

PRACTICE EXAM 18: 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. At a 2026 systemwide leadership review, the executive frames the issue this way: a nurse executive inherits a service line with low trust after several failed initiatives. What should the leader do first?
 - A. Listen to stakeholders, acknowledge the history, and establish shared priorities
 - B. Announce a new initiative to demonstrate momentum
 - C. Replace managers before examining the causes
 - D. Ask staff to move forward without revisiting the past

2. During a cross-campus planning session, leaders ask: which behavior best reflects authentic leadership during a period of workforce uncertainty?
 - A. Project certainty about outcomes that remain unknown
 - B. Align stated values with visible behavior while remaining open about limits
 - C. Delegate all difficult messages to human resources
 - D. Use personal stories to avoid discussing operational facts

3. While preparing an enterprise decision, the nurse executive considers: a board meeting becomes tense when a director challenges the nursing strategy. How should the executive respond?
 - A. Invite the challenge, clarify the evidence, and address the decision criteria
 - B. Interrupt the director to preserve the presentation schedule

- C. Defend the strategy before hearing the concern
- D. Ask the board chair to remove the disagreement from the minutes

4. In a quarterly governance discussion, the key question is: a health system is mapping stakeholders for a regional access project. Which factor should receive the greatest attention?

- A. The stakeholder with the most frequent meeting attendance
- B. Only the preferences of senior executives
- C. Each stakeholder's influence, interests, impact, and needed engagement
- D. The order in which stakeholders respond to email

5. As a new service model is evaluated, the team asks: a hospital wants to understand why a promising initiative did not spread beyond its pilot unit. Which leadership approach is most useful?

- A. Require every unit to copy the pilot exactly
- B. Study the pilot context, adoption barriers, local adaptations, and implementation capacity
- C. Declare the pilot unsuccessful because spread was slow
- D. Ask the pilot team to persuade other units informally

6. During a postimplementation huddle, leaders revisit: which environmental-scan finding should most influence a strategy for expanding elder-care services?

- A. The executive team's preferred service name
- B. A single favorable patient comment
- C. The current department budget without external data
- D. Changing population needs, workforce capacity, competitors, policy, and community resources

7. At a workforce and quality council meeting, the situation is: a strategic planning group has completed an extensive SWOT analysis but still has no priorities. What should happen next?

- A. Add more strengths and weaknesses to the analysis

- B. Publish the SWOT as the final strategic plan
- C. Ask each department to select every attractive opportunity
- D. Translate findings into choices, tradeoffs, measurable objectives, and accountable owners

8. When a regional partnership reaches this point, the executive asks: a strategic plan depends on a grant that may not be renewed. Which planning action is strongest?

- A. Assume renewal because the current grant is performing well
- B. Stop the strategy until the funding decision is final
- C. Identify alternative scenarios, funding triggers, and a sustainable base plan
- D. Spend the full grant before considering continuation

9. In a board-facing review, leaders need to decide: a department goal improves appointment access but conflicts with the system's equity commitment. What should the executive do?

- A. Revise the goal and measures so access improvement includes equitable distribution
- B. Keep the goal because total access increased
- C. Remove equity from the strategic plan to simplify reporting
- D. Let each clinic define equity differently

10. As the organization tests a new operating model, the question becomes: a board quality committee is reviewing a patient-safety dashboard. Which governance question is most appropriate?

- A. Which nurse reviewed each individual chart
- B. What risks exist, what action follows, and when is the update?
- C. Why did the board not approve the unit's daily assignments
- D. How can the committee direct bedside workflow

11. During an executive coaching conversation, the leader asks: a governance committee has advisory authority, but leaders treat its recommendations as mandatory. What should be clarified?

- A. That all committees should have identical authority
- B. That recommendations should never be reconsidered
- C. That the chair can act without communicating with executives
- D. The committee's mandate, decision rights, reporting relationship, and executive accountability

12. While reviewing system performance, the executive needs to know: a transformation program includes six projects that depend on one data platform. Which oversight action is most important?

- A. Let each project optimize its own schedule
- B. Prioritize the project with the most visible sponsor
- C. Manage the portfolio for shared dependencies, capacity, risks, and sequencing
- D. Add parallel work without checking platform capacity

13. At a 2026 systemwide leadership review, the executive frames the issue this way: a complex project lacks agreed acceptance criteria. What should the executive sponsor require before launch?

- A. Define deliverables, quality standards, decision owners, measures, and approval conditions
- B. Begin work and define success after completion
- C. Use the vendor's standard definition of done
- D. Measure only whether the project stayed on budget

14. During a cross-campus planning session, leaders ask: a project manager reports a risk but cannot obtain a decision from the steering group. What should the sponsor do?

- A. Set an escalation deadline and name the decision maker
- B. Ask the manager to keep waiting for consensus
- C. Make a private decision without documenting it
- D. Remove the risk from the project report

15. While preparing an enterprise decision, the nurse executive considers: frontline staff are asked to adopt a new clinical scheduling workflow. Which change strategy is strongest?

- A. Send one organizationwide memo and monitor compliance
- B. Use local champions, practice-based testing, feedback, and visible leadership support
- C. Require adoption before training is available
- D. Ask only senior managers to test the workflow

16. In a quarterly governance discussion, the key question is: a readiness assessment shows strong enthusiasm for a new model but low staffing capacity. What should the executive conclude?

- A. Launch immediately because enthusiasm guarantees adoption
- B. Cancel the model because capacity is not yet adequate
- C. Ignore capacity and measure only attitudes
- D. Build capacity and address constraints before setting a broad implementation date

17. As a new service model is evaluated, the team asks: a pilot team requests systemwide expansion after meeting its process target. Which additional decision criterion is essential?

- A. The number of staff who attended the pilot launch
- B. Evidence of outcome benefit, safety, equity, usability, and implementation readiness
- C. The sponsor's enthusiasm for the intervention
- D. Whether the pilot received favorable publicity

18. During a postimplementation huddle, leaders revisit: a project is completed on schedule, but the intended savings have not appeared. What should the executive review?

- A. Declare success because the deliverables were accepted
- B. Blame the project team for the missing savings
- C. The benefits assumption, ownership, adoption, and postimplementation operating conditions
- D. Delete the savings measure because it is inconvenient

19. At a workforce and quality council meeting, the situation is: which coaching question best helps a director who struggles to prioritize competing requests?

- A. What criteria will you use to decide which work advances the strategic goal?
- B. Why can you not simply work faster
- C. Would you like me to choose your priorities
- D. Which request seems most urgent to you personally

20. When a regional partnership reaches this point, the executive asks: a senior nurse asks for a mentor, but the executive believes the nurse also needs sponsorship. What is the distinction?

- A. Mentoring is formal discipline, while sponsorship is informal punishment
- B. Mentoring develops perspective, while sponsorship uses influence to create opportunities
- C. Mentoring replaces performance feedback, while sponsorship replaces evaluation
- D. Mentoring and sponsorship are identical terms for the same meeting

21. In a board-facing review, leaders need to decide: a succession candidate is technically strong but has never led across professional groups. Which development assignment is best?

- A. Promote immediately to expose the gap
- B. Keep the candidate in place until a vacancy occurs
- C. Choose a different candidate based only on tenure
- D. Give the candidate a cross-functional role with coaching and defined readiness evidence

22. As the organization tests a new operating model, the question becomes: a talent review repeatedly labels one group as lacking executive presence without behavioral examples. What should the leader change?

- A. Accept the label because several leaders use it
- B. Remove the group from succession discussions
- C. Define observable criteria and calibrate assessments for consistency and bias
- D. Ask the group to imitate the current executive team

23. During an executive coaching conversation, the leader asks: two service leaders disagree about ownership of a shared care pathway. What should the executive facilitate?

- A. A vote based on which service has more staff
- B. A compromise that leaves the handoffs undefined
- C. A written agreement on roles, handoffs, outcomes, and escalation
- D. A private assignment that is not shared with the teams

24. While reviewing system performance, the executive needs to know: a negotiation over shared clinic space is becoming positional. Which executive move is most constructive?

- A. Offer the space to the group with the louder advocate
- B. Trade unrelated concessions to end the discussion
- C. Require both groups to accept the executive's first proposal
- D. Ask each group to state its underlying needs and compare options against objective criteria

25. At a 2026 systemwide leadership review, the executive frames the issue this way: a committee has broad agreement on a goal but disagreement about the first implementation step. What should the chair do?

- A. Record agreement, define criteria, and assign the next decision
- B. Require complete unanimity before any action
- C. Allow each member to start a different approach
- D. End the committee because agreement is incomplete

26. During a cross-campus planning session, leaders ask: a nurse executive must explain a service reduction to employees and community partners. Which message structure is strongest?

- A. Emphasize only the financial savings
- B. State the decision, evidence, effects, mitigations, and opportunities for questions
- C. Use reassuring language without naming the effect
- D. Release separate messages that omit difficult details

27. While preparing an enterprise decision, the nurse executive considers: a rumor spreads that a hospital will close a unit, but leaders have not made a decision. What should the executive communicate?

- A. Deny every possibility even while options are being reviewed
- B. What is known, what is undecided, how decisions will be made, and when updates will occur
- C. Wait until the final decision to speak
- D. Ask managers to give different explanations based on local concerns

28. In a quarterly governance discussion, the key question is: a board asks why staff did not speak up about a deteriorating process. Which leadership response is best?

- A. Examine psychological safety, hierarchy, workload, and the reliability of escalation channels
- B. Conclude that staff lacked commitment
- C. Require more reporting without changing leader response
- D. Focus only on the last person who noticed the problem

29. As a new service model is evaluated, the team asks: an executive feels defensive during a meeting about a failed initiative. Which action best demonstrates self-regulation?

- A. Counter the criticism with the speaker's past mistakes
- B. End the meeting before the issue is discussed
- C. Pause, identify the reaction, and respond to the evidence and concern
- D. Speak more forcefully to reestablish authority

30. During a postimplementation huddle, leaders revisit: leaders say respect is a core value, but high-performing managers are excused for humiliating staff. What should change?

- A. Rewrite the values statement with stronger language
- B. Ask staff to become more resilient
- C. Measure respect through attendance at culture meetings
- D. Apply conduct expectations and consequences consistently, including to high performers

31. At a workforce and quality council meeting, the situation is: which leading indicator would best help an executive monitor a strategic workforce-retention initiative?

- A. Completion of targeted manager actions and early staff-experience trends
- B. Last year's final turnover rate only
- C. The number of retention posters displayed
- D. The total number of executive meetings held

32. When a regional partnership reaches this point, the executive asks: a strategy scorecard contains only financial measures. What should the executive add?

- A. More financial measures from each department
- B. Measures of activity without a strategic link
- C. Customer, process, workforce, equity, and outcome measures tied to the strategy
- D. A single satisfaction score for the entire system

33. In a board-facing review, leaders need to decide: a capital proposal claims a new platform will improve efficiency. Which business-case element is missing if no baseline is shown?

- A. A longer vendor feature list
- B. A promise that the platform will be innovative
- C. The sponsor's personal enthusiasm for the purchase
- D. A credible comparison of current performance, incremental cost, expected benefit, and risk

34. As the organization tests a new operating model, the question becomes: a service line is profitable on paper but depends on another unit absorbing substantial support costs. What should the executive analyze?

- A. The service line's gross revenue alone
- B. Full-cost allocation, shared capacity, contribution, and systemwide opportunity cost

- C. Only the unit's direct clinical salaries
- D. Whether the service has the most visible brand

35. During an executive coaching conversation, the leader asks: a workforce forecast changes sharply when projected volume changes modestly. What should the executive request?

- A. The most optimistic volume forecast
- B. A single staffing number without assumptions
- C. A sensitivity analysis showing the assumptions and threshold where staffing changes
- D. A forecast that hides the calculation to avoid debate

36. While reviewing system performance, the executive needs to know: a reimbursement model rewards fewer admissions, but leaders worry that necessary care may be deferred. What should be monitored?

- A. Admissions volume alone
- B. Savings without reviewing clinical outcomes
- C. The payer's satisfaction with reduced utilization only
- D. Appropriate utilization, outcomes, access, patient experience, and unintended delays

37. At a 2026 systemwide leadership review, the executive frames the issue this way: a payer proposes a quality bonus based on an outcome that disproportionately reflects social barriers. What should the executive negotiate?

- A. Acceptance of the bonus without examining the measure
- B. Risk adjustment, equity safeguards, improvement support, and transparent attribution
- C. Rejection of all outcome-based payment
- D. A target based only on the highest-performing population

38. During a cross-campus planning session, leaders ask: two projects have similar projected returns, but one strengthens a critical safety capability. How should the portfolio decide?

- A. Compare strategic importance, risk reduction, capacity, timing, and opportunity cost
- B. Choose the project with the more attractive presentation
- C. Fund the project submitted first
- D. Split resources equally regardless of minimum requirements

39. While preparing an enterprise decision, the nurse executive considers: a vendor consistently misses response targets in a clinical-support contract. What should the executive do?

- A. Review performance data, contract remedies, root causes, and service-continuity options
- B. Renew automatically to preserve the relationship
- C. Terminate immediately without reviewing obligations
- D. Ignore misses if the vendor is well known

40. In a quarterly governance discussion, the key question is: a community partnership has strong goodwill but no agreement about shared data or responsibilities. What should leaders create?

- A. An informal promise to resolve issues later
- B. A hospital-only plan that the partner can endorse
- C. A referral target without shared outcome measures
- D. A written operating agreement covering purpose, roles, data, resources, measures, and review

41. As a new service model is evaluated, the team asks: an innovation team wants to scale an idea after one enthusiastic focus group. What should the executive require?

- A. Immediate scale because the concept is popular
- B. A larger marketing campaign before testing
- C. A staged test using representative users, outcomes, risks, equity, and feasibility
- D. A permanent pilot with no decision criteria

42. During a postimplementation huddle, leaders revisit: a nurse executive is asked to testify publicly about a proposed staffing policy. Which approach is most responsible?

- A. Promise outcomes that have not been evaluated
- B. Use accurate evidence, distinguish organizational policy from personal opinion, and state limitations
- C. Present only data supporting the preferred position
- D. Avoid discussing uncertainty to sound decisive

43. At a workforce and quality council meeting, the situation is: a board dashboard reports a favorable outcome, but leaders cannot explain the data's source or owner. What should change?

- A. Add more dashboard colors
- B. Define data ownership, lineage, definitions, validation, and decision use
- C. Report the outcome more frequently without validation
- D. Remove the measure because it is difficult to explain

44. When a regional partnership reaches this point, the executive asks: a crisis requires several leaders to make rapid decisions while the chief executive is unavailable. What should have been established?

- A. A plan that depends on contacting one executive
- B. A promise that leaders will use personal judgment
- C. A longer policy without decision assignments
- D. Delegated authority, succession coverage, communication channels, and escalation rules

45. In a board-facing review, leaders need to decide: after a merger, leaders want to document lessons from the integration. Which review method is strongest?

- A. Celebrate completion without examining the work
- B. Archive the project files without discussion
- C. Compare expected results, actual variation, and assigned follow-up
- D. Ask each leader to remember lessons privately

46. As the organization tests a new operating model, the question becomes: a cross-functional initiative has unclear authority for resolving disputes about shared resources. What should the executive sponsor do?

- A. Name the accountable decision maker, criteria, escalation route, and response time
- B. Let disputes continue until one group gives up
- C. Ask the most senior participant to decide informally
- D. Create another committee without changing authority

47. During an executive coaching conversation, the leader asks: a strategic proposal has strong clinical support but would reduce access in a neighboring community. What should the executive do?

- A. Approve it because the clinical benefit is compelling
- B. Avoid the decision because every option has tradeoffs
- C. Make the distributional effect visible and redesign the proposal with affected stakeholders
- D. Ask the neighboring community to adapt without consultation

48. While reviewing system performance, the executive needs to know: a strategic planning retreat produces competing priorities from different divisions. Which facilitation step is most useful?

- A. Award priority to the division with the largest budget
- B. Average all proposals without examining strategic fit
- C. Ask the chief executive to select a favorite privately
- D. Return the group to mission, evidence, capacity, and agreed decision criteria

49. At a 2026 systemwide leadership review, the executive frames the issue this way: a project sponsor wants to add new features late in implementation without changing the deadline. What should the leader require?

- A. Add the features because the vendor says they are minor
- B. Assess the change's effect on scope, risk, resources, testing, and benefits before approval
- C. Reject every change without reviewing value
- D. Ask staff to absorb the work through overtime

50. During a cross-campus planning session, leaders ask: a senior leader must choose an interim director while a search continues. Which process is most defensible?

- A. Use transparent criteria, clarify authority, and communicate the interim role and review period
- B. Select the longest-serving employee automatically
- C. Name a favorite without explaining the choice
- D. Leave the role vacant until the final hire

51. While preparing an enterprise decision, the nurse executive considers: a hospital is preparing for a new accrediting review. Which readiness practice is most reliable?

- A. Test actual practice against requirements and close gaps with accountable owners
- B. Collect documents without observing workflow
- C. Prepare only the units named in the last review
- D. Ask staff to memorize every standard

52. In a quarterly governance discussion, the key question is: a policy library contains several versions of the same medication procedure. What should the quality leader establish?

- A. Ask staff to choose the version they prefer
- B. Version control, approval history, effective dates, and removal of obsolete copies
- C. Keep every version available for comparison
- D. Update the title without changing document control

53. As a new service model is evaluated, the team asks: a community hospital is planning for a prolonged power outage. Which preparedness step is most important?

- A. Purchase supplies without mapping essential functions
- B. Assume routine staffing will be sufficient
- C. Write a plan that addresses only the first hour
- D. Identify critical functions, backup capacity, dependencies, and restoration priorities

54. During a postimplementation huddle, leaders revisit: during a multiunit emergency, two departments issue conflicting instructions. What should the incident leader do?

- A. Allow each department to continue independently
- B. Ask staff to choose the instruction they trust
- C. Use a common command structure and confirm one operational communication channel
- D. Delay action until every leader agrees publicly

55. At a workforce and quality council meeting, the situation is: a unit has several near misses involving a new device, but no patient has been harmed. What is the best quality response?

- A. Wait for a harmful event before changing the process
- B. Stop reporting to protect the device project
- C. Treat the near misses as signals, investigate the workflow, and strengthen defenses
- D. Assume users need only another reminder

56. When a regional partnership reaches this point, the executive asks: a review team says an error occurred because a nurse was careless. What should the quality leader ask next?

- A. Why was the nurse not more cautious
- B. Which punishment will deter similar behavior
- C. Whether the policy can be made longer
- D. What conditions, workload, design, and information shaped the action?

57. In a board-facing review, leaders need to decide: a staff member bypassed a safety check because the usual workflow was impossible during a surge. Which response is fairest?

- A. Examine the decision, constraints, risk, and reasonableness
- B. Punish the staff member automatically
- C. Excuse every workaround during a surge
- D. Ignore the event because no harm occurred

58. As the organization tests a new operating model, the question becomes: a family reports that a serious error was not explained clearly after the event. What should the executive ensure?

- A. Wait until the legal review is complete before communicating
- B. A timely, truthful disclosure process with patient support and documented follow-up
- C. Provide only a written apology without facts
- D. Ask the family to contact the unit manager privately

59. During an executive coaching conversation, the leader asks: a root-cause analysis has identified many contributing factors but no action plan. What should occur next?

- A. Prioritize system changes, assign owners, define measures, and set review dates
- B. Publish the analysis as the intervention
- C. Choose the easiest action regardless of risk
- D. Close the review because causes were documented

60. While reviewing system performance, the executive needs to know: which corrective action is strongest after repeated wrong-patient labeling?

- A. Send a reminder about attention to detail
- B. Redesign identification and verification steps, then monitor reliability
- C. Ask staff to sign a promise
- D. Add a poster without changing the workflow

61. At a 2026 systemwide leadership review, the executive frames the issue this way: a team is assessing the risk of a new infusion process before launch. Which tool is most appropriate?

- A. A retrospective review after the first adverse event
- B. A vendor brochure describing intended use
- C. An informal opinion from one experienced clinician
- D. A prospective failure mode and effects analysis with planned mitigations

62. During a cross-campus planning session, leaders ask: a risk register lists hazards but does not show which ones need immediate action. What should be added?

- A. Alphabetical ordering of hazards
- B. A narrative from the most senior leader
- C. Consistent ratings for likelihood, impact, detectability, and mitigation status
- D. Removal of low-frequency hazards regardless of severity

63. While preparing an enterprise decision, the nurse executive considers: a corrective-action team reports that education was completed but the defect persists. What should the executive do?

- A. Repeat the same education more often
- B. Close the plan because attendance was high
- C. Reassess the process, strengthen the intervention, and measure performance in practice
- D. Blame staff for not remembering the lesson

64. In a quarterly governance discussion, the key question is: a hospital compares catheter-associated infection rates between units with different device exposure. What is necessary?

- A. Use comparable definitions and exposure-based denominators before interpreting variation
- B. Rank units by raw infection counts
- C. Exclude the unit with the most devices
- D. Use the lowest rate without checking measurement

65. As a new service model is evaluated, the team asks: which process measure best evaluates a new medication-reconciliation workflow?

- A. The number of reconciliation meetings
- B. The proportion of transitions with all defined reconciliation steps completed
- C. The number of medication forms printed
- D. The annual satisfaction score alone

66. During a postimplementation huddle, leaders revisit: a fall-prevention intervention reduces falls but increases use of restraints. Which measure should be added?

- A. The number of fall-prevention posters
- B. The number of staff trained
- C. The number of committee meetings
- D. A balancing measure that detects unintended restriction or harm

67. At a workforce and quality council meeting, the situation is: a run chart shows a sustained improvement shortly after a staffing change. What should the team do next?

- A. Declare the staffing change as the sole cause
- B. Ignore the improvement until a full year passes
- C. Replace the measure with a more favorable one
- D. Review the pattern, examine other explanations, and continue monitoring the intervention

68. When a regional partnership reaches this point, the executive asks: a control chart shows increased variation after a new supplier is introduced. What is the best first step?

- A. Verify the data and investigate the process for a special cause
- B. Recalculate limits until the variation disappears
- C. Average extreme values into the baseline
- D. Change the entire process without investigation

69. In a board-facing review, leaders need to decide: a team predicts that a revised discharge checklist will reduce omitted follow-up appointments. Which improvement method fits?

- A. Launch the checklist across every unit immediately
- B. Run a small test, study results, and adapt
- C. Wait for a perfect checklist before testing
- D. Measure only whether the checklist was printed

70. As the organization tests a new operating model, the question becomes: a process map shows that three teams independently call the same patient after discharge. What should the team explore?

- A. How to add a fourth call for reassurance
- B. Which team deserves credit for the contacts
- C. Ownership, duplicate work, information flow, and a coordinated contact plan
- D. Whether the map should omit patient-facing steps

71. During an executive coaching conversation, the leader asks: a quality team uses repeated why-questions but stops at staff behavior. What should the facilitator encourage?

- A. Continue examining policies, design, resources, communication, and conditions around the behavior
- B. End the analysis because a person was identified
- C. Add more why-questions about personal motivation
- D. Replace the review with a satisfaction survey

72. While reviewing system performance, the executive needs to know: a practice team finds strong quantitative evidence but limited local experience with the intervention. What should happen before adoption?

- A. Adopt the intervention exactly as published
- B. Appraise applicability, engage users, adapt carefully, and define outcome monitoring
- C. Reject it because local experience is limited
- D. Wait until every comparable hospital adopts it

73. At a 2026 systemwide leadership review, the executive frames the issue this way: a quality improvement project has produced generalizable findings and plans to publish identifiable data. What should leaders do?

- A. Assume improvement work never needs review
- B. Publish first and seek review afterward
- C. Clarify the activity's purpose and obtain the appropriate institutional review

D. Avoid documenting the project to keep it informal

74. During a cross-campus planning session, leaders ask: a handoff audit shows staff use the agreed tool but omit key risk information. What is the strongest response?

- A. Require staff to sign the handoff policy
- B. Add more fields without user testing
- C. Stop auditing because the tool is present
- D. Observe the workflow, refine the tool, practice the missing behavior, and remeasure

75. While preparing an enterprise decision, the nurse executive considers: medication discrepancies are found after patients transfer between units. Which intervention should be prioritized?

- A. Ask each unit to create its own medication list
- B. Send a general reminder about documentation
- C. Add another list without assigning ownership
- D. Define responsibility at the handoff and verify the medication list with the patient

76. In a quarterly governance discussion, the key question is: a unit's pressure-injury rate is improving, but prevention practices vary widely between shifts. What should leaders do?

- A. Celebrate the average rate and stop observation
- B. Require identical care without assessing context
- C. Standardize essential practices, support local adaptation, and monitor reliability by shift
- D. Focus only on the shift with the best results

77. As a new service model is evaluated, the team asks: a cluster of postoperative infections is suspected. What should the quality team do first?

- A. Confirm the signal, define cases, review time and location, and begin investigation
- B. Announce an outbreak before verifying the pattern

- C. Assume one staff member caused every case
- D. Close the operating area permanently without assessment

78. During a postimplementation huddle, leaders revisit: falls occur mainly during toileting among patients with a particular mobility pattern. Which response is best?

- A. Apply the same intervention to every patient regardless of risk
- B. Use the pattern to target rounding, assistance, environment, and outcome monitoring
- C. Tell patients to request help more often
- D. Measure only total falls after the change

79. At a workforce and quality council meeting, the situation is: a safety-culture survey shows low confidence in escalation. Which action is most likely to improve the result?

- A. Make leader responses visible, practice escalation, and track follow-up
- B. Repeat the survey until confidence increases
- C. Publish the score without changing routines
- D. Tell staff that escalation is already expected

80. When a regional partnership reaches this point, the executive asks: a dashboard combines data from different months with changing definitions. What should happen before trend interpretation?

- A. Smooth the values to create a continuous line
- B. Reconcile definitions, dates, sources, and denominators, then annotate known changes
- C. Report the trend because the direction looks favorable
- D. Delete months with inconvenient results

81. In a board-facing review, leaders need to decide: overall patient experience improves, but one language group reports worsening communication. What should the quality leader do?

- A. Report only the overall improvement

- B. Assume the subgroup result is random
- C. Stratify the results, investigate barriers, and design a targeted response
- D. Remove language data to avoid comparison

82. As the organization tests a new operating model, the question becomes: a chart-review project cannot examine every record. Which sampling practice best supports credible results?

- A. Select records that are easiest to retrieve
- B. Review only favorable outcomes
- C. Change criteria whenever the sample becomes inconvenient
- D. Use predefined inclusion criteria and a transparent sampling method

83. During an executive coaching conversation, the leader asks: a safety survey has a low response rate from night-shift employees. What should leaders consider?

- A. Assume night staff have no concerns
- B. Nonresponse bias and whether the findings represent all affected work groups
- C. Treat the overall score as fully representative
- D. Stop surveying because participation is difficult

84. While reviewing system performance, the executive needs to know: an emergency drill shows that staff do not know who can authorize patient transfers. What should the organization do?

- A. Add the finding to the report without an owner
- B. Wait for a real emergency to clarify authority
- C. Clarify authority, communicate the role, test it again, and track the gap to closure
- D. Ask staff to use personal judgment during the next drill

85. At a 2026 systemwide leadership review, the executive frames the issue this way: a disaster after-action review identifies redundant documentation during surge operations. What is the best next step?

- A. Redesign information flow, assign owners, and validate the process
- B. Keep every form because redundancy feels safer
- C. Delete all documentation during a surge
- D. Wait until the next disaster to test changes

86. During a cross-campus planning session, leaders ask: a critical monitoring system has one backup that has never been tested. What should the quality leader require?

- A. Assume the backup will work because it was purchased
- B. Add another untested backup
- C. Wait for a failure before testing
- D. Test failover under realistic conditions and document recovery performance

87. While preparing an enterprise decision, the nurse executive considers: a nurse believes an immediate device-related hazard exists during a procedure. Which safety culture behavior should leaders support?

- A. Pause the work, voice the concern, and obtain a prompt safety assessment
- B. Wait until the procedure ends to avoid disruption
- C. Continue unless a senior physician agrees first
- D. Document the concern only after the patient is discharged

88. In a quarterly governance discussion, the key question is: a quality team wants to monitor antibiotic stewardship but has not agreed on the outcome definition. What should happen first?

- A. Report the easiest measure to collect
- B. Choose a target before defining the outcome
- C. Define the numerator, denominator, population, time frame, and intended use
- D. Combine unrelated antibiotic activities into one score

89. As a new service model is evaluated, the team asks: a patient-identification audit finds that compliance is high in the emergency department but low during transport. What should leaders do?

- A. Report the hospitalwide average only
- B. Blame transport staff for the difference
- C. Apply the emergency department workflow without testing it
- D. Study the transport workflow, engage staff, strengthen defenses, and remeasure by setting

90. During a postimplementation huddle, leaders revisit: an employee requests a modified schedule because of a documented limitation. What should the manager do first?

- A. Deny the request because schedules must remain identical
- B. Use the accommodation process to assess essential functions and workable options
- C. Ask coworkers to determine whether the limitation is legitimate
- D. Require full medical details in a staff meeting

91. At a workforce and quality council meeting, the situation is: a job description lists tasks that no longer reflect the actual role. Why should the executive address this?

- A. Older descriptions are acceptable if managers understand them
- B. Accurate essential functions support fair hiring, accommodation, evaluation, and competency decisions
- C. The description matters only during recruitment
- D. Informal expectations are more flexible than written duties

92. When a regional partnership reaches this point, the executive asks: a unit has repeated injuries during patient transfers. Which workforce-safety response is strongest?

- A. Tell employees to lift more carefully
- B. Discipline the last employee injured
- C. Assess the task, equipment, staffing, training, and environmental controls
- D. Stop reporting injuries until a solution is found

93. In a board-facing review, leaders need to decide: employees report a chemical exposure but worry that reporting will harm their evaluations. What should the executive ensure?

- A. Protect reporting, investigate the exposure, and separate safety review from retaliation
- B. Ask employees to report only confirmed injuries
- C. Tell managers to handle exposure concerns informally
- D. Delay the review until annual evaluations

94. As the organization tests a new operating model, the question becomes: a promotion panel says a candidate is not a good long-term fit but provides no job-related examples. What should change?

- A. Accept the panel's intuition as sufficient
- B. Choose the candidate with the most senior sponsor
- C. Remove all judgment from leadership selection
- D. Use defined competencies, behavioral evidence, and consistent scoring criteria

95. During an executive coaching conversation, the leader asks: a hiring process produces different pass rates across demographic groups. What should human resources examine?

- A. The group with the lowest pass rate only
- B. Whether to hide the results from managers
- C. Job relevance, validity, consistent administration, and possible adverse impact
- D. Whether to keep the tool because it is familiar

96. While reviewing system performance, the executive needs to know: an employee reports that a supervisor reduced opportunities after the employee raised a safety concern. What should happen?

- A. Tell the employee that assignments are discretionary
- B. Ask the employee to stop raising concerns
- C. Wait for a second complaint before investigating
- D. Conduct a prompt impartial review of timing, rationale, and comparable treatment

97. At a 2026 systemwide leadership review, the executive frames the issue this way: a manager wants to send a high-potential employee to a conference without identifying a development goal. What should the executive recommend?

- A. Link the learning opportunity to a capability gap, application plan, and follow-up
- B. Approve travel because conferences are motivating
- C. Use attendance as proof of development
- D. Offer the opportunity only to the most visible employee

98. During a cross-campus planning session, leaders ask: a new nurse passed orientation but has not demonstrated independent use of a high-risk device. What should the manager do?

- A. Assign the nurse independently because orientation is complete
- B. Provide supervised practice and direct competency validation before independent assignment
- C. Remove the device from the nurse's role forever
- D. Accept a coworker's unobserved sign-off

99. While preparing an enterprise decision, the nurse executive considers: a department treats annual education attendance as proof that every nurse can perform a new procedure. What should change?

- A. Assume experienced nurses are competent automatically
- B. Require more attendance without observation
- C. Add observed performance, knowledge, judgment, and remediation when needed
- D. Wait for an adverse event to reveal gaps

100. In a quarterly governance discussion, the key question is: a nurse asks to perform a task that is not covered by the unit's role expectations. What should guide the decision?

- A. The nurse's confidence in performing the task
- B. Another unit's informal custom
- C. The desire to finish the shift faster
- D. Applicable requirements, organizational policy, education, competence, and supervision

101. As a new service model is evaluated, the team asks: a charge nurse wants to delegate a complex assessment to a new staff member. What should be considered first?

- A. Whether the charge nurse is behind schedule
- B. Patient complexity, task requirements, competence, supervision, and follow-up
- C. Whether the new staff member wants experience
- D. Whether the task is usually delegated on that unit

102. During a postimplementation huddle, leaders revisit: a manager gives an employee vague feedback that performance is not meeting expectations. What should happen next?

- A. Describe observable behavior, explain the impact, and set a specific improvement expectation
- B. Wait for the annual review to provide examples
- C. Compare the employee publicly with a peer
- D. Use a general warning without discussing the work

103. At a workforce and quality council meeting, the situation is: a clinical ladder rewards committee membership but not demonstrated practice improvement. What should the executive review?

- A. Whether advancement criteria measure meaningful capability, outcomes, and contribution
- B. Add more committee positions to increase participation
- C. Remove all professional development levels
- D. Promote the most active meeting attendee

104. When a regional partnership reaches this point, the executive asks: some staff members dominate meetings while others with relevant expertise remain silent. Which action is best?

- A. Ask quieter staff to speak without changing the meeting
- B. Let the dominant speakers decide efficiently
- C. Set participation norms, use inclusive facilitation, and invite structured input

D. Ban disagreement to create harmony

105. In a board-facing review, leaders need to decide: a workforce survey shows that immigrant nurses feel excluded from informal information networks. What should the executive do?

- A. Tell nurses to build their own networks
- B. Treat informal networks as outside leadership responsibility
- C. Offer one cultural celebration without changing work processes
- D. Examine communication practices, access, inclusion, language needs, and leader behavior

106. As the organization tests a new operating model, the question becomes: a staff member reports repeated belittling by a respected colleague. Which response is most appropriate?

- A. Tell the staff member to avoid the colleague
- B. Protect the work environment, document the concern, investigate fairly, and address conduct
- C. Ask the staff member to confront the colleague alone
- D. Ignore the behavior because patient care was not affected

107. During an executive coaching conversation, the leader asks: a unit has rising threats from visitors. Which workforce-safety approach is strongest?

- A. Use incident data, environmental review, prevention protocols, response training, and post-event support
- B. Tell staff to manage threatening behavior individually
- C. Stop recording threats to protect the unit's reputation
- D. Rely on one annual lecture

108. While reviewing system performance, the executive needs to know: a staffing model uses the same number of nurses on every shift despite changing patient complexity. What should leaders do?

- A. Keep the fixed number because it is easy to schedule

- B. Let each shift negotiate informally
- C. Measure adequacy only by open beds
- D. Use workload, acuity, skill mix, support, and escalation capacity to plan staffing

109. At a 2026 systemwide leadership review, the executive frames the issue this way: errors rise near the end of long shifts, but managers respond only by reminding staff to be careful. What should change?

- A. Ask the same high performers to work more overtime
- B. Treat fatigue as an individual weakness
- C. Examine workload, scheduling, breaks, staffing, fatigue controls, and outcome patterns
- D. Stop tracking errors at shift end

110. During a cross-campus planning session, leaders ask: an engagement pulse survey shows declining trust after a leadership transition. What should the executive do first?

- A. Launch a morale slogan without reviewing the data
- B. Share the findings, listen for local drivers, and choose accountable actions
- C. Repeat the survey until the score improves
- D. Blame the previous leadership team

111. While preparing an enterprise decision, the nurse executive considers: a manager wants to reduce turnover but has no funds for new incentives. Which action should come first?

- A. Send a generic thank-you message
- B. Assume pay is the only retention factor
- C. Tell staff retention is their personal responsibility
- D. Use stay interviews to identify actionable drivers of commitment and frustration

112. In a quarterly governance discussion, the key question is: a burnout initiative focuses entirely on resilience classes while workload remains unsafe. What should the executive change?

- A. Pair individual support with workload, staffing, scheduling, and workflow interventions
- B. Offer more resilience classes without changing work
- C. Tell staff to use coping skills more consistently
- D. Stop measuring burnout because it is subjective

113. As a new service model is evaluated, the team asks: a new manager is held to expectations that were never explained. What is the fairest response?

- A. Begin discipline immediately for poor performance
- B. Wait until the manager fails publicly
- C. Clarify the role, provide support, set milestones, and document follow-up
- D. Compare the manager with a long-tenured peer

114. During a postimplementation huddle, leaders revisit: an employee repeatedly misses a documented standard after coaching and support. Which next step is most appropriate?

- A. Ignore the pattern because coaching was attempted
- B. Use proportionate progressive action with evidence and response opportunity
- C. Apply the harshest penalty immediately
- D. Discuss the performance informally with coworkers

115. At a workforce and quality council meeting, the situation is: new hires are paid close to the wages of experienced employees in the same role. What should the executive examine?

- A. The new-hire wage alone
- B. Whether experienced employees should simply accept the change
- C. Pay compression, internal equity, market data, experience, and retention risk
- D. A uniform pay cut for all employees

116. When a regional partnership reaches this point, the executive asks: employees say weekend schedules are assigned inconsistently across units. What should the executive require?

- A. Transparent scheduling criteria, comparable application, and a process for reviewing exceptions
- B. Let each manager use personal preference
- C. Rotate weekends without considering role requirements
- D. Tell employees to trade shifts privately

117. In a board-facing review, leaders need to decide: a shared-governance council recommends a practice change but cannot explain who approves implementation. What should happen?

- A. Approve every recommendation automatically
- B. Reject the recommendation because executives remain accountable
- C. Ask the council to implement it without governance review
- D. Clarify council authority, executive accountability, consultation, and implementation ownership

118. As the organization tests a new operating model, the question becomes: a professional council has low attendance because meetings conflict with clinical workload. Which improvement is strongest?

- A. Replace absent members without examining scheduling
- B. Redesign participation methods, remove access barriers, and preserve representative decision input
- C. Let the remaining members represent everyone
- D. Cancel the council and collect suggestions once a year

119. During an executive coaching conversation, the leader asks: employees ask managers for advice during a union-organizing campaign. What should leaders do?

- A. Ask managers to discourage organizing in one-on-one meetings
- B. Provide accurate information, respect employee choice, and avoid coercion or retaliation
- C. Promise improvements in exchange for support
- D. Track which employees attend organizing events

120. While reviewing system performance, the executive needs to know: a talent review shows that no one is ready to assume a critical nursing role. What should the executive do?

- A. Create interim coverage and targeted development while broadening the pipeline
- B. Name the longest-serving employee immediately
- C. Wait until the vacancy occurs
- D. Keep the gap confidential to avoid concern

121. At a 2026 systemwide leadership review, the executive frames the issue this way: a primary-care network is redesigning services for patients with multiple chronic conditions. Which element is essential?

- A. Specialty visits without primary-care coordination
- B. A portal that replaces all human care coordination
- C. Separate programs optimized independently
- D. Coordinated access, continuity, comprehensive services, and patient partnership

122. During a cross-campus planning session, leaders ask: a clinic wants to add asynchronous messaging to telehealth. Which design question should leaders address first?

- A. Whether messaging can replace every visit
- B. How to maximize message volume
- C. When messaging is appropriate, who monitors it, response expectations, and escalation limits
- D. Whether staff can use personal accounts for convenience

123. While preparing an enterprise decision, the nurse executive considers: a virtual-care program has low completion among patients who share devices with family members. What should leaders evaluate?

- A. Require patients to purchase a private device
- B. Assume missed visits indicate low motivation
- C. Privacy, device access, scheduling flexibility, digital literacy, and alternative pathways
- D. Measure only the number of appointments offered

124. In a quarterly governance discussion, the key question is: a rural health system wants to develop a long-term workforce pipeline. Which strategy is strongest?

- A. Partner with local schools, clinical training programs, preceptors, and community organizations
- B. Rely on temporary clinicians indefinitely
- C. Open a facility before planning retention
- D. Copy a metropolitan recruitment model without local assessment

125. As a new service model is evaluated, the team asks: a hospital is considering a team-based model for complex care. What should leaders define before launch?

- A. Only the number of disciplines attending rounds
- B. Roles, communication, escalation, accountability, competencies, and patient outcomes
- C. A single leader who makes every clinical decision
- D. A team slogan without workflow or measures

126. During a postimplementation huddle, leaders revisit: a patient with decision-making capacity refuses a recommended treatment after receiving understandable information. Which principle applies?

- A. Override the refusal because beneficence always controls
- B. Require treatment to ensure equal outcomes
- C. Withhold risk information to avoid distress
- D. Respect autonomy through voluntary, informed acceptance or refusal

127. At a workforce and quality council meeting, the situation is: a surrogate and clinical team disagree about a treatment for a patient without documented preferences. What should guide deliberation?

- A. The loudest family member's preference
- B. The least expensive option automatically
- C. Delay until every relative agrees
- D. Use known values, then best-interest reasoning when unknown

128. When a regional partnership reaches this point, the executive asks: a hospital must allocate limited critical-care capacity during a surge. Which process is most defensible?

- A. Give priority to those with the strongest advocates
- B. Use transparent relevant criteria, consistent review, and an appeals or reassessment process
- C. Let each clinician use undisclosed personal judgment
- D. Allocate resources to the first request received

129. In a board-facing review, leaders need to decide: a family asks for a full patient record to be discussed in a public waiting area. What should the executive reinforce?

- A. Use an authorized private setting and disclose only information needed for the purpose
- B. Discuss the full record because the family is involved
- C. Use initials and speak loudly enough for all family members
- D. Share the record if the conversation is educational

130. As the organization tests a new operating model, the question becomes: an ethics consult is requested because clinicians disagree about whether a treatment remains goal-concordant. What should the consultant do?

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

131. During an executive coaching conversation, the leader asks: nurses report moral distress because institutional constraints prevent care they believe is appropriate. What should leaders address?

- A. Provide support while examining the organizational conditions causing the recurring conflict
- B. Tell nurses to remain silent to preserve professionalism
- C. Offer counseling without reviewing the care system
- D. Move nurses to other units without examining the pattern

132. While reviewing system performance, the executive needs to know: a nurse asks why a discharge process produces repeated delays. Which response supports a spirit of inquiry?

- A. Say delays are unavoidable in complex care
- B. Ask the nurse to collect data alone
- C. Frame a focused question and examine workflow data with frontline participants
- D. Change the process before defining the problem

133. At a 2026 systemwide leadership review, the executive frames the issue this way: a team wants to publish findings from a new care model that uses identifiable patient data. What should leaders do?

- A. Assume operational work never needs oversight
- B. Publish first and seek review later
- C. Avoid documenting the project to reduce burden
- D. Clarify the activity and obtain the appropriate review

134. During a cross-campus planning session, leaders ask: a hospital compares mortality across services with different referral patterns. What should executives review before judging performance?

- A. Unadjusted mortality alone
- B. Case mix, risk adjustment, data definitions, and possible access inequities
- C. The service with the sickest patients should be excluded
- D. A different outcome that is easier to compare

135. While preparing an enterprise decision, the nurse executive considers: overall blood-pressure control improves, but results worsen for patients in one neighborhood. What should the executive do?

- A. Stratify outcomes, investigate barriers, and target the response
- B. Report only the overall improvement
- C. Assume the neighborhood result is random
- D. Stop collecting location data

136. In a quarterly governance discussion, the key question is: patient narratives describe confusion after a new appointment process, although the satisfaction score is unchanged. What should leaders do?

- A. Ignore the narratives because the score did not change
- B. Use only the narrative with the most severe complaint
- C. Ask executives to interpret the comments without observing the process
- D. Combine narratives with workflow and access data to understand the experience

137. As a new service model is evaluated, the team asks: readmissions rise after a hospital shortens length of stay. Which delivery response should be examined first?

- A. Reverse every early discharge
- B. Strengthen discharge preparation, medication review, follow-up, and cross-setting communication
- C. Add inpatient testing without reviewing transitions
- D. Tell patients to call only when symptoms become severe

138. During a postimplementation huddle, leaders revisit: a specialty clinic sends referrals to primary care but rarely receives confirmation that follow-up occurred. What should leaders design?

- A. More referral forms without tracking
- B. A policy asking patients to coordinate everything
- C. A closed-loop referral process with ownership, status visibility, and escalation
- D. A monthly report that lists referrals without outcomes

139. At a workforce and quality council meeting, the situation is: a health system is selecting a new imaging platform. Which criterion should be included beyond purchase price?

- A. Interoperability, usability, safety, equity, lifecycle cost, and implementation capacity
- B. The number of features in the sales presentation
- C. The preference of the most senior radiologist
- D. A low price without support or maintenance analysis

140. When a regional partnership reaches this point, the executive asks: a clinical AI model performs well overall but poorly for one patient subgroup. What should leaders do before deployment?

- A. Deploy because the overall accuracy is high
- B. Investigate subgroup performance, local validation, mitigation, and human oversight
- C. Exclude the subgroup from model evaluation
- D. Increase automation to reduce human variation

141. In a board-facing review, leaders need to decide: a predictive model flags many patients who never experience deterioration. Which issue should the executive examine?

- A. Add more alerts to avoid missing anyone
- B. Assume the model is useful because it is complex
- C. Remove clinician review to preserve efficiency
- D. Calibration, thresholds, false positives, workflow burden, and clinical usefulness

142. As the organization tests a new operating model, the question becomes: a nurse clicks a simulated phishing link during a system exercise. What should the executive prioritize?

- A. Publicly identify the nurse as a warning
- B. Stop simulations because staff dislike them
- C. Use the event for learning, strengthen technical safeguards, and provide targeted education
- D. Rely only on an annual security lecture

143. During an executive coaching conversation, the leader asks: two clinics record the same patient outcome using different definitions. What should leaders establish?

- A. A combined report that keeps both definitions
- B. Shared definitions, data ownership, interfaces, validation, and governance
- C. A manual spreadsheet maintained by one analyst
- D. Separate dashboards that avoid comparison

144. While reviewing system performance, the executive needs to know: clinicians say electronic alerts interrupt care without adding value. Which response is best?

- A. Add more alerts to ensure visibility
- B. Turn off every alert immediately
- C. Require identical acknowledgment for all warnings
- D. Review alerts, prioritize value, test changes, and monitor risk

145. At a 2026 systemwide leadership review, the executive frames the issue this way: a new documentation system is live, but staff create workarounds outside the platform. What should the executive do?

- A. Discipline users before understanding the workaround
- B. Declare success because the system launched
- C. Observe the workflow, identify barriers, support users, and iteratively improve the system
- D. Ban all workarounds without providing a safe alternative

146. During a cross-campus planning session, leaders ask: a remote-monitoring service receives abnormal readings overnight. Which governance element is essential?

- A. Defined thresholds, responsible reviewers, response times, escalation, and patient communication
- B. A dashboard with no assigned reviewer
- C. A rule asking patients to decide whether staff respond
- D. A single daily review for every alert

147. While preparing an enterprise decision, the nurse executive considers: a community health assessment links missed appointments with transportation barriers. Which delivery response is strongest?

- A. Tell patients to arrange transportation independently
- B. Measure only appointment volume
- C. Create a program without consulting affected residents

D. Partner with community organizations and build transportation support into care planning

148. In a quarterly governance discussion, the key question is: a nurse executive wants to improve understanding of a new discharge plan. Which patient-centered method is best?

- A. Use teach-back and adapt education to language, literacy, culture, and patient priorities
- B. Provide a longer written handout
- C. Ask the patient to sign that instructions were received
- D. Deliver the same script to every patient

149. As a new service model is evaluated, the team asks: a patient-facing app is popular but not used by patients with disabilities. What should the executive require?

- A. Continue the app because total downloads are high
- B. Ask patients to adapt to the design
- C. Assess accessibility, usability, outcomes, equity, and alternative ways to receive care
- D. Remove disability information from evaluation

150. During a postimplementation huddle, leaders revisit: a behavioral-health integration program improves screening but not follow-up treatment. What should leaders examine?

- A. Increase screening volume without changing referral capacity
- B. The referral pathway, capacity, patient preferences, access barriers, and care coordination
- C. Declare success because screening improved
- D. Stop measuring follow-up because it is complex

Practice Exam 18: Answer Key and Explanations

1. A — Trust repair begins with credible listening and a shared understanding of what happened, what matters now, and what leaders will do differently. A new announcement, premature replacement, or

dismissal of history may repeat the pattern that damaged confidence. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up.

2. B — Authentic leadership combines consistency, self-awareness, transparency, and responsible action rather than relying on confidence alone. False certainty, message avoidance, and personal storytelling without facts do not create reliable 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.

3. A — Constructive challenge improves governance when leaders make the evidence and criteria visible instead of treating dissent as disloyalty. Interruption, premature defense, and hidden disagreement weaken oversight and may conceal a legitimate 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.

4. C — Stakeholder analysis helps leaders tailor engagement to power, interest, impact, and the role each group can play in implementation. Attendance, executive preference, and email order are weak substitutes for understanding influence and affected interests. 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. B — Spread depends on context, capability, workflow, leadership, and adaptation; studying those conditions produces more useful learning. Rigid copying, premature failure claims, and informal persuasion ignore the reasons implementation differs across settings. 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. D — An environmental scan connects population trends and external conditions with internal capability before leaders commit resources. A name, one comment, and an internal budget view do not describe strategic opportunity or 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.

7. D — Analysis creates value when leaders use it to choose, resource, measure, and assign responsibility for strategic action. More analysis, publication alone, and universal selection avoid the choices required for 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.

8. C — Scenario planning protects strategy by making dependencies visible and defining what leaders will do as conditions change. Assumption, indefinite delay, and spending without a continuation plan create avoidable strategic exposure. 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. A — Strategic alignment requires objectives and measures to reinforce the organization's full mission, including who benefits from improvement. Total improvement, deletion, and inconsistent definitions can conceal unequal effects and undermine the stated commitment. 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. B — Board oversight focuses on risk, management response, accountability, and escalation without taking over operational work. Individual chart review, daily assignment approval, and bedside direction blur governance with management. 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. D — Clear governance design prevents advisory work from being mistaken for delegated authority or unaccountable management action. Identical authority, permanent recommendations, and private action do not define a responsible governance relationship. 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. C — Portfolio oversight protects the enterprise from local decisions that compete for shared resources or create incompatible dependencies. Independent scheduling, sponsor visibility, and unchecked parallel work can cause systemwide delay or rework. 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. A — Acceptance criteria make completion testable and align the team, sponsor, users, and vendor around what must be delivered. Delayed definition, vendor-only standards, and budget alone cannot establish whether the project is fit for purpose. 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. A — Escalation design keeps important risks visible and ensures that stalled governance produces a timely, accountable decision. Waiting, undocumented decisions, and removal from the report conceal rather than manage exposure. 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. B — Adoption improves when trusted users help test the work and leaders respond to barriers with practical support. A memo, premature enforcement, and executive-only testing do not provide representative implementation 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.

16. D — Readiness includes motivation and capability; both must be addressed for a sustainable change. Enthusiasm alone, cancellation, and attitude-only measurement overlook the operational conditions that determine adoption. 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.

17. B — Scaling requires more than activity completion; leaders need evidence that the change creates value and can be implemented safely. Attendance, enthusiasm, and publicity do not demonstrate patient benefit or readiness to spread. 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. C — Benefits realization tests whether the work produced the value that justified the investment and identifies what must change. Schedule, blame, and measure deletion confuse delivery with realized

benefit. 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. A — A strong coaching question helps the learner identify decision criteria and apply them independently to future situations. Speed pressure, takeover, and personal urgency do not build a repeatable prioritization skill. 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. B — Mentoring supports growth through guidance, while sponsorship involves advocacy and access that the learner cannot create alone. Discipline, evaluation, and identical terminology describe neither developmental relationship accurately. 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 — Targeted stretch work lets leaders develop and observe the capabilities required for the future role before promotion. Immediate promotion, passive waiting, and tenure alone do not establish enterprise readiness. 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. C — Observable criteria and calibration make talent decisions more transparent and reduce the risk of stereotype-based evaluation. Repeated labels, exclusion, and imitation do not create fair or job-related assessment. 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. C — Explicit operating agreements reduce ambiguity and make shared accountability visible to the people doing the work. Staff count, vague compromise, and private assignment leave the pathway vulnerable to recurring conflict. 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 — Interest-based negotiation reveals what the parties need and creates a defensible way to compare alternatives. Loudness, unrelated trades, and first-proposal coercion may end discussion without solving the resource 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.

25. A — Practical consensus preserves progress by distinguishing what is settled from what still requires a defined decision. Unanimity, divergent starts, and closure can delay action or fragment 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.

26. B — Clear communication connects the decision to evidence and acknowledges consequences so stakeholders can understand the response. Savings alone, reassurance without facts, and selective messages reduce credibility and hinder problem solving. 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. B — Timely uncertainty communication reduces speculation without pretending that an unresolved decision is settled. Absolute denial, silence, and inconsistent explanations can increase anxiety and damage 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. Leaders can then adjust the approach using observed results.

28. A — Speaking up is shaped by the work environment and leader response, so the review should examine system conditions. Commitment judgments, reporting demands, and last-person focus may miss the barriers that suppressed escalation. 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 — Self-regulation allows leaders to separate emotional reaction from the substantive issue and choose a constructive response. Counterattack, avoidance, and forceful escalation can obscure learning and reduce 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.

30. D — Values become credible when leaders model them and apply consequences consistently, regardless of status or performance. Wording, staff resilience, and meeting attendance do not correct the contradictory incentive signal. 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. A — Leading indicators show whether the strategy is being implemented and whether early conditions are moving before final outcomes appear. A lagging result, posters, and meeting counts provide little information about current 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.

32. C — A balanced scorecard connects resources with the processes, people, experiences, and outcomes that create strategic value. More finance data, unrelated activity, and one broad score provide an incomplete view. 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. D — Business cases need a baseline and explicit assumptions so decision makers can evaluate incremental value rather than aspiration. Features, innovation language, and enthusiasm do not quantify the change or its 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.

34. B — Executive financial analysis considers the resources used across the system and the alternatives displaced by the service. Gross revenue, direct salaries, and branding can misstate enterprise value and resource burden. 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. C — Sensitivity analysis shows how robust a projection is and when leaders should trigger a different staffing response. Optimism, unexplained precision, and hidden calculations make the forecast difficult to govern. 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. D — Reimbursement incentives should be evaluated against the full care result so efficiency does not become underuse. Volume, savings alone, and payer satisfaction cannot reveal whether patients receive appropriate care. 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. B — Payment measures should encourage improvement without penalizing organizations for factors they cannot address or obscuring inequity. Unexamined acceptance, blanket rejection, and selective targets are incomplete stewardship responses. 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. A — Portfolio decisions weigh value and risk in context rather than treating projected return as the only criterion. Presentation quality, submission order, and equal splitting can produce an infeasible or unsafe portfolio. 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 — Vendor governance uses evidence and contractual accountability while protecting continuity and understanding the cause of failure. Automatic renewal, abrupt termination, and reputation alone do not provide responsible 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.

40. D — Partnerships become sustainable when expectations, resources, information, and accountability are explicit and reciprocal. Informality, one-sided planning, and referral counts alone leave the relationship vulnerable to misunderstanding. 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.

41. C — Innovation governance protects patients and resources by testing whether an appealing idea works across relevant conditions. Popularity, marketing, and indefinite piloting do not establish safe or useful performance. 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. B — External representation requires accuracy, transparency about limits, and disciplined separation of evidence from advocacy. Promises, selective data, and hidden uncertainty can mislead stakeholders and weaken professional 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.

43. B — Reliable oversight depends on knowing how a measure is defined, produced, checked, owned, and used. Visual polish, frequency, and deletion do not improve data reliability or accountability. 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. D — Crisis resilience depends on distributed authority and reliable communication when the usual decision maker cannot respond. Single-person dependence, personal judgment alone, and policy length do not provide operational continuity. 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. C — A structured review turns experience into shared learning and connects lessons with future action and ownership. Celebration, archiving, and private memory do not reliably change future integration work. This preserves accountability, builds trust, and gives leaders a practical basis for follow-up. It also creates a clear basis for review after implementation.

- 46. A** — Decision-rights design converts recurring conflict into a transparent and timely operating process. Attrition, informal hierarchy, and added committees can prolong the same ambiguity. 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.
- 47. C** — Executive stewardship considers who benefits, who bears burden, and how the strategy can create value without avoidable inequity. Clinical enthusiasm, paralysis, and unilateral burden shifting do not address the full system consequence. 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. D** — Shared criteria help leaders compare priorities against purpose, evidence, capacity, and the consequences of choosing one path. Budget size, averaging, and private preference can obscure strategic fit and reduce ownership. 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** — Late changes can affect safety, testing, cost, and adoption, so leaders should make tradeoffs explicit before authorizing them. Vendor reassurance, blanket rejection, and overtime hide consequences rather than managing scope. 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** — Interim appointments protect continuity when expectations, authority, and the time-limited nature of the role are clear. Tenure alone, unexplained preference, and vacancy can create confusion or avoidable operational 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.
- 51. A** — Readiness is demonstrated by reliable practice and evidence of improvement, not by a document collection exercise alone. Documents, historical scope, and memorization can miss what actually occurs in patient care. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.
- 52. B** — Document control reduces variation by making the approved, current procedure identifiable and accessible. Choice, multiple active versions, and title changes can preserve confusion at the point of care. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.
- 53. D** — Continuity planning protects the services and dependencies that must continue while recovery resources are limited. Unmapped purchasing, routine assumptions, and short-horizon planning can leave critical functions unprotected. 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** — Incident coordination depends on clear authority and consistent communication so staff can act without guessing. Independence, staff choice, and delay increase confusion and can create unsafe variation. 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** — High reliability learns from weak signals before harm occurs and uses them to improve system design. Waiting, suppressed reporting, and reminders alone leave the hazard pathway available. This

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

56. D — System-focused review examines how work conditions shape behavior instead of treating individual blame as a complete explanation. Caution demands, punishment, and longer policies may overlook the conditions that made the error more likely. 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 — Fair accountability distinguishes human error, constrained choices, and unjustifiable risk while still learning from the event. Automatic punishment, blanket excuse, and no-harm dismissal each weaken learning and accountability. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

58. B — Respectful disclosure supports transparency, learning, and patient partnership while coordinating appropriate communication and support. Legal delay, apology without information, and private referral may increase harm and distrust. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

59. A — Analysis becomes useful when findings are translated into strong actions with ownership, measurement, and follow-up. Publication, ease alone, and documentation without action do not reduce recurrence. 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 — Strong corrective action changes the process that permits error and verifies that performance improves over time. Reminders, promises, and posters depend mainly on memory and leave system vulnerability intact. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

61. D — Prospective analysis identifies possible failure points before exposure and allows the team to design defenses in advance. Retrospective review, marketing material, and one-person opinion do not provide systematic prevention. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

62. C — Agreed risk criteria help leaders compare hazards and direct limited resources to the most consequential exposures. Alphabetical order, senior narrative, and frequency alone do not represent overall risk. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

63. C — When education does not change performance, leaders should examine design, workflow, feedback, and the strength of the intervention. Repetition, attendance, and blame do not address why the defect persists. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

64. A — Meaningful benchmarking depends on comparable populations, definitions, and denominators that reflect exposure. Raw counts, exclusion, and unverified low rates can produce misleading comparisons. 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.

65. B — A process measure shows whether the intended work occurred and can be linked to later medication outcomes. Meetings, forms, and broad satisfaction do not show reliable process performance. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

66. D — Balancing measures show whether improvement in one outcome creates an adverse effect elsewhere in care. Posters, training, and meetings measure activity rather than the unintended patient effect. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

67. D — Time-series signals support investigation while requiring leaders to consider other causes before claiming attribution. Sole-cause claims, delay, and measure replacement weaken disciplined 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.

68. A — A special-cause signal calls for data verification and focused investigation before broader process redesign. Limit manipulation, averaging, and blind redesign can conceal the source of variation. 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.

69. B — Small-cycle testing links a prediction to observed performance and supports safe adaptation before spread. Immediate launch, perfectionistic delay, and printing do not demonstrate whether the process works. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

70. C — Process improvement examines unnecessary work and clarifies responsibility so patients receive coordinated communication. More calls, credit disputes, and omitted steps can increase burden or hide the actual problem. 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 — Root-cause work is stronger when it reaches system conditions that make unsafe behavior possible or likely. Stopping at a person, probing motivation alone, and surveying satisfaction do not explain system vulnerability. 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 combines external evidence with context, expertise, patient needs, implementation support, and evaluation. Exact copying, rejection, and waiting for consensus do not translate evidence responsibly. 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.

73. C — Early classification and review protect participants and clarify how data may be used and shared. 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 — Reliable handoff depends on usable design and behavior, not merely the presence of a form or template. Signatures, added fields, and stopped auditing cannot show whether critical information transfers. 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 — Safe reconciliation depends on clear ownership, shared information, and verification at transitions. Independent lists, reminders, and added paperwork can preserve the same handoff failure. 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. C — Reliable improvement requires consistent core practices and measurement that reveals whether performance is equitable across shifts. Average celebration, rigid copying, and selective focus can hide variation and weak defenses. 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 — Surveillance first establishes whether the pattern is real and defines the problem before leaders choose controls. Premature announcement, individual blame, and irreversible closure can create harm without identifying 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.

78. B — Risk-pattern analysis supports targeted prevention that combines patient needs, workflow, environment, and measurement. Uniform intervention, patient-only responsibility, and an aggregate count may miss the mechanism. 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.

79. A — Culture changes when staff see leaders respond consistently and can practice the behaviors the organization expects. Measurement, publication, and statements alone do not change the experience of speaking up. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

80. B — Trend validity depends on stable measurement and transparent handling of changes in data collection. Smoothing, favorable reporting, and deletion can create a false pattern. 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. C — Stratification reveals unequal effects that an overall average can conceal and guides focused improvement. Averages, assumptions, and data removal make disparity less visible rather than addressing it. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

82. D — Defined sampling reduces selection bias and makes findings easier to interpret, reproduce, and defend. Convenience, favorable-only review, and shifting criteria weaken the evidence. 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.

83. B — Response patterns affect interpretation, so leaders should seek inclusive data and avoid overgeneralizing from incomplete participation. Assumption, overgeneralization, and stopping measurement can conceal a distinct workforce experience. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

84. C — Exercises expose operational gaps that require assigned corrective action and retesting before a real event. Reporting without ownership, real-event learning, and personal improvisation leave the gap unresolved. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

85. A — After-action learning should remove avoidable burden while protecting essential information and verifying the revised workflow. Unexamined redundancy, total deletion, and delayed testing can create new safety risks. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

86. D — Reliability depends on demonstrated recovery, not on the existence or number of untested backup components. Purchase assumptions, added untested layers, and failure-triggered learning are weak protections. 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.

87. A — Stop-work authority allows staff to interrupt a potentially unsafe process while the concern is assessed. Delay, hierarchy, and late documentation can allow preventable harm to occur. 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.

88. C — Clear measure definitions make performance interpretable and prevent teams from comparing unlike populations or activities. Convenience, premature targets, and combined activities can create a misleading stewardship signal. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

89. D — Setting-specific variation points to a workflow or context issue that requires targeted improvement rather than broad blame. Averages, blame, and untested copying can hide the mechanism producing the risk. This links learning to measurable process change and lowers the chance of recurrence. It also creates a clear basis for review after implementation.

90. B — A structured accommodation process protects privacy and examines the job, the limitation, and reasonable operational options. Automatic denial, coworker judgment, and public disclosure are not fair or appropriate workforce processes. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

91. B — Clear role requirements create a consistent basis for workforce decisions and reduce ambiguity about performance and support. Manager familiarity, recruitment-only use, and informal expectations

can produce inconsistent or unfair decisions. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

92. C — Injury prevention examines hazards and work design while supporting staff competence and reporting. Caution, blame, and suppressed reporting do not correct the conditions causing injury. 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.

93. A — A healthy safety system makes reporting safe and uses exposure information to improve controls and response. Injury-only reporting, informality, and delay can suppress information and allow hazards to continue. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

94. D — Structured criteria make advancement decisions more transparent, job-related, and reviewable. Intuition, sponsorship, and eliminating judgment altogether do not create a fair selection process. 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.

95. C — Selection tools should be examined for job connection and unintended exclusion while preserving evidence-based assessment. Group-only focus, concealment, and familiarity do not establish fairness or validity. 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.

96. D — Retaliation concerns require timely review of facts and consistency so safety reporting does not become risky. Discretion claims, silencing, and delay can permit unfair treatment and suppress future reporting. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

97. A — Professional development is strongest when learning connects to a role need and is applied, supported, and reviewed. Motivation, attendance, and visibility do not show whether capability improves or access is equitable. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

98. B — Orientation introduces expectations, while competency validation confirms safe performance in the actual task. Completion, permanent exclusion, and unobserved sign-off do not establish 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.

99. C — Competency requires evidence of reliable performance, not merely exposure to information or years in practice. Experience assumptions, attendance, and event-triggered assessment leave capability 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.

100. D — Scope and delegation decisions require more than confidence or convenience; they depend on governing requirements and demonstrated capability. Confidence, custom, and speed can expose patients and staff to unrecognized risk. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

101. B — Safe delegation matches patient and task needs with capability, oversight, and a plan to evaluate the result. Schedule pressure, willingness, 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.

102. A — Specific feedback gives the employee a fair opportunity to understand and change the behavior. Delay, public comparison, and general warnings do not provide actionable direction. 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. A — Career systems should recognize competence and contribution rather than activity that is easy to count but weakly connected to practice. More committees, removal, and attendance alone do not show professional growth. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

104. C — Inclusive facilitation changes the conditions of participation so relevant expertise can influence decisions. Personal burden, dominance, and suppressed disagreement do not create psychological safety or better 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.

105. D — Inclusion depends on access to information and influence in daily work, not only symbolic events. Personal responsibility, dismissal, and celebration alone do not correct structural exclusion. 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.

106. B — Incivility can affect safety, retention, teamwork, and patient care, requiring a fair leadership response. Avoidance, unsupported confrontation, and patient-harm-only thresholds leave the workplace risk unresolved. 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 — Workplace violence prevention combines environmental, operational, behavioral, response, and recovery strategies. Individual burden, suppressed reporting, and annual education alone do not provide layered protection. 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.

108. D — Safe staffing requires matching capacity and capability with the work patients actually require. Ease, informal negotiation, and open beds alone do not demonstrate safe 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.

109. C — Fatigue is shaped by work design and recovery opportunities, so leaders should address system contributors and monitor effects. More overtime, individual blame, and stopped measurement can worsen risk. 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.

110. B — Engagement data become useful when leaders make the results visible and respond to the conditions staff describe. Slogans, repeated measurement, and blame do not repair trust or identify action. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

111. D — Stay interviews can reveal local factors such as workload, growth, scheduling, recognition, and leadership that leaders can address. Generic praise, pay-only assumptions, and personal responsibility do not diagnose the retention problem. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

112. A — Healthy workforce strategy addresses organizational conditions as well as individual coping and support. Classes, coping demands, and discontinued measurement leave the primary work-system drivers unchanged. 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.

113. C — Fair performance management gives clear expectations and a supported opportunity to demonstrate improvement. Immediate discipline, public failure, and comparison do not establish a fair process. 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 — Progressive management connects prior support with proportionate accountability and a documented opportunity for response. Ignoring, overreacting, and gossip do not provide consistent or fair workforce management. 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. C — Compensation review should consider external competitiveness and internal relationships so recruitment does not create avoidable inequity. New-hire focus, dismissal, and uniform cuts do not

address the underlying compensation problem. This protects fairness, supports development, and makes workforce decisions more transparent. It also creates a clear basis for review after implementation.

116. A — Fair scheduling depends on clear criteria and consistent application while recognizing legitimate operational differences. Preference, mechanical rotation, and private trades can produce inequity and hidden burden. 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 — Professional governance works when frontline voice and formal accountability are connected through clear decision rights. 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.

118. B — Governance is credible when participation is feasible and the resulting decisions represent the workforce affected. Replacement, dominance, and annual suggestions can reduce representation and ownership. 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. B — A fair labor-relations approach preserves employee choice while ensuring leaders communicate responsibly and lawfully. Opposition, 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.

120. A — A readiness gap requires continuity planning plus deliberate development or recruitment before a crisis occurs. Tenure alone, delay, and concealment do not protect the organization or build capability. 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.

121. D — Patient-centered delivery organizes services around the person's needs and connects care across settings and disciplines. Uncoordinated specialty care, portal substitution, and departmental optimization fragment the patient's experience. 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. C — Asynchronous care is safe only when its clinical scope, ownership, response, privacy, and escalation are explicit. Universal replacement, volume, and personal accounts can create missed needs and privacy 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.

123. C — Digital equity requires understanding practical access and preserving safe options when technology or privacy conditions are limited. Device purchase demands, patient blame, and offer counts do not show whether care was reachable. This keeps decisions patient-centered, evidence-informed, equitable, and accountable to outcomes. It also creates a clear basis for review after implementation.

124. A — Sustainable access connects education, training, recruitment, retention, and community priorities. Temporary staffing, facilities without retention, and copied models may not create durable local capacity. 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.

125. B — Team-based care requires clear roles and reliable coordination so collaboration improves outcomes rather than adding ambiguity. Attendance, one-person control, and slogans do not establish safe team function. 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.

126. D — Autonomy includes capacity, information, voluntariness, and the right to make a reasoned choice about care. Overriding, forced equality, and incomplete disclosure do not respect an informed decision. 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. D — Ethical surrogate decisions represent the patient when possible and otherwise use a reasoned best-interest analysis. Volume, cost alone, and unanimous family agreement are not reliable standards. 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. B — Fair allocation requires relevant criteria, consistency, transparency, and accountability when demand exceeds capacity. Advocacy, hidden judgment, and request order are not ethically defensible allocation methods. 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. A — Privacy-respecting care limits disclosure to an authorized purpose and uses safeguards appropriate to the setting. Full disclosure, public discussion, and education claims do not replace authorization or privacy safeguards. 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. C — Ethics consultation supports a structured process for reasoning and communication rather than taking over clinical authority. Replacement, vocal preference, and legal ruling exceed a facilitative ethics 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. A — Moral distress can reflect both emotional burden and system constraints, so response must address people and conditions. Silence, individual-only support, and relocation may leave the ethical conflict 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 — Inquiry treats frontline questions as opportunities for disciplined learning and shared problem definition. 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.

133. D — Early review protects participants and clarifies the governance pathway before data use and publication. Automatic exemption, delayed review, 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 — Fair outcome interpretation accounts for patient risk and measurement while preserving attention to variation and equity. Unadjusted ranking, exclusion, and measure substitution can mislead leaders. 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. A — Stratification reveals unequal effects and directs leaders toward modifiable barriers affecting a particular population. Aggregate reporting, assumption, and data removal can conceal disparities. 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. D — Mixed-method evaluation connects patient voice with the operational conditions that shape experience. Ignoring, selecting one story, and leader-only interpretation can miss the underlying mechanism. 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. B — Transition outcomes reflect preparation, understanding, follow-up, access, and communication across settings. Universal reversal, inpatient testing, 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. Leaders can then adjust the approach using observed results.

138. C — Closed-loop coordination connects the referral, response, responsibility, and outcome so patients do not disappear between services. Forms, patient-only coordination, and referral counts without status do not create continuity. 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.

139. A — Technology value depends on fit, integration, safety, sustainability, and the organization's ability to implement it well. Features, senior preference, and purchase price alone omit critical conditions for success. 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. B — Responsible AI governance requires attention to equity and local performance, not only aggregate accuracy. Overall accuracy, exclusion, and more automation can amplify inequity or hide unsafe 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.

141. D — Predictive value depends on calibration and workflow usefulness as well as technical sophistication. More alerts, complexity, and removal of review can create fatigue and unnecessary intervention. 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. C — Cybersecurity improves through layered controls, practice, feedback, and a fair learning response. Public blame, canceled exercises, and education alone weaken resilience and suppress reporting. 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.

143. B — Interoperability requires common meaning and accountable data governance in addition to technical exchange. Combined ambiguity, 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.

144. D — Alert design must balance clinical value, timing, workload, and the risk of missed information. More alerts, abrupt shutdown, and identical acknowledgment do not balance usability and safety. 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. C — Implementation must address workflow fit and safety so users can perform required work inside a reliable system. Punishment, launch completion, and bans without alternatives can increase hidden 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.

146. A — Remote monitoring is safe only when data connect to timely, accountable clinical action. Unassigned dashboards, patient-only triage, and fixed review intervals can delay needed 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.

147. D — Community partnerships connect care planning with practical resources and address drivers that the clinic cannot solve alone. Advice without resources, narrow measurement, and detached design leave the barrier 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.

148. A — Teach-back checks understanding and allows clinicians to adapt communication to the patient's needs and circumstances. Length, signatures, and identical scripts do not demonstrate comprehension or 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.

149. C — Technology evaluation must include accessibility and equity so popularity does not conceal exclusion. Downloads, patient adaptation, and data removal can preserve an inaccessible care pathway. 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.

150. B — Care delivery value requires a connected pathway from identification to accessible treatment and outcome monitoring. More screening, partial success, and abandoned measurement can leave patients identified but untreated. 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.