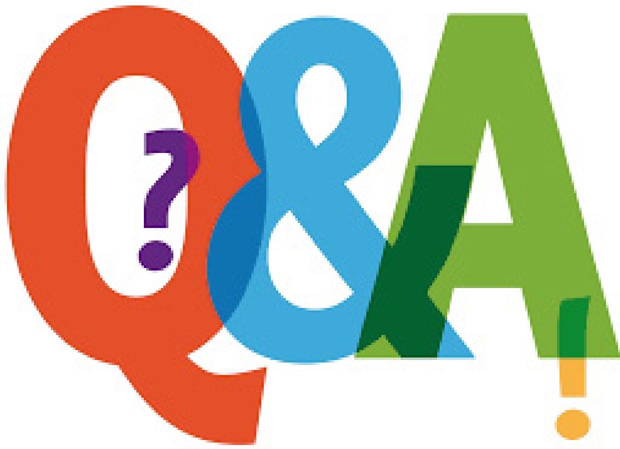

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Question: 1081

During admission assessment for a 65-year-old with advanced dementia, the nurse collects that the patient has a 10-year history of Alzheimer's, hypertension, and atrial fibrillation on anticoagulation. Psychosocially, the family reports cultural preference for family-centered decision-making rooted in Asian heritage, no formal advance directives, and the eldest son as informal decision maker. Review of systems shows agitation, poor intake, and pain on movement. Which collected data most requires documentation and immediate interdisciplinary action?

A. Psychosocial report of family dynamics and informal decision maker
B. Cultural preference for family-centered decision-making without formal proxy
C. Medical history of atrial fibrillation influencing anticoagulation decisions
D. Comprehensive review of systems indicating agitation and nutritional decline

Answer: B
Explanation: In palliative care, collecting information on cultural preferences for decision-making is essential for culturally humble practice. When no formal advance directive exists and the family relies on traditional family-centered (often eldest son) authority, this must be documented and explored early to align care with values, prevent conflicts, and guide surrogate identification per cultural context while ensuring legal compliance.

Question: 1082

A 74-year-old patient with heart failure has PPS 40% and spiritual distress about legacy. Which tool facilitates?

A. Prescribe antidepressant
B. Implement dignity therapy with chaplain
C. Refer to support group
D. Defer to family

Answer: B
Explanation: Dignity therapy addresses legacy and spiritual needs.

Question: 1083

Evaluation of caregiver education program uses which for Level 4?

A. Knowledge tests
B. Attendance

C. Decreased hospital readmissions related to unmanaged symptoms
D. Participant reactions

Answer: C
Explanation: Decreased readmissions demonstrate results-level impact.

Question: 1084

Trach patient suction-dependent, surrogate withdraws consent. Ethical process?

A. Continue suction mandatory
B. Withdraw trach care comfort ethical consent revocation anytime
C. Partial suction only
D. Require court order

Answer: B
Explanation: Withdraw trach care comfort ethical consent revocation anytime ongoing consent (2026 proxy revocation ethics), burdens cease. Require court order barrier. Continue suction mandatory invalid. Partial suction only prolongs.

Question: 1085

74yo prostate Ca bone mets, orchiectomy, depression grief. Indigenous sweat lodge pref, tribal elder decision input. ROS: cord compression, sadness. Comprehensive?

A. Dexamethasone
B. Medical/prostate depression history, spiritual/cultural Indigenous lodge elder, ROS compression/sadness, ACP tribal input
C. Elder consult
D. Grief SSRIs

Answer: B
Explanation: GU psych, spiritual elder, ROS neuro mood, ACP cultural.

Question: 1086

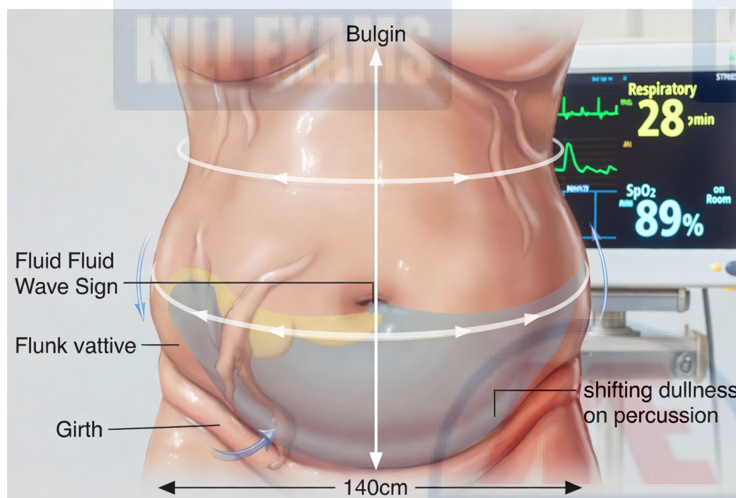
Nurse develops ketamine protocol refractory pain success 85% 20 patients. Dissemination?

A. Ignore publish
B. IRB QI approval data analysis, poster AAHPM annual, toolkit online HPNA repository
C. MD name protocol
D. Team internal use

Answer: B
Explanation: IRB QI approval data analysis, poster AAHPM annual, toolkit online HPNA repository nursing leadership publication (2026 HPNA research), scalable. Team internal use siloed. Ignoring publish loss field. MD name protocol credit wrong.

Question: 1087

A 62-year-old woman with end-stage heart failure (NYHA Class IV) and refractory ascites presents with abdominal distension and dyspnea. The palliative care team performs a bedside abdominal assessment.



Which differential diagnosis is most likely contributing to the patient's declining quality of life, and what is the primary expected outcome for the prioritized plan?

A. Refractory malignant ascites; expected outcome is complete resolution of distension through daily large-volume paracentesis
B. Refractory ascites due to decompensated cirrhosis overlap; expected outcome is improved dyspnea and comfort via indwelling catheter drainage aligned with goals of care
C. Venous congestion only; expected outcome is reduced girth with strict fluid restriction and high-dose loop diuretics
D. Acute infection; expected outcome is infection clearance with broad-spectrum antibiotics and no drainage

Answer: B

Explanation: The illustration depicts tense abdominal distension with positive fluid wave, everted umbilicus, and cachexia, consistent with refractory ascites in advanced heart failure or cirrhosis overlap. The prioritized differential is refractory ascites impacting dyspnea and comfort. With limited prognosis, the expected outcome is symptom relief (improved breathing, reduced discomfort) through comfort-aligned interventions such as indwelling abdominal catheter drainage rather than curative or burdensome measures.

Question: 1088

A 66-year-old patient with metastatic breast cancer (prognosis weeks) has refractory bone pain. Values home care. Plan:

A. Add corticosteroid
B. Immediate palliative sedation
C. Methadone rotation and bisphosphonate if tolerated
D. Current opioid increase

Answer: C
Explanation: Rotation addresses tolerance, bisphosphonate provides adjunctive benefit.

Question: 1089

During IDT rounds, a 68-year-old ALS patient (vital capacity 25% predicted, new dysphagia per bedside swallow eval) voices fear of choking, but wife prioritizes home death over PEG tube. PT reports wheelchair-bound (Barthel Index drop 60 points), pharmacist flags secretions. Functional decline rapid. Nurse's priority in plan modification?

A. Push PEG placement for nutrition
B. Discontinue PT as futile
C. Coordinate IDT to update plan with thickened liquids, anticholinergics (glycopyrrolate 0.2mg q6h), and advance directive review aligned to home death goal
D. Increase bolus feeds despite dysphagia

Answer: C
Explanation: ALS trajectory involves bulbar decline (low VC, dysphagia); IDT collaboration modifies plan to functional status changes and goals, favoring symptom control over invasive nutrition that risks aspiration pneumonia (2026 AAN guidelines advise against PEG in poor prognosis bulbar ALS). Glycopyrrolate dosing calculated for secretions (start low to avoid delirium), thickened liquids per eval; AD review clarifies surrogate alignment. This holistic approach supports QOL, with evidence IDT interventions extend comfortable home stays by weeks. Invasive options violate goals.

Question: 1090

Dietitian asks "palliative nutrition hospice NPO?" Patient cachexia albumin 2.6 g/dL PPS 40%. Education?

A. Hospice always NPO
B. Palliative aggressive feeding
C. Nutrition identical philosophies
D. Palliative nutrition individualized QOL-focused (supplements alongside), hospice comfort-oriented burdens assessed, concurrent ASPEN guidelines

Answer: D
Explanation: Palliative nutrition individualized QOL-focused (supplements alongside), hospice comfort-oriented burdens assessed, concurrent ASPEN guidelines nutrition ethics distinction (2026 ASPEN palliative), tailored. Hospice always NPO absolutist. Palliative aggressive feeding inappropriate. Nutrition identical philosophies ignores.

Domain 2: Practice Guideline Development (11-20)

Question: 1091

Jehovah Witness no blood, GI bleed Hgb 7.1, cultural isolation grief from community shunning. Management?

A. Erythropoietin 40k units SC weekly, protonix 40 mg BID, community elder liaison grief validation
B. Isolation psych
C. No EPO
D. Transfuse

Answer: A
Explanation: Erythropoietin 40k units SC weekly, protonix 40 mg BID, community elder liaison grief validation bloodless + PPI + shunning bereavement.

Question: 1092

Agency NHHCS survey falls domain 2.8/5. QI participation?

A. Signs warning
B. Restraints apply

C. Family education only
D. Fall risk stratification (PPS<40% high risk), prevention bundle (bed alarms, PT eval ambulation plan), root cause post-fall analysis, re-survey 3.9 target

Answer: D
Explanation: Fall risk stratification (PPS<40% high risk), prevention bundle (bed alarms, PT eval ambulation plan), root cause post-fall analysis, re-survey 3.9 target NHHCS improvement CQI (2026 CMS consumer survey), systematic. Signs warning passive. Restraints apply CMS penalty. Family education only insufficient.

Question: 1093

An 85-year-old patient with dementia (prognosis weeks) has agitation-pain. Caregivers value dignity. Plan:

A. Benzodiazepine
B. Scheduled acetaminophen and low-dose opioid with sensory therapy
C. Restraints
D. High-dose antipsychotic

Answer: B
Explanation: Multimodal minimizes distress.

Question: 1094

A 61-year-old patient with end-stage renal disease not on dialysis develops uremic pericarditis with effusion. Which palliative management is most appropriate?

A. Recommend hospice without intervention
B. Use colchicine prophylaxis
C. Initiate intensive dialysis if aligned with goals or high-dose NSAIDs/corticosteroids for symptom control
D. Perform pericardiocentesis routinely

Answer: C
Explanation: Dialysis resolves uremic pericarditis if pursued; otherwise, anti-inflammatories manage symptoms. Pericardiocentesis for tamponade only.

Question: 1095

In a quiet home hospice setting, the family feels overwhelmed. Which action best creates therapeutic

environment?

A. Leave room
B. Fill silence with education
C. Sit at eye level, use calm presence, and allow silence for processing
D. Maintain clinical distance

Answer: C
Explanation: Sitting at eye level with calm presence and allowing silence fosters safety and connection. Distance or filling silence disrupts therapeutic space.

Question: 1096

Patient ventilator-dependent post-arrest (Glasgow 3, lactate 6.1 mmol/L day 3), surrogate requests withdrawal. Physiologic equivalence ethical?

A. Withhold only never withdraw
B. Withholding equivalent withdrawing ventilator ethical symmetry
C. Withdrawing active killing
D. Physician determines equivalence

Answer: B
Explanation: Withholding equivalent withdrawing ventilator ethical symmetry moral equivalence doctrine (2026 AMA ethics withdrawing life-sustaining), action/omission distinction invalid. Withdrawing active killing intentionalist fallacy. Withhold only never withdraw arbitrary. Physician determines equivalence unnecessary consensus.

Question: 1097

70yo prostate CA mets to bone on hospice, new confusion. Systems-based endocrine/metabolic assessment includes dry mucous membranes, tenting skin, urine SG 1.032, Na 148 mEq/L, glucose 320 mg/dL. Goals "no tubes" per atheist view death natural. Prior bisphosphonates. What exam priority confirms dehydration exacerbating hypercalcemia?

A. Glucose 320 mg/dL
B. Tent skin
C. Urine SG 1.032
D. Dry mucous membranes

Answer: C

Explanation: Urine specific gravity 1.032 on renal systems assessment objectively quantifies concentrated urine from hypovolemia in hypercalcemic crisis, directing SC hydration over IV per goals. Dry membranes/tenting are clinical dehydration signs, hyperglycemia from stress/corticosteroids secondary.

Question: 1098

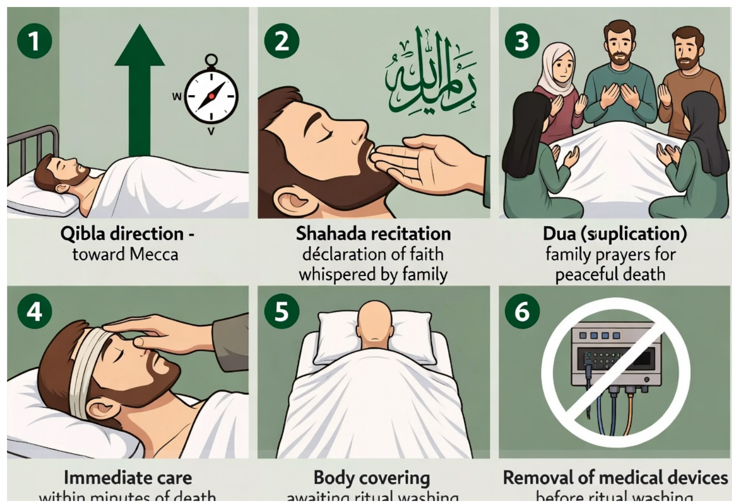
A hospital-based palliative care team receives a consult for a 68-year-old patient with advanced heart failure (NYHA Class IV, ejection fraction 15%, recurrent hospitalizations) who is receiving aggressive guideline-directed medical therapy. The patient's primary cardiologist requests clarification on whether palliative care involvement means transitioning to hospice. The patient and family are confused about the differences. Which educational approach best addresses this scenario while aligning with current standards?

A. Recommend immediate hospice referral to simplify care coordination
B. Explain that palliative care is only appropriate when curative treatment is discontinued and hospice eligibility is met
C. Provide a clear distinction that palliative care can be delivered concurrently with life-prolonging therapies at any illness stage while hospice requires certification of a prognosis of 6 months or less if the disease follows its natural course
D. Focus education solely on symptom management without addressing program differences

Answer: C
Explanation: Providing a clear distinction that palliative care can be delivered concurrently with life-prolonging therapies at any illness stage while hospice requires certification of a prognosis of 6 months or less if the disease follows its natural course accurately educates the team, patient, and family per NCP Guidelines and Medicare regulations. Explaining palliative care as only post-curative limits access and contradicts standards emphasizing early integration. Immediate hospice referral is premature without prognosis certification, and symptom-focused education without program clarification fails to address the core confusion.

Question: 1099

A 33-year-old Muslim patient with end-stage cystic fibrosis is declining rapidly. The family provides you with an illustrated guide showing Islamic death rituals they wish to observe.



The patient's oxygen saturation is 78% on BiPAP, and death is expected within hours. Based on this illustrated guide and Islamic death practices, which nursing action requires the most careful timing coordination with the family?

A. Coordinating with hospital security to allow extended family members for Dua prayers despite visitor restrictions
B. Removing all medical devices and tubes immediately after death verification to allow prompt ritual washing by same-gender family members
C. Ensuring privacy for Shahada recitation by limiting room access to immediate family members during the active dying phase
D. Facilitating bed repositioning to face Qibla direction before the patient loses consciousness to support spiritual preparation

Answer: B
Explanation: Removing all medical devices and tubes immediately after death verification to allow prompt ritual washing by same-gender family members requires the most careful timing coordination. Islamic tradition prescribes that the body should be washed (ghusl) as soon as possible after death, ideally within hours, and this ritual washing must be performed before burial, which should occur within 24 hours of death when possible. Panel 6 of the illustrated guide specifically shows the importance of removing medical devices before ritual washing. However, this practice directly intersects with hospital procedures, legal requirements, and medical examiner protocols. The nurse must coordinate multiple factors: completing required death verification and documentation, determining whether the death requires medical examiner notification (which may prohibit device removal), removing tubes and devices promptly once legally permissible, and facilitating same-gender family members' access to perform or supervise the washing. In hospital settings, ritual washing may need to occur in the patient's room or a designated space, requiring coordination with environmental services, spiritual care, and nursing staff to ensure privacy, appropriate supplies (water, clean cloths, soap), and respectful accommodation of religious requirements. The timing is critical because delays in device removal delay the washing, which delays burial, causing significant spiritual distress to the family. Proactive planning before death includes: clarifying medical examiner requirements with the physician, preparing device removal supplies, identifying same-gender family members who will perform the washing, arranging for a private space, and ensuring staff understand the time-sensitive nature of Islamic death rituals. Facilitating bed repositioning to face Qibla

direction before loss of consciousness is important but typically can be accomplished with less complex coordination and earlier in the dying process, allowing more flexibility in timing. Ensuring privacy for Shahada recitation is important but generally requires only room access limitation, which is straightforward to implement. Coordinating extended family access for Dua prayers may require advocacy with administration but does not have the same immediate post-death time pressure as device removal for ritual washing. Understanding that Islamic death rituals are time-bound religious obligations rather than preferences, and that the nurse's role includes proactive coordination to honor these practices within healthcare system constraints, demonstrates cultural competency and patient-centered care in the Muslim community.

Question: 1100

66-year-old NSCLC brain mets on hospice, new headache, seizure, Na 122 mEq/L (prior 134), euvolemic, recent IV fluids family request, SIADH suspected. Goals comfort seizure-free, prognosis weeks. Outcome measure?

A. Tolvaptan initiation rapid correction
B. Fluid restriction Na rise 6 mEq/L/day
C. Hypertonic saline Na >130
D. Seizure prophylaxis lamotrigine

Answer: B
Explanation: Fluid restriction Na rise 6 mEq/L/day safe expected outcome for SIADH correcting cerebral edema/seizures enhancing QOL without overcorrection risk herniation, standard <12 mEq/24h; hypertonic hospital-level, tolvaptan expensive unproven hospice, lamotrigine adjunct.

Question: 1101

A 49-year-old patient with advanced ovarian cancer experiences severe chemotherapy-induced peripheral neuropathy despite duloxetine and gabapentin. The team considers complementary interventions. Which option has the strongest evidence base for integration in palliative neuropathy management?

A. Topical capsaicin cream applied four times daily
B. Reiki sessions three times per week
C. Acupuncture twice weekly for 8 weeks
D. High-dose vitamin B12 injections weekly

Answer: C
Explanation: Systematic reviews support acupuncture as an effective nonpharmacologic intervention for

reducing chemotherapy-induced peripheral neuropathy severity and improving function in cancer patients, with benefits persisting post-treatment. Capsaicin is limited by irritation, vitamin B12 lacks strong evidence in this context, and Reiki shows inconsistent results for neuropathy.

Question: 1102

A CHPN identifies late hospice referrals in nursing homes. Which strategy best advocates timely access?

A. Accept current patterns
B. Require physician referral only
C. Educate facility staff on hospice eligibility, implement screening tools, and facilitate regular interdisciplinary rounds
D. Limit education to administrators

Answer: C
Explanation: Educating facility staff on hospice eligibility, implementing screening tools, and facilitating regular interdisciplinary rounds promotes timely access. Current patterns or physician-only perpetuate delays, and administrator-only limits reach.

Question: 1103

A 76-year-old patient with frailty has PPS 50%. Prognosis uses which tool?

A. Serum albumin only
B. ECOG alone
C. Laboratory values
D. PPS with surprise question

Answer: D
Explanation: Functional tools superior.

Question: 1104

SNF-hospice handoff barrier communication gaps (opioid mismatch morphine 15 mg q4h vs fentanyl prior). Barrier resolution?

A. Restart hospice titration
B. Universal palliative handoff tool EHR template (med rec CrCl-adjusted, ESAS trends, goals surrogate contact), IDT joint rounds monthly, audit reconciliation 98%
C. Verbal report only

D. Family medication list

Answer: B

Explanation: Universal palliative handoff tool EHR template (med rec CrCl-adjusted, ESAS trends, goals surrogate contact), IDT joint rounds monthly, audit reconciliation 98% standardized continuity (2026 I-PASS palliative), reliable. Verbal report only error-prone. Family medication list incomplete. Restarting hospice titration disruption.

Question: 1105

77yo COPD IPF overlap GOLD4, OSA CPAP nonadh, GA**D.** Buddhist meditation preference, no POLST. Wife surrogate. ROS: cor pulmonale BNP 450, depression. Initial?

A. Medical/COPD psych GAD history, spiritual Buddhist meditation, ROS cor pulmonale/depression, ACP POLST no/wife
B. CPAP troubleshoot
C. BNP echo
D. Meditation space

Answer: A

Explanation: Respiratory psych history, spiritual, ROS cardiac depression, ACP for non-invasive goals.

Question: 1106

A caregiver of a 78-year-old patient with dementia reports spiritual distress related to questioning "why God allows suffering." The patient is non-verbal. Which approach best facilitates spiritual health for both?

A. Advise ignoring spiritual concerns as normal
B. Refer to the hospice chaplain for life review and legacy-building activities
C. Suggest the caregiver read inspirational texts alone
D. Recommend increasing the patient's haloperidol for agitation

Answer: B

Explanation: Spiritual distress in caregivers of non-verbal patients benefits from chaplain-led interventions including life review, dignity therapy elements, and meaning-making to address existential suffering and foster peace, aligning with holistic palliative standards.

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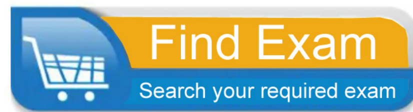

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