. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

112. D — Incentives shape behavior and can undermine safety if they reward low reporting rather than honest learning and prevention. Few reports, unreviewed volume, and high-performer exceptions can create misleading signals or unfairness. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

113. C — Compensation decisions should balance external competitiveness with internal equity and a rationale employees can understand. Recruitment urgency, dismissal, and across-the-board reduction do not create a defensible pay system. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

114. B — Professional governance is strongest when frontline authority and executive accountability are explicitly connected. Automatic approval, rejection, and unreviewed implementation each misunderstand shared governance. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

115. A — Effective governance depends on representative participation, clear expectations, and processes that make diverse expertise usable. Removal, dominance, and replacement with suggestions alone may reduce ownership and representation. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

116. C — Labor-relations leadership must respect employee choice and maintain a fair workplace while communicating accurate information. Opposition campaigns, promises, and surveillance can coerce employees and damage trust. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

117. D — A readiness gap requires both continuity protection and deliberate development or recruitment to reduce future vulnerability. Tenure-only choice, delay, and concealment do not protect the organization or develop capability. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

118. B — Inclusion requires leaders to change interaction patterns and assess whether people can influence decisions. Speaking louder, suppressing disagreement, and attendance do not address unequal participation. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

119. C — Workplace safety improves through layered prevention, reliable response, learning from events, and support after harm. Avoidance, suppressed reporting, and annual training alone do not address environmental or operational risk. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

120. A — A fair process respects the request while examining workable options, operational needs, and consistent treatment of employees. Automatic denial, coworker voting, and broad disclosure do not provide a respectful or reliable employment process. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

121. D — Patient-centered delivery connects services around the person's needs rather than organizing care only by department. Uncoordinated specialty care, portal substitution, and departmental optimization fragment the patient journey. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

122. B — Telehealth changes care location but does not remove professional, privacy, clinical, or operational responsibilities. Home-location assumptions, risk-free framing, and one workflow can leave patients and clinicians unprotected. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

123. A — Equitable digital delivery examines structural barriers and preserves safe alternatives when technology does not fit the patient. Uniform technology, volume-only measurement, and patient-blaming overlook access conditions. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

124. B — A workforce pipeline connects training, recruitment, retention, and community priorities rather than treating access as a building problem. A clinic without capacity, temporary-only staffing, and copied workflows are unlikely to sustain access. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

125. D — Staffing models should be judged by how they match demand and protect continuity, quality, workforce sustainability, and cost. Scheduled hours, imitation, and preference alone do not show whether the model can deliver safe care. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

126. C — Autonomy requires meaningful information, capacity, voluntariness, and the opportunity to accept or refuse care. Perceived benefit, equal treatment, and incomplete disclosure do not justify replacing a capable patient's choice. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

127. B — Ethical surrogate decisions represent the patient when possible and otherwise use a reasoned best-interest standard. Volume, cost alone, and unanimous family agreement are not reliable ethical decision rules. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

128. D — Fair allocation requires relevant criteria, consistency, transparency, and accountability when resources are scarce. Ability to pay, hidden judgment, and lobbying do not provide an equitable process. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

129. C — Privacy-respecting delivery limits access and disclosure to legitimate needs and uses appropriate safeguards for education. Full-record access, public discussion, and unreviewed storytelling can expose information beyond the care purpose. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

130. A — Ethics consultation supports a structured process rather than taking over clinical authority or deciding by volume. Replacement decisions, vocal-family preference, and legal ruling exceed the consultant's facilitative role. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

131. D — Moral distress can reflect unresolved conflict and system constraints, so support must include both people and conditions. Silence, individual-only counseling, and relocation may leave the underlying ethical problem unchanged. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

132. C — Evidence translation connects credible knowledge with context, implementation support, and evaluation of real-world results. Copying, waiting indefinitely, and distributing information alone do not create reliable adoption. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

133. A — Early review protects participants and clarifies the governance pathway before data use and publication decisions occur. Automatic exemption, delayed oversight, and undocumented work create avoidable ethical risk. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

134. B — Inquiry turns frontline observations into disciplined learning while preserving staff ownership of the problem and solution. Dismissal, unsupported data collection, and immediate change bypass understanding. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

135. B — Fair outcome interpretation accounts for patient risk while preserving attention to variation, quality, and equity. Unadjusted ranking, exclusion, and measure substitution can punish services or hide problems. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to

outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

136. C — Stratification prevents aggregate improvement from concealing unequal outcomes and directs attention to modifiable barriers. Averages, assumptions, and data removal make disparities less visible rather than improving care. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

137. A — Mixed-method evaluation connects what patients report with the operational conditions that shape their experience. A score alone, clinical dismissal, and leader-only interpretation can miss the mechanism of dissatisfaction. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

138. D — Readmissions can reflect gaps across preparation, medication, follow-up, access, and communication rather than one discharge decision. Universal reversal, inpatient testing alone, and patient-only responsibility do not repair the transition pathway. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

139. C — Patients and community partners contribute knowledge about burden, trust, access, and practical use that professionals may miss. Executive-only design, late feedback, and one-time approval limit meaningful partnership. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

140. D — Technology creates value when it fits care, works safely with other systems, and can be implemented equitably and sustainably. Feature count, purchase price alone, and senior preference omit the conditions that determine real-world value. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

141. A — Clinical AI requires local validation, ongoing monitoring, transparency about limits, and clear human responsibility. Vendor results, unsupervised decisions, and alert volume do not establish safe or equitable use. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

142. B — Predictive tools must be judged by discrimination, calibration, usefulness, burden, and equity in the intended workflow. More alerts, technical prestige, and removed review can amplify harm instead of improving detection. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

143. D — Layered identity controls reduce what a compromised account can reach and improve detection and response. Broad access, shared passwords, and education alone create avoidable single

points of failure. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

144. B — Interoperability requires shared meaning and governance as well as technical exchange so information remains useful across sites. More reporting, one-person workarounds, and avoided comparison preserve fragmentation. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

145. A — Reducing alert burden requires balancing sensitivity, specificity, urgency, workflow, and the risk of missed information. More alerts, abrupt shutdown, and identical acknowledgment do not balance safety with usability. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation. Leaders can then adjust the approach using observed results.

146. C — Adoption depends on fit, support, feedback, and adaptation after real use; technical launch is only one milestone. Schedule, policy, and personnel reactions do not show whether the system supports safe work. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

147. B — Monitoring creates value only when data lead to timely, accountable clinical action and communication with the patient. Unassigned dashboards, patient-only triage, and fixed daily review can delay response to deterioration. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

148. C — Community partnership connects clinical care with practical resources and keeps identified social needs part of coordinated planning. Advice without resources, narrow measurement, and detached design leave important drivers of outcomes unchanged. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

149. D — A technology may be popular yet unsafe, inequitable, ineffective, or unaffordable, so evaluation must cover value broadly. Downloads, vendor reports, and staff time alone do not establish patient or system benefit. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

150. A — Digital delivery must be evaluated for equitable communication and follow-up across the populations it serves. Overall satisfaction, family interpretation, and missing subgroup data can conceal an access or safety problem. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.