

PRACTICE EXAM 8: 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. A caregiver calls about Parker Flores, age 90, who asks whether intense grief several weeks after death is abnormal. Which intervention should the nurse prioritize?
 - A. Recommend medication before assessing the person's experience or risks
 - 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. Avoid discussion because bereavement begins only after several months

2. While reassessing Sage Scott, age 47, in an inpatient hospice unit, the nurse notes that the patient feels persistent moral distress after repeated conflicts about care. What should the nurse do next?
 - A. Withdraw emotionally from patients to prevent further involvement
 - B. Post details on social media to obtain advice from other nurses
 - C. Suppress the concern because distress proves inadequate professional resilience
 - D. Use supervision, team debriefing, and an organizational ethics resource

3. The plan of care for Winter Jones, age 54, is reviewed after the patient has fluctuating confusion and visual hallucinations. Which response best supports hospice and palliative nursing practice?
 - A. Diagnose dementia because hallucinations always indicate chronic cognitive decline
 - B. Assess for delirium, safety risks, discomfort, medications, and reversible contributors
 - C. Use physical restraints before trying environmental or symptom-focused measures

D. Provide lengthy teaching during the most confused periods of the episode

4. The nurse caring for Devon Davis, age 64, in an assisted-living apartment learns that the patient notices repeated delays in delivering comfort medications. What is the best response?

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

5. A caregiver calls about Harper Bennett, age 74, who is asked to perform a task outside personal competence. Which intervention should the nurse prioritize?

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

6. A caregiver calls about Jordan Hayes, age 78, who has escalating anxiety during episodes of breathlessness. Which intervention should the nurse prioritize?

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

7. The plan of care for Noel Brooks, age 88, is reviewed after the patient has painful lower-extremity edema and fragile skin. Which response best supports hospice and palliative nursing practice?

- A. Massage reddened bony areas vigorously to move accumulated fluid
- B. Elevate and reposition for comfort while assessing skin and circulatory tolerance

- C. Apply tight compression without evaluating arterial status or goals
- D. Limit all position changes because movement can worsen visible swelling

8. The nurse caring for Reese Thomas, age 48, in an assisted-living apartment learns that the patient cares for a stable home hospice patient who is not in crisis. What is the best response?

- A. Continue routine home care with visits based on the individualized plan
- B. Request general inpatient care because hospice patients qualify automatically
- 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

9. The plan of care for Reese Nguyen, age 46, is reviewed after the patient has advanced dementia, recurrent aspiration, and declining oral intake. Which response best supports hospice and palliative nursing practice?

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

10. The nurse caring for Winter Lewis, age 56, in an assisted-living apartment learns that the patient has a sudden functional decline after several stable weeks. What is the best response?

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

11. A hospice patient is prescribed 15 mg of a liquid analgesic. The available concentration is 20 mg/mL. How many milliliters should the nurse administer?

- A. Administer 0.375 mL of the prescribed solution
- B. Administer 1.25 mL of the prescribed solution
- C. Administer 1.5 mL of the prescribed solution
- D. Administer 0.75 mL of the prescribed solution

12. During a visit in a private home, Indigo Ibrahim, age 79, cannot manage severe symptoms safely in the current setting despite plan changes. Which action should the hospice nurse take first?

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

13. While reassessing Indigo Ellis, age 77, in an inpatient hospice unit, the nurse notes that the patient wants a ritual performed immediately after death. What should the nurse do next?

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

14. While reassessing Kai Kim, age 81, 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. Wait for severe constipation before discussing any preventive intervention
- C. Recommend restricting fluids so bowel movements occur less frequently
- D. Stop the opioid even though it is controlling otherwise severe pain

15. The nurse caring for Parker James, age 94, in an assisted-living apartment learns that the patient says illness has destroyed all meaning and asks why this is happening. What is the best response?

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

16. A caregiver calls about Taylor Hayes, age 54, 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

17. While reassessing Alex Turner, age 61, in an inpatient hospice unit, the nurse notes that the patient has a malodorous fungating wound causing embarrassment. What should the nurse do next?

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

18. While reassessing Cameron Cole, age 65, in an inpatient hospice unit, the nurse notes that the patient cannot explain how or when to use the newly delivered comfort medications. What should the nurse do next?

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

19. At an interdisciplinary review, the team hears that Indigo Kim, age 81, 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. Discharge immediately because any improvement permanently ends eligibility
- C. Ignore all improvement because prognosis is never reassessed after election
- D. Base continued eligibility only on the caregiver's preference for services

20. The plan of care for Harper Bennett, age 76, 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. Repeat the current regimen without reassessing response or pain type
- B. Assume drug-seeking behavior because all rescue medication was used
- C. Add several sedating medicines simultaneously without a defined target
- D. Review adherence, timing, total use, adverse effects, and pain mechanism before titration

21. The plan of care for Parker Ross, age 48, is reviewed after the patient observes a colleague discussing a patient in a public elevator. Which response best supports hospice and palliative nursing practice?

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

22. The nurse caring for Taylor Nolan, age 58, in an assisted-living apartment learns that the patient identifies a near miss involving look-alike medication packaging. What is the best response?

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

23. A caregiver calls about Reese Thomas, age 50, who refuses morphine because a relative says it always hastens death. Which intervention should the nurse prioritize?

- A. Tell the patient the concern is irrational and administer the medication anyway
- 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. Remove opioid therapy from consideration without discussing other preferences

24. While reassessing Emery Adams, age 75, in an inpatient hospice unit, the nurse notes that the patient is offered an expensive personal gift by a grateful family. What should the nurse do next?

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

25. The nurse caring for Devon James, age 70, 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. Withhold all oral comfort because aspiration risk can never be modified
- C. Start intravenous hydration automatically because dry mouth proves dehydration
- D. Use lemon-glycerin products repeatedly without checking for irritation

26. The nurse caring for Lane Flores, age 92, 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. Accuse the caregiver publicly before verifying the discrepancy
- 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. Alter the record so it agrees with the amount that remains

27. A caregiver calls about Jordan Nolan, age 84, 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. Present only the option favored by the attending clinician
- C. Clarify values and provide balanced information without choosing for the family
- D. Avoid answering any questions because decisions are entirely private

28. The plan of care for Noel Hill, age 94, is reviewed after the patient has urinary retention, suprapubic discomfort, and frequent small voids. Which response best supports hospice and palliative nursing practice?

- A. Assess bladder fullness and obtain timely intervention consistent with comfort goals
- 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. Increase oral fluid rapidly despite worsening suprapubic discomfort

29. While reassessing Oakley Irwin, age 45, 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. Crush every formulation together without checking whether crushing is safe
- B. Assess an alternative route that preserves comfort and reliable delivery
- C. Discontinue analgesia because equivalent relief requires the oral route
- D. Continue oral tablets despite repeated choking during administration

30. During a visit in a private home, Cameron Price, age 73, receives a family request to omit a significant symptom from the record. Which action should the hospice nurse take first?

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

31. The nurse caring for Winter Singh, age 62, in an assisted-living apartment learns that the patient reports pain only when being turned in bed. What is the best response?

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

32. The nurse caring for Bailey Brooks, age 66, 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. Begin aggressive hydration to reverse every observed physiologic change
- B. Withhold information until the family specifically asks about prognosis
- C. Explain that the pattern may indicate approaching death and review the comfort plan
- D. Promise that death will occur within a precise number of hours

33. While reassessing Gray Ellis, age 79, in an inpatient hospice unit, the nurse notes that the patient reports severe pain but appears calm and is talking with visitors. What should the nurse do next?

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

34. During a visit in a private home, Kai Vega, age 89, has new unilateral weakness and difficulty speaking. Which action should the hospice nurse take first?

- A. Assume the symptoms are expected progression and perform no assessment
- B. Promise full neurologic recovery if transfer occurs immediately

- C. Give food and oral medication before checking swallowing safety
- D. Clarify goals while rapidly assessing onset, safety, and desired level of intervention

35. At an interdisciplinary review, the team hears that Oakley Price, age 49, has severe pruritus with jaundice and excoriated skin. Which nursing action is most appropriate?

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

36. The nurse caring for Winter Flores, age 68, in an assisted-living apartment learns that the patient is asked for patient information by a relative not authorized to receive it. What is the best response?

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

37. A caregiver calls about Taylor Nolan, age 60, who has localized bone pain that remains severe despite systemic medication. Which intervention should the nurse prioritize?

- A. Avoid interdisciplinary consultation because localized pain is solely a nursing issue
- B. Discuss mechanism-focused options such as positioning, adjuvants, or palliative radiation
- 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

38. A caregiver calls about Winter Usman, age 64, who has limited English proficiency during a complex goals discussion. Which intervention should the nurse prioritize?

- A. Arrange a qualified interpreter and speak directly to the patient

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

39. The plan of care for Devon Nguyen, age 74, is reviewed after the patient reports that a family member is taking the patient's controlled medication. Which response best supports hospice and palliative nursing practice?

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

40. The nurse caring for Harper Lewis, age 84, in an assisted-living apartment learns that the patient asks what to expect as oral intake and alertness decrease. What is the best response?

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

41. A caregiver calls about Lane Flores, age 94, who has a valid directive but currently expresses a different informed preference. Which intervention should the nurse prioritize?

- 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

42. While reassessing Oakley Scott, age 51, 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. State that dyspnea is absent because the saturation has not declined
- 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. Focus only on oxygen flow without assessing anxiety or symptom intensity

43. During a visit in a private home, Sage Owens, age 61, 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. Begin forced oral fluids to thin secretions despite impaired swallowing
- D. Reposition gently and explain the sound while assessing for patient distress

44. While reassessing Cameron Adams, age 77, in an inpatient hospice unit, the nurse notes that the patient feels persistent moral distress after repeated conflicts about care. What should the nurse do next?

- 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

45. At an interdisciplinary review, the team hears that Cameron Price, age 75, nods during teaching but cannot describe the medication plan. Which nursing action is most appropriate?

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

46. The nurse caring for Jordan Flores, age 94, in an assisted-living apartment learns that the patient notices repeated delays in delivering comfort medications. What is the best response?

- 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

47. The plan of care for Jordan Brooks, age 92, is reviewed after the patient describes a cultural practice unfamiliar to the hospice team. Which response best supports hospice and palliative nursing practice?

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

48. While reassessing Quinn Owens, age 61, 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. Perform the task because a manager's request overrides competence concerns
- B. Delegate the task to an unlicensed caregiver without assessing suitability
- C. Decline until appropriate training, supervision, and scope requirements are met
- D. Attempt the task once and report only if an adverse event occurs

49. At an interdisciplinary review, the team hears that Quinn Kim, age 59, is exhausted and says caregiving can no longer continue without relief. Which nursing action is most appropriate?

- 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

50. The plan of care for Parker Bennett, age 54, is reviewed after the patient becomes difficult to arouse shortly after an analgesic dose increase. Which response best supports hospice and palliative nursing practice?

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

51. The nurse caring for Taylor Singh, age 64, in an assisted-living apartment learns that the patient describes burning, electric pain radiating along one leg. What is the best response?

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

52. During a visit in a private home, Emery Ibrahim, age 83, asks whether intense grief several weeks after death is abnormal. Which action should the hospice nurse take first?

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

53. At an interdisciplinary review, the team hears that Indigo Cole, age 93, 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. Ask staff to improvise the ritual without guidance from the family
- 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

54. The plan of care for Noel Foster, age 56, is reviewed after the patient cares for a stable home hospice patient who is not in crisis. Which response best supports hospice and palliative nursing practice?

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

55. The nurse caring for Lane James, age 48, 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. Administer every available antiemetic at once without identifying a target
- C. Stop all medications permanently before contacting the prescribing clinician
- D. Assess timing, likely mechanism, bowel status, and other associated findings

56. At an interdisciplinary review, the team hears that Indigo Martin, age 87, has decision-making capacity but asks the nurse not to share details with relatives. Which nursing action is most appropriate?

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

57. While reassessing Morgan Grant, age 47, in an inpatient hospice unit, the nurse notes that the patient reports a new symptom that conflicts with the assumptions in the current plan. What should the nurse do next?

- A. Continue the existing plan until the next mandatory recertification review
- B. Dismiss the report because earlier documentation described the symptom differently

- C. Perform a focused assessment and bring the new findings to the interdisciplinary team
- D. Change the medical plan independently without consulting an authorized prescriber

58. A caregiver calls about Taylor Usman, age 66, who develops predictable severe pain during dressing changes. Which intervention should the nurse prioritize?

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

59. The plan of care for Harper Davis, age 94, 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. Use caregiver respite as the sole rationale for acute symptom management
- C. Maintain routine care because changing levels indicates failure by the team
- D. End hospice enrollment before arranging any higher-intensity palliation

60. While reassessing Indigo Evans, age 45, in an inpatient hospice unit, the nurse notes that the patient says illness has destroyed all meaning and asks why this is happening. What should the nurse do next?

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

61. At an interdisciplinary review, the team hears that Oakley Martin, age 61, has a prognosis consistent with hospice eligibility but improves temporarily. Which nursing action is most appropriate?

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

62. While reassessing Sage Grant, age 71, 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. Wait for a visitor to complain before taking any action
- C. Join the discussion quietly because no patient name was initially spoken
- D. Stop the conversation and address the privacy breach through policy channels

63. A caregiver calls about Noel Thomas, age 54, 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. Use vital signs as the only reliable measure of pain intensity
- C. Administer analgesia only after the patient becomes verbally communicative
- D. Record no pain because a numeric rating cannot be obtained

64. The plan of care for Reese Patel, age 64, is reviewed after the patient develops myoclonus, hallucinations, and increasing sedation after opioid escalation. Which response best supports hospice and palliative nursing practice?

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

65. During a visit in a private home, Val Evans, age 71, has abdominal distention, colicky pain, vomiting, and no stool. Which action should the hospice nurse take first?

- 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

66. At an interdisciplinary review, the team hears that Cameron Chen, age 81, begins a scheduled opioid and has no bowel regimen. Which nursing action is most appropriate?

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

67. A caregiver calls about Winter Brooks, age 70, who has multiple comorbidities and gives inconsistent accounts of medication use. Which intervention should the nurse prioritize?

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

68. The nurse caring for Lane Thomas, age 54, in an assisted-living apartment learns that the patient is afraid that using rescue medication correctly will cause addiction. What is the best response?

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

69. A caregiver calls about Parker Patel, age 64, 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. Present only the option favored by the attending clinician
- C. Clarify values and provide balanced information without choosing for the family
- D. Avoid answering any questions because decisions are entirely private

70. The nurse caring for Parker Lewis, age 62, in an assisted-living apartment learns that the patient uses every rescue dose and still reports poorly controlled pain. What is the best response?

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

71. The nurse caring for Reese Singh, age 66, in an assisted-living apartment learns that the patient has fluctuating confusion and visual hallucinations. What is the best response?

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

72. A caregiver calls about Winter Long, age 76, who has escalating anxiety during episodes of breathlessness. Which intervention should the nurse prioritize?

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

73. The plan of care for Devon Jones, age 86, is reviewed after the patient refuses morphine because a relative says it always hastens death. Which response best supports hospice and palliative nursing practice?

- A. Ask the relative to authorize treatment instead of speaking with the patient
- B. Remove opioid therapy from consideration without discussing other preferences
- 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

74. The plan of care for Lane Foster, age 58, is reviewed after the patient identifies a near miss involving look-alike medication packaging. Which response best supports hospice and palliative nursing practice?

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

75. During a visit in a private home, Cameron Price, age 79, appears unable to understand a proposed change in care. Which action should the hospice nurse take first?

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

76. At an interdisciplinary review, the team hears that Morgan Chen, age 57, has painful lower-extremity edema and fragile skin. Which nursing action is most appropriate?

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

77. A caregiver calls about Jordan Brooks, age 46, who develops new restlessness and fluctuating attention. Which intervention should the nurse prioritize?

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

78. The plan of care for Noel Thomas, age 56, 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

79. The plan of care for Finley Davis, age 46, is reviewed after the patient is offered an expensive personal gift by a grateful family. Which response best supports hospice and palliative nursing practice?

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

80. A caregiver calls about Finley White, age 94, who has limited English proficiency during a complex goals discussion. Which intervention should the nurse prioritize?

- A. Postpone all communication until the patient learns common medical terms
- B. Arrange a qualified interpreter and speak directly to the patient

- C. Rely on gestures and obtain agreement without confirming comprehension
- D. Use a young family member because relatives understand the situation best

81. At an interdisciplinary review, the team hears that Gray Young, age 45, has a malodorous fungating wound causing embarrassment. Which nursing action is most appropriate?

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

82. During a visit in a private home, Morgan Ibrahim, age 61, reports that a family member is taking the patient's controlled medication. Which action should the hospice nurse take first?

- 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

83. The plan of care for Harper Usman, age 94, is reviewed after the patient states a wish to remain home while the family requests hospitalization. Which response best supports hospice and palliative nursing practice?

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

84. The plan of care for Winter Foster, age 84, is reviewed after the patient finds a controlled-substance count that does not match the record. Which response best supports hospice and palliative nursing practice?

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

85. While reassessing Alex Green, age 85, in an inpatient hospice unit, the nurse notes that the patient asks what to expect as oral intake and alertness decrease. What should the nurse do next?

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

86. A caregiver calls about Reese Singh, age 68, who is being transferred from an inpatient unit to home hospice. Which intervention should the nurse prioritize?

- 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

87. The plan of care for Winter Long, age 78, is reviewed after the patient has advanced dementia, recurrent aspiration, and declining oral intake. Which response best supports hospice and palliative nursing practice?

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

88. The nurse caring for Devon Jones, age 88, in an assisted-living apartment learns that the patient has a sudden functional decline after several stable weeks. What is the best response?

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

89. A caregiver calls about Harper Davis, age 48, who cannot explain how or when to use the newly delivered comfort medications. Which intervention should the nurse prioritize?

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

90. The plan of care for Lane Bennett, age 58, is reviewed after the patient can no longer swallow an effective oral analgesic regimen. Which response best supports hospice and palliative nursing practice?

- 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

91. The plan of care for Taylor Ross, age 80, 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. Ask the family to vote on which preference should control treatment
- B. Follow the older document without discussing the patient's present wishes
- C. Clarify the current capable choice and communicate it to the care team
- D. Delay documentation until the patient can meet with an attorney

92. The nurse caring for Reese Brooks, age 72, 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. 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

93. At an interdisciplinary review, the team hears that Emery Cole, age 47, nods during teaching but cannot describe the medication plan. Which nursing action is most appropriate?

- 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

94. While reassessing Cameron Kim, age 89, in an inpatient hospice unit, the nurse notes that the patient reports pain only when being turned in bed. What should the nurse do next?

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

95. The plan of care for Finley White, age 46, 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. Disclose the full plan because family members are involved in daily caregiving

D. Avoid documenting the patient's communication preference in the care plan

96. During a visit in a private home, Oakley Young, age 71, receives a family request to omit a significant symptom from the record. Which action should the hospice nurse take first?

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

97. The nurse caring for Lane Diaz, 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. Start intravenous hydration automatically because dry mouth proves dehydration
- C. Use lemon-glycerin products repeatedly without checking for irritation
- D. Withhold all oral comfort because aspiration risk can never be modified

98. A caregiver calls about Winter Jones, age 88, 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

99. A caregiver calls about Bailey Patel, age 92, who describes a cultural practice unfamiliar to the hospice team. Which intervention should the nurse prioritize?

- A. Ask what the practice means and how the team can support it safely
- B. Refuse the practice because it is not part of standard hospice routine

- C. Apply assumptions learned from another family with a similar background
- D. Ask a relative to speak for the patient without first seeking permission

100. The plan of care for Winter Bennett, age 84, 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. Continue the existing plan until the next mandatory recertification review
- C. Perform a focused assessment and bring the new findings to the interdisciplinary team
- D. Dismiss the report because earlier documentation described the symptom differently

101. The nurse caring for Devon Singh, age 94, in an assisted-living apartment learns that the patient has multiple comorbidities and gives inconsistent accounts of medication use. What is the best response?

- 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

102. The nurse caring for Finley Brooks, age 48, 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. Accept the self-report and complete a multidimensional pain assessment
- C. Lower the pain rating because behavior does not match the reported severity
- D. Delay treatment until objective signs such as tachycardia become evident

103. While reassessing Kai Ellis, age 61, in an inpatient hospice unit, the nurse notes that the patient appears unable to understand a proposed change in care. What should the nurse do next?

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

104. While reassessing Morgan Kim, age 65, 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. Replace all analgesics with massage regardless of fracture or instability risk
- B. Avoid interdisciplinary consultation because localized pain is solely a nursing issue
- C. Discuss mechanism-focused options such as positioning, adjuvants, or palliative radiation
- D. Conclude that no further palliation is possible once an opioid has been tried

105. The plan of care for Winter Lewis, age 90, is reviewed after the patient feels persistent moral distress after repeated conflicts about care. Which response best supports hospice and palliative nursing practice?

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

106. The plan of care for Reese Flores, age 76, is reviewed after the patient has urinary retention, suprapubic discomfort, and frequent small voids. Which response best supports hospice and palliative nursing practice?

- 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

107. The nurse caring for Winter Diaz, age 86, 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. Give food and oral medication before checking swallowing safety
- C. Promise full neurologic recovery if transfer occurs immediately
- D. Assume the symptoms are expected progression and perform no assessment

108. A caregiver calls about Jordan Jones, age 64, who notices repeated delays in delivering comfort medications. Which intervention should the nurse prioritize?

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

109. The plan of care for Noel Davis, age 74, is reviewed after the patient is asked to perform a task outside personal competence. Which response best supports hospice and palliative nursing practice?

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

110. The plan of care for Jordan Bennett, age 60, is reviewed after the patient becomes difficult to arouse shortly after an analgesic dose increase. Which response best supports hospice and palliative nursing practice?

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

111. The nurse caring for Noel Singh, age 70, in an assisted-living apartment learns that the patient develops new restlessness and fluctuating attention. What is the best response?

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

112. The nurse caring for Parker Brooks, age 74, in an assisted-living apartment learns that the patient has severe pruritus with jaundice and excoriated skin. What is the best response?

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

113. During a visit in a private home, Alex Owens, age 93, is exhausted and says caregiving can no longer continue without relief. Which action should the hospice nurse take first?

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

114. The plan of care for Bailey Patel, age 94, 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. Assume the decline proves death will occur within the next twenty-four hours
- B. Tell the caregiver that functional change is expected and requires no follow-up

- C. Stop all medications without reviewing their purpose or current benefit
- D. Reassess function, intake, symptoms, and caregiver needs with the team

115. The plan of care for Devon White, age 48, is reviewed after the patient describes burning, electric pain radiating along one leg. Which response best supports hospice and palliative nursing practice?

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

116. The nurse caring for Noel Flores, age 76, in an assisted-living apartment learns that the patient cares for a stable home hospice patient who is not in crisis. What is the best response?

- 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

117. A caregiver calls about Lane Nolan, age 68, 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

118. While reassessing Val Owens, age 93, in an inpatient hospice unit, the nurse notes that the patient cannot manage severe symptoms safely in the current setting despite plan changes. What should the nurse do next?

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

119. During a visit in a private home, Cameron Irwin, age 53, has a prognosis consistent with hospice eligibility but improves temporarily. Which action should the hospice nurse take first?

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

120. While reassessing Sage Price, age 83, 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. State that dyspnea is absent because the saturation has not declined
- C. Focus only on oxygen flow without assessing anxiety or symptom intensity
- D. Require bed rest in a flat position until breathing becomes regular

121. During a visit in a private home, Alex Martin, age 93, develops noisy upper-airway secretions during active dying. Which action should the hospice nurse take first?

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

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

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

123. A caregiver calls about Harper Thomas, age 60, who has nausea that began after a medication change. Which intervention should the nurse prioritize?

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

124. While reassessing Kai Kim, age 67, in an inpatient hospice unit, the nurse notes that the patient cannot self-report pain because of advanced cognitive impairment. What should the nurse do next?

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

125. The nurse caring for Parker James, age 80, in an assisted-living apartment learns that the patient asks whether intense grief several weeks after death is abnormal. What is the best response?

- A. Recommend medication before assessing the person's experience or risks
- B. Avoid discussion because bereavement begins only after several months
- 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

126. A caregiver calls about Taylor Hayes, age 90, who wants a ritual performed immediately after death. Which intervention should the nurse prioritize?

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

127. At an interdisciplinary review, the team hears that Val Ibrahim, age 91, has abdominal distention, colicky pain, vomiting, and no stool. Which nursing action is most appropriate?

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

128. A caregiver calls about Bailey Usman, age 48, who is being transferred from an inpatient unit to home hospice. Which intervention should the nurse prioritize?

- A. Send only the discharge medication list because hospice will repeat the assessment
- 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. Complete a structured handoff covering symptoms, medications, equipment, and contacts

129. While reassessing Emery Irwin, age 55, in an inpatient hospice unit, the nurse notes that the patient develops myoclonus, hallucinations, and increasing sedation after opioid escalation. What should the nurse do next?

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

130. During a visit in a private home, Indigo Green, age 65, has advanced dementia, recurrent aspiration, and declining oral intake. Which action should the hospice nurse take first?

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

131. A caregiver calls about Noel Flores, age 78, who says illness has destroyed all meaning and asks why this is happening. Which intervention should the nurse prioritize?

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

132. At an interdisciplinary review, the team hears that Oakley Grant, age 79, has fluctuating confusion and visual hallucinations. Which nursing action is most appropriate?

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

133. While reassessing Sage Ellis, age 89, 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

134. During a visit in a private home, Alex Vega, age 49, has painful lower-extremity edema and fragile skin. Which action should the hospice nurse take first?

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

135. At an interdisciplinary review, the team hears that Emery Price, age 59, is afraid that using rescue medication correctly will cause addiction. Which nursing action is most appropriate?

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

136. While reassessing Indigo Martin, age 69, in an inpatient hospice unit, the nurse notes that the patient asks the nurse to make a treatment decision on the patient's behalf. What should the nurse do next?

- 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

137. At an interdisciplinary review, the team hears that Indigo Ibrahim, age 67, has a sudden functional decline after several stable weeks. Which nursing action is most appropriate?

- A. Document expected decline and defer assessment until the next scheduled visit
- B. Increase every symptom medication because decline indicates uncontrolled suffering
- 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

138. At an interdisciplinary review, the team hears that Quinn Ellis, age 89, observes a colleague discussing a patient in a public elevator. Which nursing action is most appropriate?

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

139. A caregiver calls about Noel Davis, age 78, who begins a scheduled opioid and has no bowel regimen. Which intervention should the nurse prioritize?

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

140. A caregiver calls about Winter White, age 50, who has limited English proficiency during a complex goals discussion. Which intervention should the nurse prioritize?

- 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

141. During a visit in a private home, Val Martin, age 45, uses every rescue dose and still reports poorly controlled pain. Which action should the hospice nurse take first?

- A. Repeat the current regimen without reassessing response or pain type
- B. Add several sedating medicines simultaneously without a defined target
- C. Review adherence, timing, total use, adverse effects, and pain mechanism before titration

D. Assume drug-seeking behavior because all rescue medication was used

142. A caregiver calls about Devon Long, age 58, who has a malodorous fungating wound causing embarrassment. Which intervention should the nurse prioritize?

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

143. A caregiver calls about Finley Thomas, age 62, who refuses morphine because a relative says it always hastens death. Which intervention should the nurse prioritize?

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

144. While reassessing Indigo Kim, age 69, in an inpatient hospice unit, the nurse notes that the patient cannot explain how or when to use the newly delivered comfort medications. What should the nurse do next?

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

145. The nurse caring for Noel James, age 82, in an assisted-living apartment learns that the patient has dry mouth and repeatedly requests small sips. What is the best response?

- A. Withhold all oral comfort because aspiration risk can never be modified

- B. Start intravenous hydration automatically because dry mouth proves dehydration
- C. Provide frequent mouth care and offer safe sips according to swallowing ability
- D. Use lemon-glycerin products repeatedly without checking for irritation

146. The nurse caring for Parker Ross, age 86, in an assisted-living apartment learns that the patient can no longer swallow an effective oral analgesic regimen. What is the best response?

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

147. While reassessing Val Turner, age 49, in an inpatient hospice unit, the nurse notes that the patient has urinary retention, suprapubic discomfort, and frequent small voids. What should the nurse do next?

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

148. During a visit in a private home, Cameron Moore, age 59, reports that a family member is taking the patient's controlled medication. Which action should the hospice nurse take first?

- 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

149. While reassessing Cameron Irwin, age 57, in an inpatient hospice unit, the nurse notes that the patient shows cool extremities, mottling, reduced urine output, and longer sleep periods. What should the nurse do next?

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

150. At an interdisciplinary review, the team hears that Indigo Reed, age 73, has new unilateral weakness and difficulty speaking. Which nursing action is most appropriate?

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

Practice Exam 8: Answer Key and Explanations

1. 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..

2. 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..

3. B — 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..

4. 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..

5. A — 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..

6. C — 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..

7. B — 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..

8. 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.

9. C — 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..

10. D — 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.

11. D — Volume equals the ordered dose divided by the available concentration: 15 mg divided by 20 mg/mL equals 0.75 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..

12. C — 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.

13. 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..

14. 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..

15. 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..

16. 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..

17. B — 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..

18. 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..

19. 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..

20. 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..

21. C — 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..

22. A — 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..

23. 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..

24. D — 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..

25. A — 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..

26. 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..

27. C — 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..

28. 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..

29. 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..

30. D — 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..

31. A — 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.

32. C — 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.

33. 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.

34. D — 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..

35. D — 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..

36. C — 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..

37. B — 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..

38. 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..

39. D — 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..

40. 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..

41. 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..

42. 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..

43. 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..

44. A — 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..

45. B — 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..

46. 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..

47. A — 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..

48. 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..

49. 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..

50. 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..

51. A — 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..

52. D — 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..

53. 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..

54. B — 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.

55. 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..

56. 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..

57. C — 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..

58. 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..

59. 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.

60. B — 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..

61. C — 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..

62. D — 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..

63. 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..

64. 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..

65. 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..

66. B — 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..

67. A — 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..

68. 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..

69. C — 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..

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

73. 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..

74. 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..

75. 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..

76. 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..

77. 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.

78. 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..

79. A — 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..

80. B — 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..

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82. 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..

83. D — 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.

84. 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..

85. B — 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..

86. 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.

87. A — 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..

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89. C — 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..

90. 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..

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92. 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.

93. 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..

94. B — 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.

95. 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..

96. C — 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..

97. A — 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..

98. D — 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..

99. A — 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..

100. C — 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..

101. 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..

102. 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.

103. 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..

104. C — 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..

105. 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..

106. 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..

107. 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..

108. 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..

109. 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..

110. B — 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..

111. B — 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.

112. 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..

113. A — 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..

114. 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..

115. 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..

116. 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.

117. 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.

118. B — 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.

119. 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..

120. 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..

121. 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..

122. C — 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..

123. B — 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..

124. D — 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..

125. 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..

126. A — 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..

127. C — 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..

128. D — 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.

129. B — 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..

130. A — 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..

131. 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..

132. 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..

133. 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..

134. A — 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..

135. A — 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..

136. 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..

137. 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.

138. D — 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..

139. D — 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..

140. 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..

141. C — 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..

142. B — 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..

143. B — 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..

144. A — 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..

145. C — 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..

146. D — 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..

147. B — 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..

148. 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..

149. A — 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.

150. D — 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..