

PRACTICE EXAM 10: AMBULATORY CARE NURSING (AMB-BC) SIMULATION (150 QUESTIONS)

This 150-question practice examination is aligned to the ANCC Ambulatory Care Nursing Test Content Outline effective September 11, 2026. The actual examination allows 3 hours for 150 questions; 125 are scored and 25 are unscored pretest questions. Select the single best answer for each item.

1. A patient reports sudden trouble speaking and new unilateral arm weakness. What is the nurse's best initial action during an early-morning telephone call?

- A. Direct the patient to activate emergency services immediately
- B. Arrange a routine office visit for tomorrow
- C. Send stroke-prevention education by portal during this care encounter
- D. Ask the patient to complete a symptom diary

2. A patient receiving chemotherapy calls with a fever and shaking chills. What is the nurse's best initial action while reviewing a portal message?

- A. Advise waiting to see whether symptoms improve overnight
- B. Suggest taking a new supplement at home during this care encounter
- C. Use the urgent escalation pathway and arrange immediate evaluation
- D. Schedule routine vaccine counseling next month during this care encounter

3. A patient with asthma says a rescue inhaler is no longer relieving severe wheezing. What is the nurse's best initial action during a same-day triage visit?

- A. Recommend routine inhaler education later in the week
- B. Ask the patient to stop all prescribed inhalers
- C. Assess severity and activate urgent emergency support as indicated

D. Focus first on insurance authorization questions during this care encounter

4. A patient with chronic kidney disease reports markedly reduced urine output and increasing weakness. What is the nurse's best initial action after a recent transition of care?

A. Advise unrestricted fluid intake without assessment during this care encounter

B. Tell the patient the symptoms are expected during this care encounter

C. Postpone discussion until the annual physical during this care encounter

D. Obtain focused assessment data and arrange prompt clinical review

5. A patient using a continuous glucose monitor reports repeated low-glucose alarms and confusion. What is the nurse's best initial action while the primary clinician is in another encounter?

A. Ask the patient to silence all future alarms during this care encounter

B. Assess consciousness, ability to self-treat, and need for emergency help

C. Delay action until a routine laboratory visit during this care encounter

D. Tell the patient to change every medication independently during this care encounter

6. A patient reports severe headache with new vision change after a procedure. What is the nurse's best initial action during a late-afternoon follow-up call?

A. Screen for neurologic red flags and coordinate urgent evaluation

B. Offer general relaxation techniques as the only intervention

C. Schedule a routine follow-up several weeks later during this care encounter

D. Advise driving to the clinic without assessment during this care encounter

7. A patient reports a new painful, swollen calf and shortness of breath after a long trip. What is the nurse's best initial action after reviewing home-monitoring information?

A. Treat the report as urgent and arrange emergency evaluation

B. Recommend a nonurgent stretching program during this care encounter

- C. Tell the patient to monitor symptoms for a week
- D. Begin travel-health teaching before triage during this care encounter

8. A patient with diabetes has a foot wound that is becoming darker and has a foul odor. What is the nurse's best initial action while coordinating a virtual visit?

- A. Advise using an unprescribed topical product during this care encounter
- B. Assess for infection or ischemia and coordinate same-day evaluation
- C. Delay contact until the next routine podiatry visit
- D. Document only the patient's preferred pharmacy during this care encounter

9. A patient reports sudden trouble speaking and new unilateral arm weakness. What is the nurse's best initial action during an early-morning telephone call?

- A. Arrange a routine office visit for tomorrow
- B. Send stroke-prevention education by portal during this care encounter
- C. Ask the patient to complete a symptom diary
- D. Direct the patient to activate emergency services immediately

10. A patient receiving chemotherapy calls with a fever and shaking chills. What is the nurse's best initial action while reviewing a portal message?

- A. Advise waiting to see whether symptoms improve overnight
- B. Suggest taking a new supplement at home during this care encounter
- C. Use the urgent escalation pathway and arrange immediate evaluation
- D. Schedule routine vaccine counseling next month during this care encounter

11. A patient with asthma says a rescue inhaler is no longer relieving severe wheezing. What is the nurse's best initial action during a same-day triage visit?

- A. Recommend routine inhaler education later in the week

- B. Ask the patient to stop all prescribed inhalers
- C. Assess severity and activate urgent emergency support as indicated
- D. Focus first on insurance authorization questions during this care encounter

12. A patient with chronic kidney disease reports markedly reduced urine output and increasing weakness. What is the nurse's best initial action after a recent transition of care?

- A. Obtain focused assessment data and arrange prompt clinical review
- B. Advise unrestricted fluid intake without assessment during this care encounter
- C. Tell the patient the symptoms are expected during this care encounter
- D. Postpone discussion until the annual physical during this care encounter

13. A patient using a continuous glucose monitor reports repeated low-glucose alarms and confusion. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Ask the patient to silence all future alarms during this care encounter
- B. Delay action until a routine laboratory visit during this care encounter
- C. Tell the patient to change every medication independently during this care encounter
- D. Assess consciousness, ability to self-treat, and need for emergency help

14. A patient reports severe headache with new vision change after a procedure. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Offer general relaxation techniques as the only intervention
- B. Screen for neurologic red flags and coordinate urgent evaluation
- C. Schedule a routine follow-up several weeks later during this care encounter
- D. Advise driving to the clinic without assessment during this care encounter

15. A patient reports a new painful, swollen calf and shortness of breath after a long trip. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Recommend a nonurgent stretching program during this care encounter
- B. Treat the report as urgent and arrange emergency evaluation
- C. Tell the patient to monitor symptoms for a week
- D. Begin travel-health teaching before triage during this care encounter

16. A patient with diabetes has a foot wound that is becoming darker and has a foul odor. What is the nurse's best initial action while coordinating a virtual visit?

- A. Advise using an unprescribed topical product during this care encounter
- B. Delay contact until the next routine podiatry visit
- C. Document only the patient's preferred pharmacy during this care encounter
- D. Assess for infection or ischemia and coordinate same-day evaluation

17. A patient reports sudden trouble speaking and new unilateral arm weakness. What is the nurse's best initial action during an early-morning telephone call?

- A. Direct the patient to activate emergency services immediately
- B. Arrange a routine office visit for tomorrow
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- A. Recommend routine inhaler education later in the week
- B. Ask the patient to stop all prescribed inhalers
- C. Assess severity and activate urgent emergency support as indicated
- D. Focus first on insurance authorization questions during this care encounter

20. A patient with chronic kidney disease reports markedly reduced urine output and increasing weakness. What is the nurse's best initial action after a recent transition of care?

- A. Obtain focused assessment data and arrange prompt clinical review
- B. Advise unrestricted fluid intake without assessment during this care encounter
- C. Tell the patient the symptoms are expected during this care encounter
- D. Postpone discussion until the annual physical during this care encounter

21. A patient using a continuous glucose monitor reports repeated low-glucose alarms and confusion. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Ask the patient to silence all future alarms during this care encounter
- B. Assess consciousness, ability to self-treat, and need for emergency help
- C. Delay action until a routine laboratory visit during this care encounter
- D. Tell the patient to change every medication independently during this care encounter

22. A patient reports severe headache with new vision change after a procedure. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Offer general relaxation techniques as the only intervention
- B. Schedule a routine follow-up several weeks later during this care encounter
- C. Advise driving to the clinic without assessment during this care encounter
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23. A patient reports a new painful, swollen calf and shortness of breath after a long trip. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Recommend a nonurgent stretching program during this care encounter
- B. Tell the patient to monitor symptoms for a week
- C. Begin travel-health teaching before triage during this care encounter
- D. Treat the report as urgent and arrange emergency evaluation

24. A patient with diabetes has a foot wound that is becoming darker and has a foul odor. What is the nurse's best initial action while coordinating a virtual visit?

- A. Advise using an unprescribed topical product during this care encounter
- B. Delay contact until the next routine podiatry visit
- C. Assess for infection or ischemia and coordinate same-day evaluation
- D. Document only the patient's preferred pharmacy during this care encounter

25. A patient reports sudden trouble speaking and new unilateral arm weakness. What is the nurse's best initial action during an early-morning telephone call?

- A. Direct the patient to activate emergency services immediately
- B. Arrange a routine office visit for tomorrow
- C. Send stroke-prevention education by portal during this care encounter
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- D. Begin travel-health teaching before triage during this care encounter

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- A. Assess for infection or ischemia and coordinate same-day evaluation
- B. Advise using an unprescribed topical product during this care encounter
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- D. Document only the patient's preferred pharmacy during this care encounter

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- B. Send stroke-prevention education by portal during this care encounter
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36. A patient with chronic kidney disease reports markedly reduced urine output and increasing weakness. What is the nurse's best initial action after a recent transition of care?

- A. Obtain focused assessment data and arrange prompt clinical review
- B. Advise unrestricted fluid intake without assessment during this care encounter
- C. Tell the patient the symptoms are expected during this care encounter
- D. Postpone discussion until the annual physical during this care encounter

37. A patient using a continuous glucose monitor reports repeated low-glucose alarms and confusion. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Ask the patient to silence all future alarms during this care encounter
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40. A patient with diabetes has a foot wound that is becoming darker and has a foul odor. What is the nurse's best initial action while coordinating a virtual visit?

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- D. Postpone discussion until the annual physical during this care encounter

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- A. Ask the patient to silence all future alarms during this care encounter
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- D. Document only the patient's preferred pharmacy during this care encounter

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61. A patient using a continuous glucose monitor reports repeated low-glucose alarms and confusion. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Ask the patient to silence all future alarms during this care encounter
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- D. Tell the patient to change every medication independently during this care encounter

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- A. Offer general relaxation techniques as the only intervention
- B. Schedule a routine follow-up several weeks later during this care encounter
- C. Advise driving to the clinic without assessment during this care encounter
- D. Screen for neurologic red flags and coordinate urgent evaluation

63. A patient is leaving the hospital with a new oxygen plan and limited family support. What is the nurse's best initial action during an early-morning telephone call?

- A. Assume the patient will obtain supplies independently
- B. Delay planning until the first complication occurs
- C. Provide only a billing phone number during this care encounter
- D. Confirm equipment, teaching, contacts, and follow-up before discharge

64. A patient misses several appointments because the clinic schedule conflicts with work hours. What is the nurse's best initial action while reviewing a portal message?

- A. Explore flexible access options and collaborate on a realistic plan
- B. Remove the patient from follow-up without discussion during this care encounter
- C. Document nonadherence and take no action during this care encounter
- D. Require the patient to use only one appointment time

65. A wound-care patient has trouble performing the ordered dressing change at home. What is the nurse's best initial action during a same-day triage visit?

- A. Tell the patient to skip dressing changes
- B. Reassess technique and arrange appropriate teaching or support
- C. Recommend using any available household material during this care encounter
- D. Wait until the wound worsens before helping

66. A patient receives an unexpected abnormal point-of-care test result. What is the nurse's best initial action after a recent transition of care?

- A. Change treatment independently without verification during this care encounter
- B. Discard the result without a record during this care encounter
- C. Verify patient identity, collection process, and device quality controls
- D. Assume the result is always correct during this care encounter

67. A patient is leaving the hospital with a new oxygen plan and limited family support. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Assume the patient will obtain supplies independently
- B. Confirm equipment, teaching, contacts, and follow-up before discharge
- C. Delay planning until the first complication occurs
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68. A patient misses several appointments because the clinic schedule conflicts with work hours. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Remove the patient from follow-up without discussion during this care encounter
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69. A wound-care patient has trouble performing the ordered dressing change at home. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Reassess technique and arrange appropriate teaching or support
- B. Tell the patient to skip dressing changes
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70. A patient receives an unexpected abnormal point-of-care test result. What is the nurse's best initial action while coordinating a virtual visit?

- A. Change treatment independently without verification during this care encounter
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- A. Remove the patient from follow-up without discussion during this care encounter
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- C. Provide only a billing phone number during this care encounter
- D. Confirm equipment, teaching, contacts, and follow-up before discharge

84. A patient misses several appointments because the clinic schedule conflicts with work hours. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Remove the patient from follow-up without discussion during this care encounter
- B. Document nonadherence and take no action during this care encounter
- C. Explore flexible access options and collaborate on a realistic plan
- D. Require the patient to use only one appointment time

85. A wound-care patient has trouble performing the ordered dressing change at home. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Tell the patient to skip dressing changes
- B. Reassess technique and arrange appropriate teaching or support
- C. Recommend using any available household material during this care encounter
- D. Wait until the wound worsens before helping

86. A patient receives an unexpected abnormal point-of-care test result. What is the nurse's best initial action while coordinating a virtual visit?

- A. Verify patient identity, collection process, and device quality controls
- B. Change treatment independently without verification during this care encounter
- C. Discard the result without a record during this care encounter
- D. Assume the result is always correct during this care encounter

87. A staff member reports a near miss involving a look-alike medication. What is the nurse's best initial action during an early-morning telephone call?

- A. Keep the event private because no injury occurred
- B. Wait until a patient is harmed to report it
- C. File a factual safety report through the approved system
- D. Share the event publicly with patient details during this care encounter

88. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action while reviewing a portal message?

- A. Perform the service to avoid inconvenience
- B. Delegate it to an untrained coworker
- C. Leave the patient without an explanation
- D. Seek help from an authorized, competent clinician

89. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action during a same-day triage visit?

- A. Study the workflow and contributing data before selecting changes
- B. Assign blame to the most recent staff member
- C. Adopt a solution without understanding the process during this care encounter
- D. Stop tracking the delays because they are obvious

90. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action after a recent transition of care?

- A. Add more details so the discussion is complete
- B. Redirect the discussion to an appropriate private setting
- C. Assume employee status removes privacy obligations during this care encounter
- D. Record the conversation for later teaching during this care encounter

91. A staff member reports a near miss involving a look-alike medication. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Keep the event private because no injury occurred
- B. File a factual safety report through the approved system
- C. Wait until a patient is harmed to report it
- D. Share the event publicly with patient details during this care encounter

92. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Perform the service to avoid inconvenience
- B. Delegate it to an untrained coworker
- C. Seek help from an authorized, competent clinician
- D. Leave the patient without an explanation

93. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Assign blame to the most recent staff member
- B. Adopt a solution without understanding the process during this care encounter
- C. Stop tracking the delays because they are obvious
- D. Study the workflow and contributing data before selecting changes

94. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action while coordinating a virtual visit?

- A. Redirect the discussion to an appropriate private setting
- B. Add more details so the discussion is complete
- C. Assume employee status removes privacy obligations during this care encounter
- D. Record the conversation for later teaching during this care encounter

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- C. Wait until a patient is harmed to report it
- D. Share the event publicly with patient details during this care encounter

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- C. Delegate it to an untrained coworker
- D. Leave the patient without an explanation

97. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action during a same-day triage visit?

- A. Assign blame to the most recent staff member
- B. Adopt a solution without understanding the process during this care encounter
- C. Stop tracking the delays because they are obvious
- D. Study the workflow and contributing data before selecting changes

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- B. Assume employee status removes privacy obligations during this care encounter
- C. Redirect the discussion to an appropriate private setting
- D. Record the conversation for later teaching during this care encounter

99. A staff member reports a near miss involving a look-alike medication. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Keep the event private because no injury occurred
- B. Wait until a patient is harmed to report it
- C. Share the event publicly with patient details during this care encounter
- D. File a factual safety report through the approved system

100. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Perform the service to avoid inconvenience
- B. Seek help from an authorized, competent clinician
- C. Delegate it to an untrained coworker
- D. Leave the patient without an explanation

101. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Assign blame to the most recent staff member
- B. Adopt a solution without understanding the process during this care encounter
- C. Study the workflow and contributing data before selecting changes
- D. Stop tracking the delays because they are obvious

102. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action while coordinating a virtual visit?

- A. Redirect the discussion to an appropriate private setting
- B. Add more details so the discussion is complete
- C. Assume employee status removes privacy obligations during this care encounter
- D. Record the conversation for later teaching during this care encounter

103. A staff member reports a near miss involving a look-alike medication. What is the nurse's best initial action during an early-morning telephone call?

- A. Keep the event private because no injury occurred
- B. Wait until a patient is harmed to report it
- C. File a factual safety report through the approved system
- D. Share the event publicly with patient details during this care encounter

104. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action while reviewing a portal message?

- A. Seek help from an authorized, competent clinician
- B. Perform the service to avoid inconvenience
- C. Delegate it to an untrained coworker
- D. Leave the patient without an explanation

105. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action during a same-day triage visit?

- A. Assign blame to the most recent staff member
- B. Adopt a solution without understanding the process during this care encounter
- C. Stop tracking the delays because they are obvious
- D. Study the workflow and contributing data before selecting changes

106. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action after a recent transition of care?

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- D. Share the event publicly with patient details during this care encounter

108. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Perform the service to avoid inconvenience
- B. Seek help from an authorized, competent clinician
- C. Delegate it to an untrained coworker
- D. Leave the patient without an explanation

109. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Study the workflow and contributing data before selecting changes
- B. Assign blame to the most recent staff member
- C. Adopt a solution without understanding the process during this care encounter
- D. Stop tracking the delays because they are obvious

110. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action while coordinating a virtual visit?

- A. Add more details so the discussion is complete
- B. Assume employee status removes privacy obligations during this care encounter
- C. Record the conversation for later teaching during this care encounter
- D. Redirect the discussion to an appropriate private setting

111. A staff member reports a near miss involving a look-alike medication. What is the nurse's best initial action during an early-morning telephone call?

- A. File a factual safety report through the approved system
- B. Keep the event private because no injury occurred
- C. Wait until a patient is harmed to report it
- D. Share the event publicly with patient details during this care encounter

112. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action while reviewing a portal message?

- A. Perform the service to avoid inconvenience
- B. Delegate it to an untrained coworker
- C. Seek help from an authorized, competent clinician
- D. Leave the patient without an explanation

113. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action during a same-day triage visit?

- A. Assign blame to the most recent staff member
- B. Study the workflow and contributing data before selecting changes
- C. Adopt a solution without understanding the process during this care encounter
- D. Stop tracking the delays because they are obvious

114. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action after a recent transition of care?

- A. Add more details so the discussion is complete
- B. Assume employee status removes privacy obligations during this care encounter
- C. Record the conversation for later teaching during this care encounter
- D. Redirect the discussion to an appropriate private setting

115. A staff member reports a near miss involving a look-alike medication. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Keep the event private because no injury occurred
- B. File a factual safety report through the approved system
- C. Wait until a patient is harmed to report it
- D. Share the event publicly with patient details during this care encounter

116. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action during a late-afternoon follow-up call?

- A. Perform the service to avoid inconvenience
- B. Delegate it to an untrained coworker
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- D. Leave the patient without an explanation

117. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action after reviewing home-monitoring information?

- A. Study the workflow and contributing data before selecting changes
- B. Assign blame to the most recent staff member
- C. Adopt a solution without understanding the process during this care encounter
- D. Stop tracking the delays because they are obvious

118. A colleague discusses a patient's test result in a public hallway. What is the nurse's best initial action while coordinating a virtual visit?

- A. Add more details so the discussion is complete
- B. Assume employee status removes privacy obligations during this care encounter
- C. Record the conversation for later teaching during this care encounter
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- A. Keep the event private because no injury occurred
- B. Wait until a patient is harmed to report it
- C. Share the event publicly with patient details during this care encounter
- D. File a factual safety report through the approved system

120. A nurse is asked to provide a service beyond the nurse's verified competency. What is the nurse's best initial action while reviewing a portal message?

- A. Seek help from an authorized, competent clinician
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121. A team notices repeated delays in returning urgent patient calls. What is the nurse's best initial action during a same-day triage visit?

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- D. Record the conversation for later teaching during this care encounter

123. A patient appears overwhelmed after receiving several new self-management instructions. What is the nurse's best initial action during an early-morning telephone call?

- A. Prioritize the essential actions and use teach-back
- B. Deliver every detail in one long lecture
- C. Avoid discussing warning signs to reduce stress
- D. Use unexplained technical terminology during this care encounter

124. A patient with limited English proficiency needs new medication education. What is the nurse's best initial action while reviewing a portal message?

- A. Ask a child relative to interpret the details
- B. Speak louder in English until agreement is shown
- C. Use an unverified app as the sole interpreter
- D. Use a qualified interpreter and accessible plain-language materials

125. A patient with low vision needs instructions for a home monitoring device. What is the nurse's best initial action during a same-day triage visit?

- A. Give only standard small-print instructions during this care encounter during this care encounter
- B. Provide an accessible format and verify that the patient can use it
- C. Skip education because reading is difficult during this care encounter during this care encounter
- D. Assume a family member will teach the patient during this care encounter

126. A patient prefers portal messages for routine education. What is the nurse's best initial action after a recent transition of care?

- A. Assume every patient can use the portal safely
- B. Send sensitive information to an unverified email
- C. Confirm access, privacy, understanding, and an urgent-contact plan
- D. Use portal messages instead of urgent triage

127. A patient appears overwhelmed after receiving several new self-management instructions. What is the nurse's best initial action while the primary clinician is in another encounter?

- A. Deliver every detail in one long lecture
- B. Avoid discussing warning signs to reduce stress
- C. Use unexplained technical terminology during this care encounter
- D. Prioritize the essential actions and use teach-back

128. A patient with limited English proficiency needs new medication education. What is the nurse's best initial action during a late-afternoon follow-up call?

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- C. Speak louder in English until agreement is shown
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- C. Use portal messages instead of urgent triage
- D. Confirm access, privacy, understanding, and an urgent-contact plan

Practice Exam 10: Answer Key and Explanations

- 1. A** — Sudden focal neurologic deficits can signal a time-sensitive cerebrovascular emergency. The nurse should activate the emergency pathway immediately and avoid delays for routine scheduling or extended history-taking. Education and symptom tracking do not address the immediate threat. Safe ambulatory triage identifies red flags promptly and connects the patient with emergency evaluation.
- 2. C** — Fever and chills in a patient receiving chemotherapy may indicate serious infection and require prompt evaluation. The nurse should follow the approved urgent pathway, assess relevant warning signs, and give clear instructions. Waiting overnight, suggesting unverified home treatments, or addressing unrelated preventive care can delay management of a potentially life-threatening condition.
- 3. C** — Failure of rescue medication to relieve severe wheezing can indicate worsening respiratory compromise. The nurse should rapidly assess severity, ability to speak, associated symptoms, and need for emergency services. Routine education, blanket medication discontinuation, and administrative tasks do not address the immediate risk or provide an appropriate safety response. This approach supports clear communication and safe ambulatory care.
- 4. D** — Markedly reduced urine output with weakness can reflect a clinically important change requiring timely assessment. The nurse should gather focused information, review symptoms of instability, and use the escalation plan. Blanket fluid advice, reassurance without assessment, and delayed review can be unsafe because they do not identify the underlying cause or patient-specific treatment needs.
- 5. B** — Repeated low-glucose alarms with confusion may indicate hypoglycemia requiring immediate action. The nurse should assess consciousness, swallowing ability, available support, and access to emergency care or the individualized treatment plan. Silencing alarms, delaying care, or directing unsupervised medication changes can worsen risk and does not address immediate patient safety. This approach supports clear communication and safe ambulatory care.
- 6. A** — Severe headache with new vision change is a red-flag combination that requires focused assessment and urgent disposition. The nurse should follow the clinical protocol and ensure safe transportation when escalation is needed. Relaxation advice, distant follow-up, and unassessed driving recommendations can delay evaluation and expose the patient to avoidable harm.
- 7. A** — Painful calf swelling with shortness of breath can represent a serious thromboembolic concern. The ambulatory nurse should prioritize emergency assessment rather than conservative home suggestions or delayed monitoring. Travel teaching can be useful later, but it must not replace urgent triage. The immediate goal is safe disposition and timely access to definitive evaluation.
- 8. B** — A darkening, malodorous diabetic foot wound may indicate infection, tissue compromise, or both. The nurse should obtain focused information, review systemic symptoms, and coordinate same-day evaluation according to protocol. Unprescribed products, delayed contact, and administrative documentation do not address the potential for rapid deterioration or limb-threatening complications. This approach supports clear communication and safe ambulatory care.

9. D — Sudden focal neurologic deficits can signal a time-sensitive cerebrovascular emergency. The nurse should activate the emergency pathway immediately and avoid delays for routine scheduling or extended history-taking. Education and symptom tracking do not address the immediate threat. Safe ambulatory triage identifies red flags promptly and connects the patient with emergency evaluation.

10. C — Fever and chills in a patient receiving chemotherapy may indicate serious infection and require prompt evaluation. The nurse should follow the approved urgent pathway, assess relevant warning signs, and give clear instructions. Waiting overnight, suggesting unverified home treatments, or addressing unrelated preventive care can delay management of a potentially life-threatening condition.

11. C — Failure of rescue medication to relieve severe wheezing can indicate worsening respiratory compromise. The nurse should rapidly assess severity, ability to speak, associated symptoms, and need for emergency services. Routine education, blanket medication discontinuation, and administrative tasks do not address the immediate risk or provide an appropriate safety response. This approach supports clear communication and safe ambulatory care.

12. A — Markedly reduced urine output with weakness can reflect a clinically important change requiring timely assessment. The nurse should gather focused information, review symptoms of instability, and use the escalation plan. Blanket fluid advice, reassurance without assessment, and delayed review can be unsafe because they do not identify the underlying cause or patient-specific treatment needs.

13. D — Repeated low-glucose alarms with confusion may indicate hypoglycemia requiring immediate action. The nurse should assess consciousness, swallowing ability, available support, and access to emergency care or the individualized treatment plan. Silencing alarms, delaying care, or directing unsupervised medication changes can worsen risk and does not address immediate patient safety. This approach supports clear communication and safe ambulatory care.

14. B — Severe headache with new vision change is a red-flag combination that requires focused assessment and urgent disposition. The nurse should follow the clinical protocol and ensure safe transportation when escalation is needed. Relaxation advice, distant follow-up, and unassessed driving recommendations can delay evaluation and expose the patient to avoidable harm.

15. B — Painful calf swelling with shortness of breath can represent a serious thromboembolic concern. The ambulatory nurse should prioritize emergency assessment rather than conservative home suggestions or delayed monitoring. Travel teaching can be useful later, but it must not replace urgent triage. The immediate goal is safe disposition and timely access to definitive evaluation.

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17. A — Sudden focal neurologic deficits can signal a time-sensitive cerebrovascular emergency. The nurse should activate the emergency pathway immediately and avoid delays for routine scheduling or extended history-taking. Education and symptom tracking do not address the immediate threat. Safe ambulatory triage identifies red flags promptly and connects the patient with emergency evaluation.

18. C — Fever and chills in a patient receiving chemotherapy may indicate serious infection and require prompt evaluation. The nurse should follow the approved urgent pathway, assess relevant warning signs, and give clear instructions. Waiting overnight, suggesting unverified home treatments, or addressing unrelated preventive care can delay management of a potentially life-threatening condition.

19. C — Failure of rescue medication to relieve severe wheezing can indicate worsening respiratory compromise. The nurse should rapidly assess severity, ability to speak, associated symptoms, and need for emergency services. Routine education, blanket medication discontinuation, and administrative tasks do not address the immediate risk or provide an appropriate safety response. This approach supports clear communication and safe ambulatory care.

20. A — Markedly reduced urine output with weakness can reflect a clinically important change requiring timely assessment. The nurse should gather focused information, review symptoms of instability, and use the escalation plan. Blanket fluid advice, reassurance without assessment, and delayed review can be unsafe because they do not identify the underlying cause or patient-specific treatment needs.

21. B — Repeated low-glucose alarms with confusion may indicate hypoglycemia requiring immediate action. The nurse should assess consciousness, swallowing ability, available support, and access to emergency care or the individualized treatment plan. Silencing alarms, delaying care, or directing unsupervised medication changes can worsen risk and does not address immediate patient safety. This approach supports clear communication and safe ambulatory care.

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23. D — Painful calf swelling with shortness of breath can represent a serious thromboembolic concern. The ambulatory nurse should prioritize emergency assessment rather than conservative home suggestions or delayed monitoring. Travel teaching can be useful later, but it must not replace urgent triage. The immediate goal is safe disposition and timely access to definitive evaluation.

24. C — A darkening, malodorous diabetic foot wound may indicate infection, tissue compromise, or both. The nurse should obtain focused information, review systemic symptoms, and coordinate same-day evaluation according to protocol. Unprescribed products, delayed contact, and administrative documentation do not address the potential for rapid deterioration or limb-threatening complications. This approach supports clear communication and safe ambulatory care.

25. A — Sudden focal neurologic deficits can signal a time-sensitive cerebrovascular emergency. The nurse should activate the emergency pathway immediately and avoid delays for routine scheduling or extended history-taking. Education and symptom tracking do not address the immediate threat. Safe ambulatory triage identifies red flags promptly and connects the patient with emergency evaluation.

26. B — Fever and chills in a patient receiving chemotherapy may indicate serious infection and require prompt evaluation. The nurse should follow the approved urgent pathway, assess relevant warning signs, and give clear instructions. Waiting overnight, suggesting unverified home treatments, or addressing unrelated preventive care can delay management of a potentially life-threatening condition.

27. A — Failure of rescue medication to relieve severe wheezing can indicate worsening respiratory compromise. The nurse should rapidly assess severity, ability to speak, associated symptoms, and need for emergency services. Routine education, blanket medication discontinuation, and administrative tasks do not address the immediate risk or provide an appropriate safety response. This approach supports clear communication and safe ambulatory care.

28. C — Markedly reduced urine output with weakness can reflect a clinically important change requiring timely assessment. The nurse should gather focused information, review symptoms of instability, and use the escalation plan. Blanket fluid advice, reassurance without assessment, and delayed review can be unsafe because they do not identify the underlying cause or patient-specific treatment needs.

29. D — Repeated low-glucose alarms with confusion may indicate hypoglycemia requiring immediate action. The nurse should assess consciousness, swallowing ability, available support, and access to emergency care or the individualized treatment plan. Silencing alarms, delaying care, or directing unsupervised medication changes can worsen risk and does not address immediate patient safety. This approach supports clear communication and safe ambulatory care.

30. B — Severe headache with new vision change is a red-flag combination that requires focused assessment and urgent disposition. The nurse should follow the clinical protocol and ensure safe transportation when escalation is needed. Relaxation advice, distant follow-up, and unassessed driving recommendations can delay evaluation and expose the patient to avoidable harm.

31. B — Painful calf swelling with shortness of breath can represent a serious thromboembolic concern. The ambulatory nurse should prioritize emergency assessment rather than conservative home suggestions or delayed monitoring. Travel teaching can be useful later, but it must not replace urgent triage. The immediate goal is safe disposition and timely access to definitive evaluation.

32. A — A darkening, malodorous diabetic foot wound may indicate infection, tissue compromise, or both. The nurse should obtain focused information, review systemic symptoms, and coordinate same-day evaluation according to protocol. Unprescribed products, delayed contact, and administrative documentation do not address the potential for rapid deterioration or limb-threatening complications. This approach supports clear communication and safe ambulatory care.

33. D — Sudden focal neurologic deficits can signal a time-sensitive cerebrovascular emergency. The nurse should activate the emergency pathway immediately and avoid delays for routine scheduling or extended history-taking. Education and symptom tracking do not address the immediate threat. Safe ambulatory triage identifies red flags promptly and connects the patient with emergency evaluation.

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64. A — Missed visits may reflect structural barriers rather than lack of interest. The nurse should explore feasible options, clarify patient goals, and coordinate appropriate access while maintaining clinical follow-up. Removing the patient, documenting without intervention, or imposing one schedule does not address the barrier and may worsen disparities in care continuity.

65. B — Difficulty with a dressing change requires reassessment of technique, supplies, dexterity, vision, pain, and support needs. The nurse can reinforce ordered care and coordinate additional

education or services. Skipping care, using unsuitable materials, or waiting for deterioration risks infection and delays a practical solution to the patient's immediate self-management barrier.

66. C — Unexpected point-of-care results should be verified before clinical action. Identification, specimen handling, device status, and quality controls help identify possible error and support reliable interpretation. Independently changing treatment, discarding the result, or accepting it blindly bypasses safeguards. The nurse should document the process and communicate verified findings to the appropriate clinician.

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87. C — Near-miss reports help organizations identify system vulnerabilities before harm occurs. A factual report through the approved process supports learning, trend analysis, and prevention. Keeping the event private, waiting for an injury, or sharing patient details publicly undermines safety culture and confidentiality. The nurse's role includes timely reporting and participation in safer systems.

88. D — Professional accountability requires recognizing competency boundaries and ensuring that the patient receives help from an appropriately qualified person. Performing an unfamiliar service or delegating to untrained staff creates avoidable risk. Leaving without explanation is also inappropriate. The nurse should communicate clearly, maintain patient trust, and facilitate a timely, safe next step.

89. A — Quality improvement begins with a clear problem definition and an understanding of the current workflow. Data and staff perspectives reveal handoffs, capacity issues, and system barriers. Blame, premature solutions, and stopping measurement can hide causes. The nurse leader should use structured inquiry to select, test, and evaluate a practical improvement.

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124. D — Qualified interpreters support accurate, confidential communication and allow the nurse to assess understanding. Plain-language materials reinforce the teaching. Children should not interpret complex clinical information, and unverified translation tools can introduce errors. Speaking louder does not address language access. The nurse should select communication methods that support informed, safe decisions.

125. B — Teaching should be adapted to the patient's functional needs and preferences. Large print, audio, tactile supports, or accessible technology may help, followed by return demonstration or teach-back. Small print, skipping education, and assumptions about family support create barriers. The nurse should ensure that the patient can safely use the device and knows when to seek help.

126. C — Portal communication can reinforce education when access, privacy, and comprehension are confirmed. Patients also need clear instructions about urgent symptoms and alternate contact methods. Assuming access, using unverified channels, or substituting electronic messaging for urgent triage can create safety and confidentiality problems. The nurse should match the communication method to clinical urgency and patient capability.

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139. A — When patients are overwhelmed, education should focus first on immediate safety actions, key warning signs, and the next manageable step. Teach-back confirms what the patient understands. An information dump, omitted warnings, and unexplained jargon increase cognitive burden. The nurse should build learning over time in a way that supports confidence and safe action at home.

140. D — Qualified interpreters support accurate, confidential communication and allow the nurse to assess understanding. Plain-language materials reinforce the teaching. Children should not interpret complex clinical information, and unverified translation tools can introduce errors. Speaking louder does not address language access. The nurse should select communication methods that support informed, safe decisions.

141. B — Teaching should be adapted to the patient's functional needs and preferences. Large print, audio, tactile supports, or accessible technology may help, followed by return demonstration or teach-back. Small print, skipping education, and assumptions about family support create barriers. The nurse should ensure that the patient can safely use the device and knows when to seek help.

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