

PRACTICE EXAM 5: CHPN CERTIFIED HOSPICE AND PALLIATIVE NURSE SIMULATION (150 QUESTIONS)

This standalone practice exam contains 150 four-option questions and is designed for a three-hour session. Select the single best answer for every question. The current HPCC CHPN examination contains 135 scored items and 15 unscored pretest items. The minimum passing score is 500 on the reported 200-800 scaled-score range.

1. During a visit in a private home, Quinn Reed, age 57, finds a controlled-substance count that does not match the record. Which action should the hospice nurse take first?

- A. Alter the record so it agrees with the amount that remains
- B. Secure the medication, reassess the count, document, and escalate per policy
- C. Ignore the mismatch because the patient is receiving end-of-life care
- D. Accuse the caregiver publicly before verifying the discrepancy

2. The nurse caring for Taylor Flores, age 64, in an assisted-living apartment learns that the patient nods during teaching but cannot describe the medication plan. What is the best response?

- A. Repeat all instructions rapidly so the entire plan is covered again
- B. Document successful education because the caregiver agreed during the visit
- C. Provide additional written pages without checking literacy or understanding
- D. Use teach-back with plain language and demonstrate one task at a time

3. A hospice patient is prescribed 11.25 mg of a liquid analgesic. The available concentration is 10 mg/mL. How many milliliters should the nurse administer?

- A. Administer 2.25 mL of the prescribed solution
- B. Administer 1.625 mL of the prescribed solution
- C. Administer 1.125 mL of the prescribed solution

D. Administer 0.562 mL of the prescribed solution

4. A caregiver calls about Devon Jones, age 78, who develops predictable severe pain during dressing changes. Which intervention should the nurse prioritize?

- A. Increase the long-acting dose immediately without reviewing baseline pain
- B. Plan a rapid-onset rescue dose before the painful procedure
- C. Delay analgesia until the procedure confirms that severe pain has begun
- D. Cancel all future wound care because procedural pain cannot be prevented

5. While reassessing Gray Vega, age 85, in an inpatient hospice unit, the nurse notes that the patient has worsening weakness and spends nearly the entire day in bed. What should the nurse do next?

- A. Stop all medications without reviewing their purpose or current benefit
- B. Tell the caregiver that functional change is expected and requires no follow-up
- C. Assume the decline proves death will occur within the next twenty-four hours
- D. Reassess function, intake, symptoms, and caregiver needs with the team

6. During a visit in a private home, Kai Price, age 45, states a wish to remain home while the family requests hospitalization. Which action should the hospice nurse take first?

- A. Explore the patient's informed preferences and facilitate a goals-of-care discussion
- B. Ask the attending physician to decide without further patient participation
- C. Arrange hospitalization immediately and revisit preferences after the transfer
- D. Follow the family's request because relatives provide most of the daily care

7. During a visit in a private home, Morgan Chen, age 49, develops noisy upper-airway secretions during active dying. Which action should the hospice nurse take first?

- A. Begin forced oral fluids to thin secretions despite impaired swallowing
- B. Tell the family the sound proves that the patient is suffocating

- C. Perform repeated deep suctioning as the routine first intervention
- D. Reposition gently and explain the sound while assessing for patient distress

8. At an interdisciplinary review, the team hears that Quinn Turner, age 59, describes a cultural practice unfamiliar to the hospice team. Which nursing action is most appropriate?

- A. Ask a relative to speak for the patient without first seeking permission
- B. Apply assumptions learned from another family with a similar background
- C. Ask what the practice means and how the team can support it safely
- D. Refuse the practice because it is not part of standard hospice routine

9. A caregiver calls about Taylor Hill, age 66, who cannot self-report pain because of advanced cognitive impairment. Which intervention should the nurse prioritize?

- A. Combine an observational pain tool with caregiver knowledge and clinical assessment
- B. Administer analgesia only after the patient becomes verbally communicative
- C. Record no pain because a numeric rating cannot be obtained
- D. Use vital signs as the only reliable measure of pain intensity

10. While reassessing Alex Adams, age 73, in an inpatient hospice unit, the nurse notes that the patient receives a family request to omit a significant symptom from the record. What should the nurse do next?

- A. Create a separate unofficial note that is not available to the team
- B. Document the assessment accurately and explain why the record must be complete
- C. Record only interventions so the symptom remains indirectly concealed
- D. Delete the finding because the family controls all hospice documentation

11. During a visit in a private home, Emery Reed, age 83, is exhausted and says caregiving can no longer continue without relief. Which action should the hospice nurse take first?

- A. Tell the caregiver that accepting hospice requires providing continuous care

- B. Assess immediate safety and mobilize respite and interdisciplinary support
- C. Recommend permanent placement before exploring available supports and preferences
- D. Wait for a crisis because caregiver fatigue is not a patient-care concern

12. The nurse caring for Harper Flores, age 90, in an assisted-living apartment learns that the patient develops myoclonus, hallucinations, and increasing sedation after opioid escalation. What is the best response?

- A. Assess for opioid neurotoxicity and contributing renal or hydration problems
- B. Escalate the same opioid because the symptoms prove pain remains uncontrolled
- C. Reassure the family that these findings are always normal near death
- D. Stop all analgesia abruptly and provide no alternative pain treatment

13. A caregiver calls about Lane Diaz, age 50, who begins a scheduled opioid and has no bowel regimen. Which intervention should the nurse prioritize?

- A. Recommend restricting fluids so bowel movements occur less frequently
- B. Wait for severe constipation before discussing any preventive intervention
- C. Assess bowel function and initiate preventive management according to the plan
- D. Stop the opioid even though it is controlling otherwise severe pain

14. The plan of care for Parker Usman, age 60, is reviewed after the patient uses every rescue dose and still reports poorly controlled pain. Which response best supports hospice and palliative nursing practice?

- A. Add several sedating medicines simultaneously without a defined target
- B. Assume drug-seeking behavior because all rescue medication was used
- C. Repeat the current regimen without reassessing response or pain type
- D. Review adherence, timing, total use, adverse effects, and pain mechanism before titration

15. While reassessing Quinn Vega, age 61, in an inpatient hospice unit, the nurse notes that the patient is asked for patient information by a relative not authorized to receive it. What should the nurse do next?

- A. Verify permission before disclosing protected information
- B. Share details because close relatives are automatically entitled to the record
- C. Confirm the hospice enrollment but withhold only medication information
- D. Send the information and ask the patient for permission at the next visit

16. During a visit in a private home, Val Price, age 71, feels persistent moral distress after repeated conflicts about care. Which action should the hospice nurse take first?

- A. Suppress the concern because distress proves inadequate professional resilience
- B. Use supervision, team debriefing, and an organizational ethics resource
- C. Withdraw emotionally from patients to prevent further involvement
- D. Post details on social media to obtain advice from other nurses

17. The plan of care for Winter Ross, age 72, is reviewed after the patient has nausea that began after a medication change. Which response best supports hospice and palliative nursing practice?

- A. Administer every available antiemetic at once without identifying a target
- B. Assume nausea is psychological because vomiting has not occurred
- C. Stop all medications permanently before contacting the prescribing clinician
- D. Assess timing, likely mechanism, bowel status, and other associated findings

18. At an interdisciplinary review, the team hears that Emery Turner, age 85, asks whether intense grief several weeks after death is abnormal. Which nursing action is most appropriate?

- A. Avoid discussion because bereavement begins only after several months
- B. State that normal grief should resolve completely within a fixed short period
- C. Listen, assess function and safety, and explain that grief varies widely
- D. Recommend medication before assessing the person's experience or risks

19. At an interdisciplinary review, the team hears that Gray Cole, age 89, has abdominal distention, colicky pain, vomiting, and no stool. Which nursing action is most appropriate?

- A. Increase oral fiber immediately without further abdominal assessment
- B. Assess urgently for possible bowel obstruction and notify the clinical team
- C. Encourage a large meal to stimulate normal intestinal motility
- D. Reassure the caregiver that constipation alone never requires urgent review

20. While reassessing Kai Adams, age 49, in an inpatient hospice unit, the nurse notes that the patient has fluctuating confusion and visual hallucinations. What should the nurse do next?

- A. Diagnose dementia because hallucinations always indicate chronic cognitive decline
- B. Provide lengthy teaching during the most confused periods of the episode
- C. Use physical restraints before trying environmental or symptom-focused measures
- D. Assess for delirium, safety risks, discomfort, medications, and reversible contributors

21. The nurse caring for Parker White, age 62, in an assisted-living apartment learns that the patient refuses morphine because a relative says it always hastens death. What is the best response?

- A. Remove opioid therapy from consideration without discussing other preferences
- B. Ask the relative to authorize treatment instead of speaking with the patient
- C. Explore the concern and explain the purpose, dosing, monitoring, and expected effects
- D. Tell the patient the concern is irrational and administer the medication anyway

22. The plan of care for Parker Singh, age 60, is reviewed after the patient is being transferred from an inpatient unit to home hospice. Which response best supports hospice and palliative nursing practice?

- A. Complete a structured handoff covering symptoms, medications, equipment, and contacts
- B. Delay communication until the first home visit has already been completed
- C. Ask the family to relay clinical changes and pending care needs from memory
- D. Send only the discharge medication list because hospice will repeat the assessment

23. While reassessing Alex Ibrahim, age 79, in an inpatient hospice unit, the nurse notes that the patient can no longer swallow an effective oral analgesic regimen. What should the nurse do next?

- A. Continue oral tablets despite repeated choking during administration
- B. Assess an alternative route that preserves comfort and reliable delivery
- C. Discontinue analgesia because equivalent relief requires the oral route
- D. Crush every formulation together without checking whether crushing is safe

24. At an interdisciplinary review, the team hears that Alex Ellis, age 77, has advanced dementia, recurrent aspiration, and declining oral intake. Which nursing action is most appropriate?

- A. Tell the family that all assisted oral feeding must stop immediately
- B. Recommend feeding-tube placement as the required response to reduced intake
- C. Avoid discussing nutrition because the decision belongs only to the prescriber
- D. Clarify goals and explain the benefits and burdens of available feeding approaches

25. While reassessing Emery Vega, age 87, in an inpatient hospice unit, the nurse notes that the patient has escalating anxiety during episodes of breathlessness. What should the nurse do next?

- A. Treat dyspnea and anxiety together using calm coaching and the prescribed plan
- B. Use confrontation to prove that the patient is receiving enough air
- C. Leave the room to reduce stimulation until the episode resolves unaided
- D. Explain that anxiety is the sole cause and stop evaluating respiratory distress

26. During a visit in a private home, Indigo Price, age 47, has painful lower-extremity edema and fragile skin. Which action should the hospice nurse take first?

- A. Apply tight compression without evaluating arterial status or goals
- B. Limit all position changes because movement can worsen visible swelling
- C. Elevate and reposition for comfort while assessing skin and circulatory tolerance
- D. Massage reddened bony areas vigorously to move accumulated fluid

27. During a visit in a private home, Kai Chen, age 51, notices repeated delays in delivering comfort medications. Which action should the hospice nurse take first?

- A. Remind staff to work faster without examining the medication workflow
- B. Discipline the most recent nurse before reviewing contributing conditions
- C. Map the process, measure delays, and test a targeted improvement
- D. Collect complaints indefinitely without defining an improvement measure

28. A caregiver calls about Parker Brooks, age 64, who has a malodorous fungating wound causing embarrassment. Which intervention should the nurse prioritize?

- A. Address odor, exudate, pain, and privacy with a comfort-focused wound plan
- B. Avoid discussing odor because acknowledging it may increase embarrassment
- C. Keep the wound uncovered so moisture cannot accumulate beneath a dressing
- D. Use aggressive debridement automatically regardless of bleeding risk or goals

29. The plan of care for Taylor Thomas, age 74, is reviewed after the patient reports pain only when being turned in bed. Which response best supports hospice and palliative nursing practice?

- A. Keep the patient in one position indefinitely to prevent all movement-related pain
- B. Perform turning rapidly so the painful episode lasts fewer seconds
- C. Increase baseline sedation without evaluating the turning technique
- D. Coordinate gentle positioning and premedication based on the predictable trigger

30. During a visit in a private home, Alex Kim, age 81, has dry mouth and repeatedly requests small sips. Which action should the hospice nurse take first?

- A. Withhold all oral comfort because aspiration risk can never be modified
- B. Provide frequent mouth care and offer safe sips according to swallowing ability
- C. Start intravenous hydration automatically because dry mouth proves dehydration
- D. Use lemon-glycerin products repeatedly without checking for irritation

31. The plan of care for Bailey Lewis, age 82, is reviewed after the patient is asked to perform a task outside personal competence. Which response best supports hospice and palliative nursing practice?

- A. Attempt the task once and report only if an adverse event occurs
- B. Delegate the task to an unlicensed caregiver without assessing suitability
- C. Perform the task because a manager's request overrides competence concerns
- D. Decline until appropriate training, supervision, and scope requirements are met

32. The plan of care for Devon Singh, age 86, is reviewed after the patient has a sudden functional decline after several stable weeks. Which response best supports hospice and palliative nursing practice?

- A. Increase every symptom medication because decline indicates uncontrolled suffering
- B. Document expected decline and defer assessment until the next scheduled visit
- C. Assess for an acute reversible problem before attributing the change to progression
- D. Tell the family that sudden changes are never reversible in hospice care

33. At an interdisciplinary review, the team hears that Indigo Scott, age 49, cares for a stable home hospice patient who is not in crisis. Which nursing action is most appropriate?

- A. Continue routine home care with visits based on the individualized plan
- B. Use inpatient respite care as long-term residential placement for the patient
- C. Begin continuous home care solely because a relative prefers constant staff presence
- D. Request general inpatient care because hospice patients qualify automatically

34. At an interdisciplinary review, the team hears that Kai Ellis, age 53, cannot explain how or when to use the newly delivered comfort medications. Which nursing action is most appropriate?

- A. Document nonadherence and ask another family member to assume care
- B. Use teach-back and create a simple written medication schedule
- C. Repeat the same instructions more loudly without checking comprehension
- D. Remove all as-needed medicines until the next interdisciplinary meeting

35. At an interdisciplinary review, the team hears that Morgan Kim, age 57, wants a ritual performed immediately after death. Which nursing action is most appropriate?

- A. Begin routine postmortem care before asking what the ritual requires
- B. Refuse all delays because hospice procedures must be identical for every family
- C. Clarify the ritual and coordinate it when consistent with law and safety
- D. Ask staff to improvise the ritual without guidance from the family

36. The nurse caring for Taylor Bennett, age 76, in an assisted-living apartment learns that the patient reports severe pain but appears calm and is talking with visitors. What is the best response?

- A. Delay treatment until objective signs such as tachycardia become evident
- B. Accept the self-report and complete a multidimensional pain assessment
- C. Ask visitors to decide whether the patient's pain report is credible
- D. Lower the pain rating because behavior does not match the reported severity

37. During a visit in a private home, Val Chen, age 77, shows cool extremities, mottling, reduced urine output, and longer sleep periods. Which action should the hospice nurse take first?

- A. Begin aggressive hydration to reverse every observed physiologic change
- B. Withhold information until the family specifically asks about prognosis
- C. Promise that death will occur within a precise number of hours
- D. Explain that the pattern may indicate approaching death and review the comfort plan

38. A caregiver calls about Devon Brooks, age 90, who has urinary retention, suprapubic discomfort, and frequent small voids. Which intervention should the nurse prioritize?

- A. Assess bladder fullness and obtain timely intervention consistent with comfort goals
- B. Label the behavior as agitation without examining for a physical cause
- C. Wait for complete absence of urine before notifying the clinical team
- D. Increase oral fluid rapidly despite worsening suprapubic discomfort

39. A caregiver calls about Finley Hill, age 94, who cannot manage severe symptoms safely in the current setting despite plan changes. Which intervention should the nurse prioritize?

- A. End hospice enrollment before arranging any higher-intensity palliation
- B. Use caregiver respite as the sole rationale for acute symptom management
- C. Maintain routine care because changing levels indicates failure by the team
- D. Coordinate the level of care needed for short-term intensive symptom management

40. During a visit in a private home, Kai Kim, age 57, has new unilateral weakness and difficulty speaking. Which action should the hospice nurse take first?

- A. Promise full neurologic recovery if transfer occurs immediately
- B. Give food and oral medication before checking swallowing safety
- C. Clarify goals while rapidly assessing onset, safety, and desired level of intervention
- D. Assume the symptoms are expected progression and perform no assessment

41. During a visit in a private home, Morgan Reed, age 61, has a prognosis consistent with hospice eligibility but improves temporarily. Which action should the hospice nurse take first?

- A. Discharge immediately because any improvement permanently ends eligibility
- B. Review the overall trajectory and documentation rather than using one good day alone
- C. Ignore all improvement because prognosis is never reassessed after election
- D. Base continued eligibility only on the caregiver's preference for services

42. At an interdisciplinary review, the team hears that Quinn Khan, age 71, observes a colleague discussing a patient in a public elevator. Which nursing action is most appropriate?

- A. Stop the conversation and address the privacy breach through policy channels
- B. Wait for a visitor to complain before taking any action
- C. Record the event only in the patient's symptom-management note
- D. Join the discussion quietly because no patient name was initially spoken

43. While reassessing Val Ibrahim, age 81, in an inpatient hospice unit, the nurse notes that the patient has severe pruritus with jaundice and excoriated skin. What should the nurse do next?

- A. Apply an irritating fragranced product to every excoriated area
- B. Assess likely causes and use skin protection plus mechanism-directed symptom measures
- C. Dismiss itching because it is less urgent than visible jaundice
- D. Encourage vigorous scratching because it temporarily reduces the sensation

44. While reassessing Alex Owens, age 85, in an inpatient hospice unit, the nurse notes that the patient has localized bone pain that remains severe despite systemic medication. What should the nurse do next?

- A. Discuss mechanism-focused options such as positioning, adjuvants, or palliative radiation
- B. Avoid interdisciplinary consultation because localized pain is solely a nursing issue
- C. Conclude that no further palliation is possible once an opioid has been tried
- D. Replace all analgesics with massage regardless of fracture or instability risk

45. During a visit in a private home, Emery Irwin, age 45, becomes difficult to arouse shortly after an analgesic dose increase. Which action should the hospice nurse take first?

- A. Assume the finding reflects natural sleep because the patient has hospice care
- B. Document adequate comfort and wait until the next routine visit
- C. Give the next dose early to prevent pain when the patient awakens
- D. Assess respiratory status, sedation, timing, and other contributing medications immediately

46. At an interdisciplinary review, the team hears that Cameron Reed, age 87, says illness has destroyed all meaning and asks why this is happening. Which nursing action is most appropriate?

- A. Promise that spiritual distress will resolve once pain is controlled
- B. Redirect the conversation to physical symptoms because meaning is not clinical
- C. Remain present, explore the concern, and offer spiritual-care support if desired
- D. Provide a personal religious explanation as the definitive answer

47. At an interdisciplinary review, the team hears that Kai Martin, age 59, identifies a near miss involving look-alike medication packaging. Which nursing action is most appropriate?

- A. Take no action because the patient did not receive the wrong medication
- B. Report the near miss and seek a system change that reduces selection error
- C. Warn only the nurse involved and leave storage unchanged
- D. Remove the package without documenting the underlying hazard

48. While reassessing Oakley Grant, age 69, in an inpatient hospice unit, the nurse notes that the patient reports frightening breathlessness while oxygen saturation is unchanged from baseline. What should the nurse do next?

- A. Position upright, reduce air hunger, and evaluate the individualized dyspnea plan
- B. Focus only on oxygen flow without assessing anxiety or symptom intensity
- C. State that dyspnea is absent because the saturation has not declined
- D. Require bed rest in a flat position until breathing becomes regular

49. The plan of care for Reese Thomas, age 76, is reviewed after the patient describes burning, electric pain radiating along one leg. Which response best supports hospice and palliative nursing practice?

- A. Wait for complete loss of sensation before changing the analgesic plan
- B. Treat the report as anxiety because neuropathic pain lacks visible findings
- C. Use only nonpharmacologic measures regardless of pain severity or goals
- D. Assess neuropathic features and discuss an appropriate adjuvant analgesic

50. The nurse caring for Winter Patel, age 86, in an assisted-living apartment learns that the patient develops predictable severe pain during dressing changes. What is the best response?

- A. Plan a rapid-onset rescue dose before the painful procedure
- B. Delay analgesia until the procedure confirms that severe pain has begun
- C. Increase the long-acting dose immediately without reviewing baseline pain
- D. Cancel all future wound care because procedural pain cannot be prevented

51. The nurse caring for Bailey White, age 90, in an assisted-living apartment learns that the patient is offered an expensive personal gift by a grateful family. What is the best response?

- A. Trade the gift for additional visits outside the established plan
- B. Accept the gift privately so the family does not feel rejected
- C. Thank the family and follow agency policy while maintaining professional boundaries
- D. Ask another employee to accept it and transfer it after discharge

52. A caregiver calls about Winter Hayes, age 82, who is afraid that using rescue medication correctly will cause addiction. Which intervention should the nurse prioritize?

- A. Remove rescue medication even though severe symptoms remain likely
- B. Tell the caregiver to hide every medication from the patient
- C. Explore the fear and teach the intended use, monitoring, and safe storage
- D. Dismiss the concern because substance-related risks never occur in hospice

53. The plan of care for Devon Brooks, age 92, is reviewed after the patient has decision-making capacity but asks the nurse not to share details with relatives. Which response best supports hospice and palliative nursing practice?

- A. Ask the family to obtain information directly from the electronic record
- B. Respect the request and clarify what information may be shared
- C. Avoid documenting the patient's communication preference in the care plan
- D. Disclose the full plan because family members are involved in daily caregiving

54. The nurse caring for Harper Thomas, age 52, in an assisted-living apartment learns that the patient reports a new symptom that conflicts with the assumptions in the current plan. What is the best response?

- A. Continue the existing plan until the next mandatory recertification review
- B. Dismiss the report because earlier documentation described the symptom differently
- C. Change the medical plan independently without consulting an authorized prescriber

D. Perform a focused assessment and bring the new findings to the interdisciplinary team

55. During a visit in a private home, Oakley Irwin, age 71, develops noisy upper-airway secretions during active dying. Which action should the hospice nurse take first?

- A. Perform repeated deep suctioning as the routine first intervention
- B. Tell the family the sound proves that the patient is suffocating
- C. Reposition gently and explain the sound while assessing for patient distress
- D. Begin forced oral fluids to thin secretions despite impaired swallowing

56. The nurse caring for Reese Bennett, age 78, in an assisted-living apartment learns that the patient finds a controlled-substance count that does not match the record. What is the best response?

- A. Ignore the mismatch because the patient is receiving end-of-life care
- B. Secure the medication, reassess the count, document, and escalate per policy
- C. Alter the record so it agrees with the amount that remains
- D. Accuse the caregiver publicly before verifying the discrepancy

57. A caregiver calls about Winter Singh, age 88, who has nausea that began after a medication change. Which intervention should the nurse prioritize?

- A. Assess timing, likely mechanism, bowel status, and other associated findings
- B. Assume nausea is psychological because vomiting has not occurred
- C. Stop all medications permanently before contacting the prescribing clinician
- D. Administer every available antiemetic at once without identifying a target

58. During a visit in a private home, Val Ibrahim, age 83, has multiple comorbidities and gives inconsistent accounts of medication use. Which action should the hospice nurse take first?

- A. Discard every medication that was prescribed before hospice enrollment
- B. Copy the electronic medication list without comparing it with medicines in the home

- C. Assume inconsistent reporting means intentional nonadherence by the patient
- D. Reconcile prescriptions, actual use, effects, and access barriers with the caregiver

59. During a visit in a private home, Gray Ellis, age 55, has abdominal distention, colicky pain, vomiting, and no stool. Which action should the hospice nurse take first?

- A. Assess urgently for possible bowel obstruction and notify the clinical team
- B. Encourage a large meal to stimulate normal intestinal motility
- C. Increase oral fiber immediately without further abdominal assessment
- D. Reassure the caregiver that constipation alone never requires urgent review

60. At an interdisciplinary review, the team hears that Kai Vega, age 65, has fluctuating confusion and visual hallucinations. Which nursing action is most appropriate?

- A. Diagnose dementia because hallucinations always indicate chronic cognitive decline
- B. Assess for delirium, safety risks, discomfort, medications, and reversible contributors
- C. Provide lengthy teaching during the most confused periods of the episode
- D. Use physical restraints before trying environmental or symptom-focused measures

61. While reassessing Oakley Price, age 75, in an inpatient hospice unit, the nurse notes that the patient has escalating anxiety during episodes of breathlessness. What should the nurse do next?

- A. Use confrontation to prove that the patient is receiving enough air
- B. Explain that anxiety is the sole cause and stop evaluating respiratory distress
- C. Leave the room to reduce stimulation until the episode resolves unaided
- D. Treat dyspnea and anxiety together using calm coaching and the prescribed plan

62. The plan of care for Lane Singh, age 64, is reviewed after the patient appears unable to understand a proposed change in care. Which response best supports hospice and palliative nursing practice?

- A. Proceed with the change because the recommendation is clinically reasonable

- B. Assume incapacity because the patient has a serious life-limiting diagnosis
- C. Assess decision-making capacity for this decision and identify the authorized surrogate if needed
- D. Ask any available relative to consent without checking legal authority

63. A caregiver calls about Lane Nolan, age 62, who asks the nurse to make a treatment decision on the patient's behalf. Which intervention should the nurse prioritize?

- A. Select the option the nurse would want for a close relative
- B. Clarify values and provide balanced information without choosing for the family
- C. Present only the option favored by the attending clinician
- D. Avoid answering any questions because decisions are entirely private

64. The plan of care for Parker Hill, age 72, is reviewed after the patient has limited English proficiency during a complex goals discussion. Which response best supports hospice and palliative nursing practice?

- A. Use a young family member because relatives understand the situation best
- B. Postpone all communication until the patient learns common medical terms
- C. Rely on gestures and obtain agreement without confirming comprehension
- D. Arrange a qualified interpreter and speak directly to the patient

65. The nurse caring for Taylor Foster, age 82, in an assisted-living apartment learns that the patient reports that a family member is taking the patient's controlled medication. What is the best response?

- A. Replace the medication repeatedly without documenting the discrepancy
- B. Ignore the report to preserve family relationships during end-of-life care
- C. Protect immediate safety and follow policy for assessment, reporting, and medication control
- D. Confront the suspected person alone without first considering safety

66. During a visit in a private home, Emery Price, age 51, receives a family request to omit a significant symptom from the record. Which action should the hospice nurse take first?

- A. Document the assessment accurately and explain why the record must be complete
- B. Delete the finding because the family controls all hospice documentation
- C. Create a separate unofficial note that is not available to the team
- D. Record only interventions so the symptom remains indirectly concealed

67. The plan of care for Finley Ross, age 52, is reviewed after the patient develops new restlessness and fluctuating attention. Which response best supports hospice and palliative nursing practice?

- A. Assess for reversible causes while reviewing the established goals of care
- B. Ask the family to manage the behavior without further clinical assessment
- C. Transfer the patient to an emergency department before contacting the team
- D. Label the behavior terminal agitation and request immediate deep sedation

68. The plan of care for Harper Diaz, age 56, is reviewed after the patient asks what to expect as oral intake and alertness decrease. Which response best supports hospice and palliative nursing practice?

- A. Avoid anticipatory teaching because it could increase caregiver anxiety
- B. Recommend forcing food and fluid whenever the patient sleeps longer
- C. Give a precise prediction of the date and hour of death
- D. Describe common changes, uncertainty in timing, and specific comfort actions

69. At an interdisciplinary review, the team hears that Morgan Cole, age 69, has worsening weakness and spends nearly the entire day in bed. Which nursing action is most appropriate?

- A. Stop all medications without reviewing their purpose or current benefit
- B. Tell the caregiver that functional change is expected and requires no follow-up
- C. Reassess function, intake, symptoms, and caregiver needs with the team
- D. Assume the decline proves death will occur within the next twenty-four hours

70. At an interdisciplinary review, the team hears that Val Vega, age 91, has painful lower-extremity edema and fragile skin. Which nursing action is most appropriate?

- A. Apply tight compression without evaluating arterial status or goals
- B. Elevate and reposition for comfort while assessing skin and circulatory tolerance
- C. Limit all position changes because movement can worsen visible swelling
- D. Massage reddened bony areas vigorously to move accumulated fluid

71. The plan of care for Taylor Lewis, age 86, is reviewed after the patient cannot self-report pain because of advanced cognitive impairment. Which response best supports hospice and palliative nursing practice?

- A. Record no pain because a numeric rating cannot be obtained
- B. Combine an observational pain tool with caregiver knowledge and clinical assessment
- C. Administer analgesia only after the patient becomes verbally communicative
- D. Use vital signs as the only reliable measure of pain intensity

72. While reassessing Val Martin, age 87, in an inpatient hospice unit, the nurse notes that the patient has a valid directive but currently expresses a different informed preference. What should the nurse do next?

- A. Clarify the current capable choice and communicate it to the care team
- B. Follow the older document without discussing the patient's present wishes
- C. Delay documentation until the patient can meet with an attorney
- D. Ask the family to vote on which preference should control treatment

73. At an interdisciplinary review, the team hears that Emery Scott, age 53, develops myoclonus, hallucinations, and increasing sedation after opioid escalation. Which nursing action is most appropriate?

- A. Escalate the same opioid because the symptoms prove pain remains uncontrolled
- B. Reassure the family that these findings are always normal near death
- C. Assess for opioid neurotoxicity and contributing renal or hydration problems
- D. Stop all analgesia abruptly and provide no alternative pain treatment

74. A caregiver calls about Harper Jones, age 60, who is asked for patient information by a relative not authorized to receive it. Which intervention should the nurse prioritize?

- A. Share details because close relatives are automatically entitled to the record
- B. Confirm the hospice enrollment but withhold only medication information
- C. Send the information and ask the patient for permission at the next visit
- D. Verify permission before disclosing protected information

75. The plan of care for Lane Davis, age 70, is reviewed after the patient feels persistent moral distress after repeated conflicts about care. Which response best supports hospice and palliative nursing practice?

- A. Use supervision, team debriefing, and an organizational ethics resource
- B. Withdraw emotionally from patients to prevent further involvement
- C. Post details on social media to obtain advice from other nurses
- D. Suppress the concern because distress proves inadequate professional resilience

76. While reassessing Morgan Evans, age 71, in an inpatient hospice unit, the nurse notes that the patient states a wish to remain home while the family requests hospitalization. What should the nurse do next?

- A. Arrange hospitalization immediately and revisit preferences after the transfer
- B. Explore the patient's informed preferences and facilitate a goals-of-care discussion
- C. Follow the family's request because relatives provide most of the daily care
- D. Ask the attending physician to decide without further patient participation

77. At an interdisciplinary review, the team hears that Sage Martin, age 87, notices repeated delays in delivering comfort medications. Which nursing action is most appropriate?

- A. Collect complaints indefinitely without defining an improvement measure
- B. Remind staff to work faster without examining the medication workflow
- C. Discipline the most recent nurse before reviewing contributing conditions
- D. Map the process, measure delays, and test a targeted improvement

78. The plan of care for Bailey Long, age 50, is reviewed after the patient has a malodorous fungating wound causing embarrassment. Which response best supports hospice and palliative nursing practice?

- A. Use aggressive debridement automatically regardless of bleeding risk or goals
- B. Avoid discussing odor because acknowledging it may increase embarrassment
- C. Address odor, exudate, pain, and privacy with a comfort-focused wound plan
- D. Keep the wound uncovered so moisture cannot accumulate beneath a dressing

79. The nurse caring for Finley Jones, age 60, in an assisted-living apartment learns that the patient has dry mouth and repeatedly requests small sips. What is the best response?

- A. Provide frequent mouth care and offer safe sips according to swallowing ability
- B. Use lemon-glycerin products repeatedly without checking for irritation
- C. Start intravenous hydration automatically because dry mouth proves dehydration
- D. Withhold all oral comfort because aspiration risk can never be modified

80. The nurse caring for Bailey Davis, age 46, in an assisted-living apartment learns that the patient nods during teaching but cannot describe the medication plan. What is the best response?

- A. Repeat all instructions rapidly so the entire plan is covered again
- B. Document successful education because the caregiver agreed during the visit
- C. Use teach-back with plain language and demonstrate one task at a time
- D. Provide additional written pages without checking literacy or understanding

81. The nurse caring for Jordan White, age 68, in an assisted-living apartment learns that the patient is asked to perform a task outside personal competence. What is the best response?

- A. Attempt the task once and report only if an adverse event occurs
- B. Delegate the task to an unlicensed caregiver without assessing suitability
- C. Perform the task because a manager's request overrides competence concerns

D. Decline until appropriate training, supervision, and scope requirements are met

82. A caregiver calls about Noel Ross, age 78, who cares for a stable home hospice patient who is not in crisis. Which intervention should the nurse prioritize?

- A. Request general inpatient care because hospice patients qualify automatically
- B. Continue routine home care with visits based on the individualized plan
- C. Begin continuous home care solely because a relative prefers constant staff presence
- D. Use inpatient respite care as long-term residential placement for the patient

83. During a visit in a private home, Morgan Grant, age 73, is being transferred from an inpatient unit to home hospice. Which action should the hospice nurse take first?

- A. Delay communication until the first home visit has already been completed
- B. Complete a structured handoff covering symptoms, medications, equipment, and contacts
- C. Send only the discharge medication list because hospice will repeat the assessment
- D. Ask the family to relay clinical changes and pending care needs from memory

84. During a visit in a private home, Oakley Moore, age 77, describes a cultural practice unfamiliar to the hospice team. Which action should the hospice nurse take first?

- A. Refuse the practice because it is not part of standard hospice routine
- B. Ask a relative to speak for the patient without first seeking permission
- C. Apply assumptions learned from another family with a similar background
- D. Ask what the practice means and how the team can support it safely

85. At an interdisciplinary review, the team hears that Sage Kim, age 87, is exhausted and says caregiving can no longer continue without relief. Which nursing action is most appropriate?

- A. Assess immediate safety and mobilize respite and interdisciplinary support
- B. Wait for a crisis because caregiver fatigue is not a patient-care concern

- C. Recommend permanent placement before exploring available supports and preferences
- D. Tell the caregiver that accepting hospice requires providing continuous care

86. While reassessing Alex Evans, age 47, in an inpatient hospice unit, the nurse notes that the patient has advanced dementia, recurrent aspiration, and declining oral intake. What should the nurse do next?

- A. Avoid discussing nutrition because the decision belongs only to the prescriber
- B. Tell the family that all assisted oral feeding must stop immediately
- C. Clarify goals and explain the benefits and burdens of available feeding approaches
- D. Recommend feeding-tube placement as the required response to reduced intake

87. The plan of care for Devon Ross, age 54, is reviewed after the patient asks whether intense grief several weeks after death is abnormal. Which response best supports hospice and palliative nursing practice?

- A. Avoid discussion because bereavement begins only after several months
- B. Recommend medication before assessing the person's experience or risks
- C. Listen, assess function and safety, and explain that grief varies widely
- D. State that normal grief should resolve completely within a fixed short period

88. During a visit in a private home, Gray Ibrahim, age 61, begins a scheduled opioid and has no bowel regimen. Which action should the hospice nurse take first?

- A. Wait for severe constipation before discussing any preventive intervention
- B. Assess bowel function and initiate preventive management according to the plan
- C. Stop the opioid even though it is controlling otherwise severe pain
- D. Recommend restricting fluids so bowel movements occur less frequently

89. The plan of care for Noel Thomas, age 80, is reviewed after the patient cannot manage severe symptoms safely in the current setting despite plan changes. Which response best supports hospice and palliative nursing practice?

- A. Coordinate the level of care needed for short-term intensive symptom management
- B. Maintain routine care because changing levels indicates failure by the team
- C. Use caregiver respite as the sole rationale for acute symptom management
- D. End hospice enrollment before arranging any higher-intensity palliation

90. The nurse caring for Reese Patel, age 90, in an assisted-living apartment learns that the patient has urinary retention, suprapubic discomfort, and frequent small voids. What is the best response?

- A. Increase oral fluid rapidly despite worsening suprapubic discomfort
- B. Wait for complete absence of urine before notifying the clinical team
- C. Label the behavior as agitation without examining for a physical cause
- D. Assess bladder fullness and obtain timely intervention consistent with comfort goals

91. At an interdisciplinary review, the team hears that Val Evans, age 47, has a prognosis consistent with hospice eligibility but improves temporarily. Which nursing action is most appropriate?

- A. Review the overall trajectory and documentation rather than using one good day alone
- B. Base continued eligibility only on the caregiver's preference for services
- C. Ignore all improvement because prognosis is never reassessed after election
- D. Discharge immediately because any improvement permanently ends eligibility

92. The plan of care for Taylor Singh, age 92, is reviewed after the patient wants a ritual performed immediately after death. Which response best supports hospice and palliative nursing practice?

- A. Ask staff to improvise the ritual without guidance from the family
- B. Begin routine postmortem care before asking what the ritual requires
- C. Clarify the ritual and coordinate it when consistent with law and safety
- D. Refuse all delays because hospice procedures must be identical for every family

93. During a visit in a private home, Alex Grant, age 49, has a sudden functional decline after several stable weeks. Which action should the hospice nurse take first?

- A. Increase every symptom medication because decline indicates uncontrolled suffering
- B. Assess for an acute reversible problem before attributing the change to progression
- C. Document expected decline and defer assessment until the next scheduled visit
- D. Tell the family that sudden changes are never reversible in hospice care

94. At an interdisciplinary review, the team hears that Emery Ellis, age 59, says illness has destroyed all meaning and asks why this is happening. Which nursing action is most appropriate?

- A. Redirect the conversation to physical symptoms because meaning is not clinical
- B. Promise that spiritual distress will resolve once pain is controlled
- C. Provide a personal religious explanation as the definitive answer
- D. Remain present, explore the concern, and offer spiritual-care support if desired

95. At an interdisciplinary review, the team hears that Gray Kim, age 63, uses every rescue dose and still reports poorly controlled pain. Which nursing action is most appropriate?

- A. Add several sedating medicines simultaneously without a defined target
- B. Repeat the current regimen without reassessing response or pain type
- C. Review adherence, timing, total use, adverse effects, and pain mechanism before titration
- D. Assume drug-seeking behavior because all rescue medication was used

96. While reassessing Kai Evans, age 73, in an inpatient hospice unit, the nurse notes that the patient refuses morphine because a relative says it always hastens death. What should the nurse do next?

- A. Ask the relative to authorize treatment instead of speaking with the patient
- B. Tell the patient the concern is irrational and administer the medication anyway
- C. Remove opioid therapy from consideration without discussing other preferences
- D. Explore the concern and explain the purpose, dosing, monitoring, and expected effects

97. During a visit in a private home, Oakley Chen, age 83, can no longer swallow an effective oral analgesic regimen. Which action should the hospice nurse take first?

- A. Assess an alternative route that preserves comfort and reliable delivery
- B. Continue oral tablets despite repeated choking during administration
- C. Discontinue analgesia because equivalent relief requires the oral route
- D. Crush every formulation together without checking whether crushing is safe

98. While reassessing Val Grant, age 49, in an inpatient hospice unit, the nurse notes that the patient observes a colleague discussing a patient in a public elevator. What should the nurse do next?

- A. Record the event only in the patient's symptom-management note
- B. Stop the conversation and address the privacy breach through policy channels
- C. Wait for a visitor to complain before taking any action
- D. Join the discussion quietly because no patient name was initially spoken

99. A caregiver calls about Winter Hill, age 50, who reports pain only when being turned in bed. Which intervention should the nurse prioritize?

- A. Increase baseline sedation without evaluating the turning technique
- B. Keep the patient in one position indefinitely to prevent all movement-related pain
- C. Perform turning rapidly so the painful episode lasts fewer seconds
- D. Coordinate gentle positioning and premedication based on the predictable trigger

100. At an interdisciplinary review, the team hears that Alex Irwin, age 51, cannot explain how or when to use the newly delivered comfort medications. Which nursing action is most appropriate?

- A. Remove all as-needed medicines until the next interdisciplinary meeting
- B. Use teach-back and create a simple written medication schedule
- C. Document nonadherence and ask another family member to assume care
- D. Repeat the same instructions more loudly without checking comprehension

101. The nurse caring for Harper White, age 70, in an assisted-living apartment learns that the patient has new unilateral weakness and difficulty speaking. What is the best response?

- A. Clarify goals while rapidly assessing onset, safety, and desired level of intervention
- B. Promise full neurologic recovery if transfer occurs immediately
- C. Assume the symptoms are expected progression and perform no assessment
- D. Give food and oral medication before checking swallowing safety

102. A caregiver calls about Lane Ross, age 80, who has severe pruritus with jaundice and excoriated skin. Which intervention should the nurse prioritize?

- A. Dismiss itching because it is less urgent than visible jaundice
- B. Encourage vigorous scratching because it temporarily reduces the sensation
- C. Assess likely causes and use skin protection plus mechanism-directed symptom measures
- D. Apply an irritating fragranced product to every excoriated area

103. During a visit in a private home, Kai Grant, age 75, is afraid that using rescue medication correctly will cause addiction. Which action should the hospice nurse take first?

- A. Remove rescue medication even though severe symptoms remain likely
- B. Tell the caregiver to hide every medication from the patient
- C. Explore the fear and teach the intended use, monitoring, and safe storage
- D. Dismiss the concern because substance-related risks never occur in hospice

104. The nurse caring for Noel Thomas, age 82, in an assisted-living apartment learns that the patient shows cool extremities, mottling, reduced urine output, and longer sleep periods. What is the best response?

- A. Withhold information until the family specifically asks about prognosis
- B. Explain that the pattern may indicate approaching death and review the comfort plan
- C. Begin aggressive hydration to reverse every observed physiologic change
- D. Promise that death will occur within a precise number of hours

105. A caregiver calls about Reese Patel, age 92, who asks the nurse to make a treatment decision on the patient's behalf. Which intervention should the nurse prioritize?

- A. Present only the option favored by the attending clinician
- B. Avoid answering any questions because decisions are entirely private
- C. Select the option the nurse would want for a close relative
- D. Clarify values and provide balanced information without choosing for the family

106. The plan of care for Winter James, age 52, is reviewed after the patient has limited English proficiency during a complex goals discussion. Which response best supports hospice and palliative nursing practice?

- A. Arrange a qualified interpreter and speak directly to the patient
- B. Postpone all communication until the patient learns common medical terms
- C. Use a young family member because relatives understand the situation best
- D. Rely on gestures and obtain agreement without confirming comprehension

107. The plan of care for Bailey Ross, age 56, is reviewed after the patient has decision-making capacity but asks the nurse not to share details with relatives. Which response best supports hospice and palliative nursing practice?

- A. Respect the request and clarify what information may be shared
- B. Disclose the full plan because family members are involved in daily caregiving
- C. Avoid documenting the patient's communication preference in the care plan
- D. Ask the family to obtain information directly from the electronic record

108. The nurse caring for Finley Nolan, age 66, in an assisted-living apartment learns that the patient reports severe pain but appears calm and is talking with visitors. What is the best response?

- A. Ask visitors to decide whether the patient's pain report is credible
- B. Delay treatment until objective signs such as tachycardia become evident
- C. Lower the pain rating because behavior does not match the reported severity
- D. Accept the self-report and complete a multidimensional pain assessment

109. The plan of care for Lane Thomas, age 82, is reviewed after the patient reports frightening breathlessness while oxygen saturation is unchanged from baseline. Which response best supports hospice and palliative nursing practice?

- A. Focus only on oxygen flow without assessing anxiety or symptom intensity
- B. Position upright, reduce air hunger, and evaluate the individualized dyspnea plan
- C. Require bed rest in a flat position until breathing becomes regular
- D. State that dyspnea is absent because the saturation has not declined

110. While reassessing Morgan Adams, age 83, in an inpatient hospice unit, the nurse notes that the patient reports that a family member is taking the patient's controlled medication. What should the nurse do next?

- A. Confront the suspected person alone without first considering safety
- B. Replace the medication repeatedly without documenting the discrepancy
- C. Protect immediate safety and follow policy for assessment, reporting, and medication control
- D. Ignore the report to preserve family relationships during end-of-life care

111. During a visit in a private home, Quinn Reed, age 93, identifies a near miss involving look-alike medication packaging. Which action should the hospice nurse take first?

- A. Remove the package without documenting the underlying hazard
- B. Warn only the nurse involved and leave storage unchanged
- C. Take no action because the patient did not receive the wrong medication
- D. Report the near miss and seek a system change that reduces selection error

112. A caregiver calls about Winter Ross, age 56, who develops noisy upper-airway secretions during active dying. Which intervention should the nurse prioritize?

- A. Reposition gently and explain the sound while assessing for patient distress
- B. Perform repeated deep suctioning as the routine first intervention
- C. Begin forced oral fluids to thin secretions despite impaired swallowing

D. Tell the family the sound proves that the patient is suffocating

113. A caregiver calls about Bailey Diaz, age 60, who is offered an expensive personal gift by a grateful family. Which intervention should the nurse prioritize?

- A. Ask another employee to accept it and transfer it after discharge
- B. Thank the family and follow agency policy while maintaining professional boundaries
- C. Trade the gift for additional visits outside the established plan
- D. Accept the gift privately so the family does not feel rejected

114. A caregiver calls about Devon Jones, age 64, who asks what to expect as oral intake and alertness decrease. Which intervention should the nurse prioritize?

- A. Avoid anticipatory teaching because it could increase caregiver anxiety
- B. Recommend forcing food and fluid whenever the patient sleeps longer
- C. Describe common changes, uncertainty in timing, and specific comfort actions
- D. Give a precise prediction of the date and hour of death

115. The nurse caring for Jordan Nguyen, age 80, in an assisted-living apartment learns that the patient has nausea that began after a medication change. What is the best response?

- A. Assume nausea is psychological because vomiting has not occurred
- B. Stop all medications permanently before contacting the prescribing clinician
- C. Administer every available antiemetic at once without identifying a target
- D. Assess timing, likely mechanism, bowel status, and other associated findings

116. The nurse caring for Lane Bennett, age 84, in an assisted-living apartment learns that the patient finds a controlled-substance count that does not match the record. What is the best response?

- A. Alter the record so it agrees with the amount that remains
- B. Ignore the mismatch because the patient is receiving end-of-life care

- C. Secure the medication, reassess the count, document, and escalate per policy
- D. Accuse the caregiver publicly before verifying the discrepancy

117. The plan of care for Lane Ross, age 82, is reviewed after the patient has localized bone pain that remains severe despite systemic medication. Which response best supports hospice and palliative nursing practice?

- A. Discuss mechanism-focused options such as positioning, adjuvants, or palliative radiation
- B. Replace all analgesics with massage regardless of fracture or instability risk
- C. Avoid interdisciplinary consultation because localized pain is solely a nursing issue
- D. Conclude that no further palliation is possible once an opioid has been tried

118. The plan of care for Noel Diaz, age 86, is reviewed after the patient reports a new symptom that conflicts with the assumptions in the current plan. Which response best supports hospice and palliative nursing practice?

- A. Change the medical plan independently without consulting an authorized prescriber
- B. Perform a focused assessment and bring the new findings to the interdisciplinary team
- C. Dismiss the report because earlier documentation described the symptom differently
- D. Continue the existing plan until the next mandatory recertification review

119. The plan of care for Winter Thomas, age 58, is reviewed after the patient receives a family request to omit a significant symptom from the record. Which response best supports hospice and palliative nursing practice?

- A. Document the assessment accurately and explain why the record must be complete
- B. Create a separate unofficial note that is not available to the team
- C. Record only interventions so the symptom remains indirectly concealed
- D. Delete the finding because the family controls all hospice documentation

120. At an interdisciplinary review, the team hears that Val Irwin, age 53, has multiple comorbidities and gives inconsistent accounts of medication use. Which nursing action is most appropriate?

- A. Assume inconsistent reporting means intentional nonadherence by the patient
- B. Reconcile prescriptions, actual use, effects, and access barriers with the caregiver
- C. Discard every medication that was prescribed before hospice enrollment
- D. Copy the electronic medication list without comparing it with medicines in the home

121. The plan of care for Devon Lewis, age 66, is reviewed after the patient has a valid directive but currently expresses a different informed preference. Which response best supports hospice and palliative nursing practice?

- A. Follow the older document without discussing the patient's present wishes
- B. Delay documentation until the patient can meet with an attorney
- C. Clarify the current capable choice and communicate it to the care team
- D. Ask the family to vote on which preference should control treatment

122. The plan of care for Finley Singh, age 70, is reviewed after the patient appears unable to understand a proposed change in care. Which response best supports hospice and palliative nursing practice?

- A. Assume incapacity because the patient has a serious life-limiting diagnosis
- B. Ask any available relative to consent without checking legal authority
- C. Proceed with the change because the recommendation is clinically reasonable
- D. Assess decision-making capacity for this decision and identify the authorized surrogate if needed

123. The nurse caring for Jordan Long, age 80, in an assisted-living apartment learns that the patient develops new restlessness and fluctuating attention. What is the best response?

- A. Ask the family to manage the behavior without further clinical assessment
- B. Transfer the patient to an emergency department before contacting the team
- C. Label the behavior terminal agitation and request immediate deep sedation
- D. Assess for reversible causes while reviewing the established goals of care

124. The plan of care for Parker Usman, age 46, is reviewed after the patient is asked for patient information by a relative not authorized to receive it. Which response best supports hospice and palliative nursing practice?

- A. Share details because close relatives are automatically entitled to the record
- B. Verify permission before disclosing protected information
- C. Confirm the hospice enrollment but withhold only medication information
- D. Send the information and ask the patient for permission at the next visit

125. At an interdisciplinary review, the team hears that Oakley Kim, age 91, becomes difficult to arouse shortly after an analgesic dose increase. Which nursing action is most appropriate?

- A. Assess respiratory status, sedation, timing, and other contributing medications immediately
- B. Give the next dose early to prevent pain when the patient awakens
- C. Document adequate comfort and wait until the next routine visit
- D. Assume the finding reflects natural sleep because the patient has hospice care

126. While reassessing Sage Evans, age 51, in an inpatient hospice unit, the nurse notes that the patient describes burning, electric pain radiating along one leg. What should the nurse do next?

- A. Use only nonpharmacologic measures regardless of pain severity or goals
- B. Wait for complete loss of sensation before changing the analgesic plan
- C. Assess neuropathic features and discuss an appropriate adjuvant analgesic
- D. Treat the report as anxiety because neuropathic pain lacks visible findings

127. During a visit in a private home, Alex Chen, age 61, develops predictable severe pain during dressing changes. Which action should the hospice nurse take first?

- A. Cancel all future wound care because procedural pain cannot be prevented
- B. Increase the long-acting dose immediately without reviewing baseline pain
- C. Delay analgesia until the procedure confirms that severe pain has begun
- D. Plan a rapid-onset rescue dose before the painful procedure

128. The nurse caring for Devon Nolan, age 68, in an assisted-living apartment learns that the patient nods during teaching but cannot describe the medication plan. What is the best response?

- A. Use teach-back with plain language and demonstrate one task at a time
- B. Document successful education because the caregiver agreed during the visit
- C. Repeat all instructions rapidly so the entire plan is covered again
- D. Provide additional written pages without checking literacy or understanding

129. A caregiver calls about Harper Hill, age 78, who describes a cultural practice unfamiliar to the hospice team. Which intervention should the nurse prioritize?

- A. Refuse the practice because it is not part of standard hospice routine
- B. Ask what the practice means and how the team can support it safely
- C. Ask a relative to speak for the patient without first seeking permission
- D. Apply assumptions learned from another family with a similar background

130. The plan of care for Lane Foster, age 88, is reviewed after the patient is exhausted and says caregiving can no longer continue without relief. Which response best supports hospice and palliative nursing practice?

- A. Tell the caregiver that accepting hospice requires providing continuous care
- B. Wait for a crisis because caregiver fatigue is not a patient-care concern
- C. Assess immediate safety and mobilize respite and interdisciplinary support
- D. Recommend permanent placement before exploring available supports and preferences

131. The plan of care for Noel Lewis, age 92, is reviewed after the patient cannot self-report pain because of advanced cognitive impairment. Which response best supports hospice and palliative nursing practice?

- A. Use vital signs as the only reliable measure of pain intensity

- B. Administer analgesia only after the patient becomes verbally communicative
- C. Combine an observational pain tool with caregiver knowledge and clinical assessment
- D. Record no pain because a numeric rating cannot be obtained

132. The plan of care for Parker Singh, age 46, is reviewed after the patient has worsening weakness and spends nearly the entire day in bed. Which response best supports hospice and palliative nursing practice?

- A. Tell the caregiver that functional change is expected and requires no follow-up
- B. Reassess function, intake, symptoms, and caregiver needs with the team
- C. Assume the decline proves death will occur within the next twenty-four hours
- D. Stop all medications without reviewing their purpose or current benefit

133. At an interdisciplinary review, the team hears that Val Scott, age 59, has abdominal distention, colicky pain, vomiting, and no stool. Which nursing action is most appropriate?

- A. Increase oral fiber immediately without further abdominal assessment
- B. Reassure the caregiver that constipation alone never requires urgent review
- C. Encourage a large meal to stimulate normal intestinal motility
- D. Assess urgently for possible bowel obstruction and notify the clinical team

134. While reassessing Cameron Owens, age 69, in an inpatient hospice unit, the nurse notes that the patient asks whether intense grief several weeks after death is abnormal. What should the nurse do next?

- A. Listen, assess function and safety, and explain that grief varies widely
- B. Avoid discussion because bereavement begins only after several months
- C. State that normal grief should resolve completely within a fixed short period
- D. Recommend medication before assessing the person's experience or risks

135. During a visit in a private home, Gray Irwin, age 79, wants a ritual performed immediately after death. Which action should the hospice nurse take first?

- A. Refuse all delays because hospice procedures must be identical for every family
- B. Clarify the ritual and coordinate it when consistent with law and safety
- C. Begin routine postmortem care before asking what the ritual requires
- D. Ask staff to improvise the ritual without guidance from the family

136. At an interdisciplinary review, the team hears that Kai Green, age 89, says illness has destroyed all meaning and asks why this is happening. Which nursing action is most appropriate?

- A. Remain present, explore the concern, and offer spiritual-care support if desired
- B. Provide a personal religious explanation as the definitive answer
- C. Redirect the conversation to physical symptoms because meaning is not clinical
- D. Promise that spiritual distress will resolve once pain is controlled

137. The nurse caring for Lane Hayes, age 90, in an assisted-living apartment learns that the patient has fluctuating confusion and visual hallucinations. What is the best response?

- A. Diagnose dementia because hallucinations always indicate chronic cognitive decline
- B. Use physical restraints before trying environmental or symptom-focused measures
- C. Assess for delirium, safety risks, discomfort, medications, and reversible contributors
- D. Provide lengthy teaching during the most confused periods of the episode

138. At an interdisciplinary review, the team hears that Oakley Turner, age 47, feels persistent moral distress after repeated conflicts about care. Which nursing action is most appropriate?

- A. Post details on social media to obtain advice from other nurses
- B. Withdraw emotionally from patients to prevent further involvement
- C. Suppress the concern because distress proves inadequate professional resilience
- D. Use supervision, team debriefing, and an organizational ethics resource

139. While reassessing Sage Moore, age 57, in an inpatient hospice unit, the nurse notes that the patient has escalating anxiety during episodes of breathlessness. What should the nurse do next?

- A. Leave the room to reduce stimulation until the episode resolves unaided
- B. Treat dyspnea and anxiety together using calm coaching and the prescribed plan
- C. Explain that anxiety is the sole cause and stop evaluating respiratory distress
- D. Use confrontation to prove that the patient is receiving enough air

140. A caregiver calls about Taylor Nguyen, age 58, who develops myoclonus, hallucinations, and increasing sedation after opioid escalation. Which intervention should the nurse prioritize?

- A. Escalate the same opioid because the symptoms prove pain remains uncontrolled
- B. Reassure the family that these findings are always normal near death
- C. Stop all analgesia abruptly and provide no alternative pain treatment
- D. Assess for opioid neurotoxicity and contributing renal or hydration problems

141. A caregiver calls about Winter Bennett, age 62, who states a wish to remain home while the family requests hospitalization. Which intervention should the nurse prioritize?

- A. Ask the attending physician to decide without further patient participation
- B. Follow the family's request because relatives provide most of the daily care
- C. Explore the patient's informed preferences and facilitate a goals-of-care discussion
- D. Arrange hospitalization immediately and revisit preferences after the transfer

142. The plan of care for Devon Singh, age 72, is reviewed after the patient is being transferred from an inpatient unit to home hospice. Which response best supports hospice and palliative nursing practice?

- A. Complete a structured handoff covering symptoms, medications, equipment, and contacts
- B. Ask the family to relay clinical changes and pending care needs from memory
- C. Send only the discharge medication list because hospice will repeat the assessment
- D. Delay communication until the first home visit has already been completed

143. At an interdisciplinary review, the team hears that Indigo Scott, age 85, notices repeated delays in delivering comfort medications. Which nursing action is most appropriate?

- A. Remind staff to work faster without examining the medication workflow
- B. Discipline the most recent nurse before reviewing contributing conditions
- C. Collect complaints indefinitely without defining an improvement measure
- D. Map the process, measure delays, and test a targeted improvement

144. While reassessing Morgan Owens, age 45, in an inpatient hospice unit, the nurse notes that the patient is asked to perform a task outside personal competence. What should the nurse do next?

- A. Delegate the task to an unlicensed caregiver without assessing suitability
- B. Perform the task because a manager's request overrides competence concerns
- C. Decline until appropriate training, supervision, and scope requirements are met
- D. Attempt the task once and report only if an adverse event occurs

145. A caregiver calls about Noel Patel, age 46, who has advanced dementia, recurrent aspiration, and declining oral intake. Which intervention should the nurse prioritize?

- A. Recommend feeding-tube placement as the required response to reduced intake
- B. Clarify goals and explain the benefits and burdens of available feeding approaches
- C. Tell the family that all assisted oral feeding must stop immediately
- D. Avoid discussing nutrition because the decision belongs only to the prescriber

146. While reassessing Quinn Evans, age 53, in an inpatient hospice unit, the nurse notes that the patient begins a scheduled opioid and has no bowel regimen. What should the nurse do next?

- A. Assess bowel function and initiate preventive management according to the plan
- B. Stop the opioid even though it is controlling otherwise severe pain
- C. Recommend restricting fluids so bowel movements occur less frequently
- D. Wait for severe constipation before discussing any preventive intervention

147. At an interdisciplinary review, the team hears that Alex Martin, age 69, is afraid that using rescue medication correctly will cause addiction. Which nursing action is most appropriate?

- A. Tell the caregiver to hide every medication from the patient
- B. Explore the fear and teach the intended use, monitoring, and safe storage
- C. Dismiss the concern because substance-related risks never occur in hospice
- D. Remove rescue medication even though severe symptoms remain likely

148. At an interdisciplinary review, the team hears that Cameron Turner, age 73, has painful lower-extremity edema and fragile skin. Which nursing action is most appropriate?

- A. Apply tight compression without evaluating arterial status or goals
- B. Limit all position changes because movement can worsen visible swelling
- C. Massage reddened bony areas vigorously to move accumulated fluid
- D. Elevate and reposition for comfort while assessing skin and circulatory tolerance

149. While reassessing Gray Moore, age 83, in an inpatient hospice unit, the nurse notes that the patient cares for a stable home hospice patient who is not in crisis. What should the nurse do next?

- A. Request general inpatient care because hospice patients qualify automatically
- B. Use inpatient respite care as long-term residential placement for the patient
- C. Continue routine home care with visits based on the individualized plan
- D. Begin continuous home care solely because a relative prefers constant staff presence

150. The plan of care for Jordan Foster, age 90, is reviewed after the patient has a malodorous fungating wound causing embarrassment. Which response best supports hospice and palliative nursing practice?

- A. Address odor, exudate, pain, and privacy with a comfort-focused wound plan
- B. Use aggressive debridement automatically regardless of bleeding risk or goals
- C. Keep the wound uncovered so moisture cannot accumulate beneath a dressing
- D. Avoid discussing odor because acknowledging it may increase embarrassment

Practice Exam 5: Answer Key and Explanations

- 1. B** — A discrepancy requires immediate, objective action. Securing medication, confirming facts, documenting, and following reporting procedures protect the patient and preserve evidence. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..
- 2. D** — Agreement is not proof of understanding. Teach-back and focused demonstration reveal gaps, reduce cognitive load, and allow correction before the caregiver administers medication independently. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..
- 3. C** — Volume equals the ordered dose divided by the available concentration: 11.25 mg divided by 10 mg/mL equals 1.125 mL. The other values result from doubling, halving, or adding to the calculated volume rather than applying the dose-over-concentration relationship. The nurse should independently verify the label and prescribed dose before administration..
- 4. B** — Predictable incident pain is best addressed proactively. Timing rescue analgesia before the trigger can reduce suffering while avoiding an unnecessary increase in baseline medication. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..
- 5. D** — Functional decline can signal disease progression, complications, or an unmet symptom burden. Reassessment provides the information needed to update the interdisciplinary plan and prepare caregivers. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..
- 6. A** — A patient with decision-making capacity directs care. The nurse should clarify understanding, values, and tradeoffs, then help the patient and family reach a plan that honors informed preferences. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity.
- 7. D** — Terminal secretions often distress observers more than the patient. Repositioning, mouth care, education, and selective medication can be appropriate, while deep suction may add burden. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..
- 8. C** — Cultural humility begins with curiosity and avoids treating group identity as a fixed script. The patient's explanation helps the team support meaningful practices while addressing safety. This response

protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

9. A — Loss of verbal reporting does not eliminate pain. Behavior, function, context, examination, prior patterns, and caregiver observations provide converging evidence for assessment and response. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

10. B — Accurate documentation supports continuity, accountability, and safe decision-making. Patient or family preferences belong in the record, but they do not justify removing relevant clinical findings. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

11. B — Caregiver strain can threaten both patient and caregiver safety. Prompt assessment and practical support may preserve the preferred care setting and reduce preventable crisis transfer. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

12. A — Myoclonus, hallucinations, and sedation after escalation can indicate opioid neurotoxicity, especially with impaired clearance. Prompt assessment supports dose adjustment, rotation, or other measures. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

13. C — Opioids commonly reduce gastrointestinal motility, so constipation prevention should begin early unless a contraindication exists. Ongoing assessment guides individualized bowel management. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

14. D — Frequent rescue use signals the need for systematic reassessment. The nurse should verify administration, characterize pain, identify toxicity, and communicate data needed for safe titration. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

15. A — Family relationship alone does not automatically authorize disclosure. The nurse should verify the patient's permission or another lawful basis before sharing protected information. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

16. B — Moral distress is not resolved by isolation or detachment. Structured reflection, ethics support, and organizational action can address both personal impact and recurring system contributors. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

17. D — Nausea has multiple possible mechanisms, and treatment is more effective when assessment addresses medication effects, constipation, obstruction, metabolic causes, vestibular symptoms, and anxiety. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

18. C — Early grief can be intense and highly variable. Supportive listening, risk assessment, and bereavement follow-up help distinguish expected grief from needs requiring more specialized intervention. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

19. B — Distention, colicky pain, vomiting, and obstipation can indicate obstruction. Prompt assessment is necessary because routine constipation measures may be ineffective or harmful. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

20. D — Acute fluctuating cognition suggests delirium rather than a stable dementia pattern. Assessment should address safety, pain, retention, constipation, infection, medication effects, and environmental triggers. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

21. C — Respectful exploration can correct misconceptions without coercion. Proportionate opioid therapy aims to relieve pain or dyspnea, with dosing and monitoring individualized to response. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

22. A — A structured handoff protects continuity during a vulnerable transition. Current symptoms, medication changes, equipment, pending needs, goals, and emergency contacts should reach the receiving team before arrival. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and.

23. B — Loss of swallowing calls for route reassessment, not loss of analgesia. Formulation, onset, caregiver ability, setting, and patient goals guide selection of a feasible alternative. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the

report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

24. D — Nutrition decisions in advanced illness should follow the patient's values and clinical goals. Balanced teaching supports informed choice without presenting one intervention as automatically required. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

25. A — Dyspnea and anxiety can amplify one another. Calm presence, breathing coaching, environmental measures, and appropriately prescribed therapy address both symptom experience and physiologic contributors. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

26. C — Edema care should prioritize comfort, skin protection, and tolerance. Elevation and careful repositioning may help, while compression or massage requires individualized assessment. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

27. C — Repeated delays suggest a process problem. Measurement and small tests can identify bottlenecks, assess change, and avoid relying only on vigilance or blame. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

28. A — Palliative wound care targets distressing symptoms rather than healing at any cost. Appropriate dressings, odor control, analgesia, bleeding precautions, and respectful privacy can improve quality of life. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

29. D — Movement-related pain can often be reduced by coordinated handling, positioning aids, pacing, and appropriately timed analgesia. These measures target the trigger while protecting comfort and skin care. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with.

30. B — Dry mouth often responds to meticulous oral care, moisture, and safe preferred fluids. Hydration decisions require broader assessment and goals rather than relying on one symptom. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

31. D — A nurse remains accountable for practicing within legal scope and demonstrated competence. Escalation and appropriate support protect the patient while addressing the service need. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

32. C — Hospice care does not eliminate the need to evaluate abrupt changes. Infection, medication effects, dehydration, retention, constipation, and other reversible contributors may warrant treatment when consistent with goals. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity.

33. A — Medicare hospice levels of care are based on clinical circumstances and purpose. Stable care at home generally remains routine home care rather than crisis or inpatient care. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable.

34. B — Teach-back reveals whether education was understood and gives the nurse an opportunity to correct errors. A plain schedule can reduce dosing confusion and caregiver anxiety. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

35. C — Post-death care should respect cultural and spiritual preferences whenever feasible. Early clarification allows the team to protect dignity while meeting legal and safety obligations. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

36. B — Pain is subjective, and outward behavior varies with culture, coping, fatigue, and context. The patient's report should lead assessment rather than be discounted by appearance alone. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse.

37. D — Clusters of circulatory, renal, and consciousness changes can indicate active decline, but exact timing remains uncertain. Honest preparation and a reviewed comfort plan support informed caregiving. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared.

38. A — Retention can present as discomfort, agitation, overflow voiding, or restlessness. Focused assessment can identify a reversible source of suffering and guide catheter or other management. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives

overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

39. D — When pain or symptoms cannot be managed in the current setting, the team should coordinate an appropriate higher level of hospice care rather than delay relief. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional.

40. C — New focal deficits may represent an acute neurologic event. The nurse should assess, protect safety, clarify preferences, and coordinate a response consistent with the patient's goals. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

41. B — Hospice eligibility depends on the documented clinical picture and expected course, not a single isolated day. Temporary stabilization should be interpreted within the broader trajectory. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

42. A — Public clinical discussion can expose protected information and erode trust. Immediate redirection limits disclosure, while policy-based follow-up supports accountability and prevention. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

43. B — Pruritus can cause major suffering and skin injury. Gentle skin care, trigger reduction, and cause-directed therapy should be individualized to disease, medications, and comfort goals. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

44. A — Persistent localized bone pain may benefit from combined pharmacologic, physical, and disease-directed palliative approaches. Interdisciplinary review can improve relief while considering burden and goals. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

45. D — Marked new sedation after a dose change requires prompt safety assessment. Timing, ventilation, organ function, interactions, and goals inform urgent communication and proportionate intervention. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

46. C — Spiritual distress calls for presence and patient-led exploration, not imposed beliefs. Referral may help, but the nurse's attentive response is itself an important intervention. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

47. B — Near misses reveal system vulnerabilities before harm occurs. Reporting and redesign, such as separation or clearer labeling, create stronger protection than memory-based warnings alone. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

48. A — Dyspnea is a subjective symptom and may be severe despite stable oxygen saturation. Positioning, calm presence, airflow, prescribed medication, and cause-focused assessment can reduce distress. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

49. D — Burning, electric, radiating pain suggests a neuropathic mechanism. Mechanism-based assessment supports selection of an adjuvant while preserving individualized opioid and nonpharmacologic options. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

50. A — Predictable incident pain is best addressed proactively. Timing rescue analgesia before the trigger can reduce suffering while avoiding an unnecessary increase in baseline medication. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

51. C — Professional boundaries protect the therapeutic relationship and public trust. A gracious explanation and consistent policy response acknowledge gratitude without creating obligation or unequal treatment. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

52. C — Clear education distinguishes appropriate symptom treatment from misconceptions while still addressing storage, administration, monitoring, and diversion risk. Respectful discussion supports adherence and safety. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

53. B — A capable patient controls disclosure of personal health information. Clarifying permitted communication respects autonomy while helping the team coordinate within the patient's stated boundaries. This approach gathers actionable information, preserves patient preferences, and gives the

interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

54. D — The plan of care must evolve when the patient's condition or priorities change. Focused findings allow the team to revise interventions safely and responsively. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

55. C — Terminal secretions often distress observers more than the patient. Repositioning, mouth care, education, and selective medication can be appropriate, while deep suction may add burden. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

56. B — A discrepancy requires immediate, objective action. Securing medication, confirming facts, documenting, and following reporting procedures protect the patient and preserve evidence. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

57. A — Nausea has multiple possible mechanisms, and treatment is more effective when assessment addresses medication effects, constipation, obstruction, metabolic causes, vestibular symptoms, and anxiety. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

58. D — Medication reconciliation requires comparing records with what the patient actually takes. Effects, understanding, access, and caregiver administration can reveal discrepancies that alter symptoms or safety. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

59. A — Distention, colicky pain, vomiting, and obstipation can indicate obstruction. Prompt assessment is necessary because routine constipation measures may be ineffective or harmful. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

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62. C — Capacity is decision-specific and should not be inferred solely from diagnosis. Assessment and proper surrogate identification protect autonomy and lawful decision-making. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

63. B — Advocacy supports informed decision-making rather than substituting the nurse's values. Balanced information and values clarification help the patient or surrogate choose among reasonable options. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

64. D — A qualified interpreter improves accuracy, confidentiality, and informed participation. The nurse should address the patient directly and use teach-back through the interpreter. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

65. C — Possible diversion requires a structured response that protects the patient, caregiver, staff, and medication supply. Documentation and team escalation are essential. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

66. A — Accurate documentation supports continuity, accountability, and safe decision-making. Patient or family preferences belong in the record, but they do not justify removing relevant clinical findings. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

67. A — New restlessness may reflect pain, urinary retention, constipation, medication effects, hypoxia, or delirium. A focused assessment must precede treatment and remain consistent with the patient's goals. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared.

68. D — Anticipatory guidance reduces fear and helps caregivers respond safely. Honest uncertainty should accompany practical teaching about mouth care, medication routes, positioning, and when to call hospice. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives

substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

69. C — Functional decline can signal disease progression, complications, or an unmet symptom burden. Reassessment provides the information needed to update the interdisciplinary plan and prepare caregivers. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

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72. A — A capable patient's current informed decision generally guides care. The nurse should clarify the choice, notify the appropriate clinician, and ensure the plan reflects it. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

73. C — Myoclonus, hallucinations, and sedation after escalation can indicate opioid neurotoxicity, especially with impaired clearance. Prompt assessment supports dose adjustment, rotation, or other measures. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

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89. A — When pain or symptoms cannot be managed in the current setting, the team should coordinate an appropriate higher level of hospice care rather than delay relief. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional.

90. D — Retention can present as discomfort, agitation, overflow voiding, or restlessness. Focused assessment can identify a reversible source of suffering and guide catheter or other management. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

91. A — Hospice eligibility depends on the documented clinical picture and expected course, not a single isolated day. Temporary stabilization should be interpreted within the broader trajectory. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

92. C — Post-death care should respect cultural and spiritual preferences whenever feasible. Early clarification allows the team to protect dignity while meeting legal and safety obligations. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

93. B — Hospice care does not eliminate the need to evaluate abrupt changes. Infection, medication effects, dehydration, retention, constipation, and other reversible contributors may warrant treatment when consistent with goals. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity.

94. D — Spiritual distress calls for presence and patient-led exploration, not imposed beliefs. Referral may help, but the nurse's attentive response is itself an important intervention. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

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100. B — Teach-back reveals whether education was understood and gives the nurse an opportunity to correct errors. A plain schedule can reduce dosing confusion and caregiver anxiety. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

101. A — New focal deficits may represent an acute neurologic event. The nurse should assess, protect safety, clarify preferences, and coordinate a response consistent with the patient's goals. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

102. C — Pruritus can cause major suffering and skin injury. Gentle skin care, trigger reduction, and cause-directed therapy should be individualized to disease, medications, and comfort goals. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

103. C — Clear education distinguishes appropriate symptom treatment from misconceptions while still addressing storage, administration, monitoring, and diversion risk. Respectful discussion supports adherence and safety. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

104. B — Clusters of circulatory, renal, and consciousness changes can indicate active decline, but exact timing remains uncertain. Honest preparation and a reviewed comfort plan support informed caregiving. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared.

105. D — Advocacy supports informed decision-making rather than substituting the nurse's values. Balanced information and values clarification help the patient or surrogate choose among reasonable options. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

106. A — A qualified interpreter improves accuracy, confidentiality, and informed participation. The nurse should address the patient directly and use teach-back through the interpreter. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

107. A — A capable patient controls disclosure of personal health information. Clarifying permitted communication respects autonomy while helping the team coordinate within the patient's stated boundaries. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

108. D — Pain is subjective, and outward behavior varies with culture, coping, fatigue, and context. The patient's report should lead assessment rather than be discounted by appearance alone. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse.

109. B — Dyspnea is a subjective symptom and may be severe despite stable oxygen saturation. Positioning, calm presence, airflow, prescribed medication, and cause-focused assessment can reduce distress. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

110. C — Possible diversion requires a structured response that protects the patient, caregiver, staff, and medication supply. Documentation and team escalation are essential. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

111. D — Near misses reveal system vulnerabilities before harm occurs. Reporting and redesign, such as separation or clearer labeling, create stronger protection than memory-based warnings alone. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

112. A — Terminal secretions often distress observers more than the patient. Repositioning, mouth care, education, and selective medication can be appropriate, while deep suction may add burden. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

113. B — Professional boundaries protect the therapeutic relationship and public trust. A gracious explanation and consistent policy response acknowledge gratitude without creating obligation or unequal treatment. This action supports safe, ethical, accountable practice and creates a clear path for

team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

114. C — Anticipatory guidance reduces fear and helps caregivers respond safely. Honest uncertainty should accompany practical teaching about mouth care, medication routes, positioning, and when to call hospice. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

115. D — Nausea has multiple possible mechanisms, and treatment is more effective when assessment addresses medication effects, constipation, obstruction, metabolic causes, vestibular symptoms, and anxiety. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

116. C — A discrepancy requires immediate, objective action. Securing medication, confirming facts, documenting, and following reporting procedures protect the patient and preserve evidence. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

117. A — Persistent localized bone pain may benefit from combined pharmacologic, physical, and disease-directed palliative approaches. Interdisciplinary review can improve relief while considering burden and goals. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

118. B — The plan of care must evolve when the patient's condition or priorities change. Focused findings allow the team to revise interventions safely and responsively. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

119. A — Accurate documentation supports continuity, accountability, and safe decision-making. Patient or family preferences belong in the record, but they do not justify removing relevant clinical findings. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

120. B — Medication reconciliation requires comparing records with what the patient actually takes. Effects, understanding, access, and caregiver administration can reveal discrepancies that alter symptoms or safety. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

121. C — A capable patient's current informed decision generally guides care. The nurse should clarify the choice, notify the appropriate clinician, and ensure the plan reflects it. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

122. D — Capacity is decision-specific and should not be inferred solely from diagnosis. Assessment and proper surrogate identification protect autonomy and lawful decision-making. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

123. D — New restlessness may reflect pain, urinary retention, constipation, medication effects, hypoxia, or delirium. A focused assessment must precede treatment and remain consistent with the patient's goals. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared.

124. B — Family relationship alone does not automatically authorize disclosure. The nurse should verify the patient's permission or another lawful basis before sharing protected information. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

125. A — Marked new sedation after a dose change requires prompt safety assessment. Timing, ventilation, organ function, interactions, and goals inform urgent communication and proportionate intervention. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

126. C — Burning, electric, radiating pain suggests a neuropathic mechanism. Mechanism-based assessment supports selection of an adjuvant while preserving individualized opioid and nonpharmacologic options. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

127. D — Predictable incident pain is best addressed proactively. Timing rescue analgesia before the trigger can reduce suffering while avoiding an unnecessary increase in baseline medication. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

128. A — Agreement is not proof of understanding. Teach-back and focused demonstration reveal gaps, reduce cognitive load, and allow correction before the caregiver administers medication independently. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives

substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

129. B — Cultural humility begins with curiosity and avoids treating group identity as a fixed script. The patient's explanation helps the team support meaningful practices while addressing safety. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

130. C — Caregiver strain can threaten both patient and caregiver safety. Prompt assessment and practical support may preserve the preferred care setting and reduce preventable crisis transfer. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

131. C — Loss of verbal reporting does not eliminate pain. Behavior, function, context, examination, prior patterns, and caregiver observations provide converging evidence for assessment and response. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

132. B — Functional decline can signal disease progression, complications, or an unmet symptom burden. Reassessment provides the information needed to update the interdisciplinary plan and prepare caregivers. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

133. D — Distention, colicky pain, vomiting, and obstipation can indicate obstruction. Prompt assessment is necessary because routine constipation measures may be ineffective or harmful. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

134. A — Early grief can be intense and highly variable. Supportive listening, risk assessment, and bereavement follow-up help distinguish expected grief from needs requiring more specialized intervention. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

135. B — Post-death care should respect cultural and spiritual preferences whenever feasible. Early clarification allows the team to protect dignity while meeting legal and safety obligations. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

136. A — Spiritual distress calls for presence and patient-led exploration, not imposed beliefs. Referral may help, but the nurse's attentive response is itself an important intervention. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

137. C — Acute fluctuating cognition suggests delirium rather than a stable dementia pattern. Assessment should address safety, pain, retention, constipation, infection, medication effects, and environmental triggers. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

138. D — Moral distress is not resolved by isolation or detachment. Structured reflection, ethics support, and organizational action can address both personal impact and recurring system contributors. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

139. B — Dyspnea and anxiety can amplify one another. Calm presence, breathing coaching, environmental measures, and appropriately prescribed therapy address both symptom experience and physiologic contributors. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

140. D — Myoclonus, hallucinations, and sedation after escalation can indicate opioid neurotoxicity, especially with impaired clearance. Prompt assessment supports dose adjustment, rotation, or other measures. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

141. C — A patient with decision-making capacity directs care. The nurse should clarify understanding, values, and tradeoffs, then help the patient and family reach a plan that honors informed preferences. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity.

142. A — A structured handoff protects continuity during a vulnerable transition. Current symptoms, medication changes, equipment, pending needs, goals, and emergency contacts should reach the receiving team before arrival. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and.

143. D — Repeated delays suggest a process problem. Measurement and small tests can identify bottlenecks, assess change, and avoid relying only on vigilance or blame. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives

normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

144. C — A nurse remains accountable for practicing within legal scope and demonstrated competence. Escalation and appropriate support protect the patient while addressing the service need. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable professional processes..

145. B — Nutrition decisions in advanced illness should follow the patient's values and clinical goals. Balanced teaching supports informed choice without presenting one intervention as automatically required. This approach gathers actionable information, preserves patient preferences, and gives the interdisciplinary team a sound basis for revising the plan. The alternatives make unsupported assumptions, bypass assessment, or weaken continuity and shared decision-making..

146. A — Opioids commonly reduce gastrointestinal motility, so constipation prevention should begin early unless a contraindication exists. Ongoing assessment guides individualized bowel management. This response links intervention to pain mechanism, timing, safety, and the patient's goals. The alternatives discount the report, delay relief, or change therapy without the reassessment needed to balance analgesia with adverse effects..

147. B — Clear education distinguishes appropriate symptom treatment from misconceptions while still addressing storage, administration, monitoring, and diversion risk. Respectful discussion supports adherence and safety. This response protects autonomy, understanding, dignity, and caregiver safety. The alternatives substitute assumptions or professional preferences for patient-led communication and do not verify that the resulting plan is both informed and workable..

148. D — Edema care should prioritize comfort, skin protection, and tolerance. Elevation and careful repositioning may help, while compression or massage requires individualized assessment. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..

149. C — Medicare hospice levels of care are based on clinical circumstances and purpose. Stable care at home generally remains routine home care rather than crisis or inpatient care. This action supports safe, ethical, accountable practice and creates a clear path for team follow-through. The alternatives normalize risk, bypass policy, or rely on secrecy and individual vigilance instead of reliable.

150. A — Palliative wound care targets distressing symptoms rather than healing at any cost. Appropriate dressings, odor control, analgesia, bleeding precautions, and respectful privacy can improve quality of life. This response addresses suffering while preserving proportionate, goal-concordant care. The alternatives overlook important causes, rely on a single observation, or add burdens without first establishing how the intervention would improve comfort..