

PRACTICE EXAM 11: AMBULATORY CARE NURSING (AMB-BC) SIMULATION (150 QUESTIONS)

This is an original study aid, not an official ANCC examination or product. It contains 150 questions and mirrors the current AMB-BC format: 3 hours, 125 scored questions, and 25 unscored pretest questions. Select the single best answer for each item.

1. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Focus only on the patient portal password
- D. Use emergency triage and arrange immediate evaluation

2. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Assess for emergency warning signs and direct urgent evaluation
- D. Provide fall-prevention education instead of triage during this clinical encounter

3. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Obtain focused symptom information and escalate promptly
- B. Reassure the patient that dizziness is always benign
- C. Delay assessment until an annual device check

D. Ask only about the preferred pharmacy

4. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Coordinate same-day urgent clinical assessment
- D. Provide unrelated nutrition teaching

5. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Focus only on the patient portal password
- D. Use emergency triage and arrange immediate evaluation

6. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Assess for emergency warning signs and direct urgent evaluation
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

7. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Reassure the patient that dizziness is always benign
- B. Obtain focused symptom information and escalate promptly

- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

8. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Coordinate same-day urgent clinical assessment
- D. Provide unrelated nutrition teaching

9. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Focus only on the patient portal password
- D. Use emergency triage and arrange immediate evaluation

10. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Assess for emergency warning signs and direct urgent evaluation
- B. Recommend ordinary activity without further questions during this clinical encounter
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

11. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Reassure the patient that dizziness is always benign

- B. Delay assessment until an annual device check
- C. Obtain focused symptom information and escalate promptly
- D. Ask only about the preferred pharmacy

12. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Coordinate same-day urgent clinical assessment
- C. Tell the patient to wait for routine laboratory work
- D. Provide unrelated nutrition teaching

13. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Use emergency triage and arrange immediate evaluation
- B. Schedule routine pulmonary education next month
- C. Recommend delaying care until the morning
- D. Focus only on the patient portal password

14. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Provide fall-prevention education instead of triage during this clinical encounter
- D. Assess for emergency warning signs and direct urgent evaluation

15. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Obtain focused symptom information and escalate promptly
- B. Reassure the patient that dizziness is always benign
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

16. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Provide unrelated nutrition teaching
- D. Coordinate same-day urgent clinical assessment

17. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Use emergency triage and arrange immediate evaluation
- D. Focus only on the patient portal password

18. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Assess for emergency warning signs and direct urgent evaluation
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

19. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Obtain focused symptom information and escalate promptly
- B. Reassure the patient that dizziness is always benign
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

20. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Provide unrelated nutrition teaching
- D. Coordinate same-day urgent clinical assessment

21. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Use emergency triage and arrange immediate evaluation
- D. Focus only on the patient portal password

22. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Assess for emergency warning signs and direct urgent evaluation
- D. Provide fall-prevention education instead of triage during this clinical encounter

23. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Reassure the patient that dizziness is always benign
- B. Obtain focused symptom information and escalate promptly
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

24. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Coordinate same-day urgent clinical assessment
- C. Tell the patient to wait for routine laboratory work
- D. Provide unrelated nutrition teaching

25. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Use emergency triage and arrange immediate evaluation
- B. Schedule routine pulmonary education next month
- C. Recommend delaying care until the morning
- D. Focus only on the patient portal password

26. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Provide fall-prevention education instead of triage during this clinical encounter
- D. Assess for emergency warning signs and direct urgent evaluation

27. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Reassure the patient that dizziness is always benign
- B. Delay assessment until an annual device check
- C. Ask only about the preferred pharmacy
- D. Obtain focused symptom information and escalate promptly

28. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Coordinate same-day urgent clinical assessment
- B. Suggest using a cosmetic topical product
- C. Tell the patient to wait for routine laboratory work
- D. Provide unrelated nutrition teaching

29. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Use emergency triage and arrange immediate evaluation
- D. Focus only on the patient portal password

30. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Assess for emergency warning signs and direct urgent evaluation
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

31. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Reassure the patient that dizziness is always benign
- B. Obtain focused symptom information and escalate promptly
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

32. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Provide unrelated nutrition teaching
- D. Coordinate same-day urgent clinical assessment

33. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Use emergency triage and arrange immediate evaluation
- B. Schedule routine pulmonary education next month
- C. Recommend delaying care until the morning
- D. Focus only on the patient portal password

34. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Assess for emergency warning signs and direct urgent evaluation
- D. Provide fall-prevention education instead of triage during this clinical encounter

35. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Obtain focused symptom information and escalate promptly
- B. Reassure the patient that dizziness is always benign
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

36. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Coordinate same-day urgent clinical assessment
- D. Provide unrelated nutrition teaching

37. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Focus only on the patient portal password
- D. Use emergency triage and arrange immediate evaluation

38. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Assess for emergency warning signs and direct urgent evaluation
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

39. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Reassure the patient that dizziness is always benign
- B. Obtain focused symptom information and escalate promptly
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

40. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Provide unrelated nutrition teaching
- D. Coordinate same-day urgent clinical assessment

41. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Use emergency triage and arrange immediate evaluation
- D. Focus only on the patient portal password

42. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Assess for emergency warning signs and direct urgent evaluation
- B. Recommend ordinary activity without further questions during this clinical encounter
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

43. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Reassure the patient that dizziness is always benign
- B. Delay assessment until an annual device check
- C. Obtain focused symptom information and escalate promptly
- D. Ask only about the preferred pharmacy

44. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Coordinate same-day urgent clinical assessment
- C. Tell the patient to wait for routine laboratory work
- D. Provide unrelated nutrition teaching

45. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Focus only on the patient portal password
- D. Use emergency triage and arrange immediate evaluation

46. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Assess for emergency warning signs and direct urgent evaluation
- B. Recommend ordinary activity without further questions during this clinical encounter
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

47. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Reassure the patient that dizziness is always benign
- B. Delay assessment until an annual device check
- C. Obtain focused symptom information and escalate promptly
- D. Ask only about the preferred pharmacy

48. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Coordinate same-day urgent clinical assessment
- C. Tell the patient to wait for routine laboratory work
- D. Provide unrelated nutrition teaching

49. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Use emergency triage and arrange immediate evaluation
- B. Schedule routine pulmonary education next month
- C. Recommend delaying care until the morning
- D. Focus only on the patient portal password

50. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Provide fall-prevention education instead of triage during this clinical encounter
- D. Assess for emergency warning signs and direct urgent evaluation

51. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Reassure the patient that dizziness is always benign
- B. Obtain focused symptom information and escalate promptly
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

52. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Coordinate same-day urgent clinical assessment
- D. Provide unrelated nutrition teaching

53. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Use emergency triage and arrange immediate evaluation
- B. Schedule routine pulmonary education next month
- C. Recommend delaying care until the morning
- D. Focus only on the patient portal password

54. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Wait for the next scheduled refill request during this clinical encounter
- C. Provide fall-prevention education instead of triage during this clinical encounter
- D. Assess for emergency warning signs and direct urgent evaluation

55. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Obtain focused symptom information and escalate promptly
- B. Reassure the patient that dizziness is always benign
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

56. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after reviewing the patient record?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Coordinate same-day urgent clinical assessment
- D. Provide unrelated nutrition teaching

57. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action during a telephone triage call?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Focus only on the patient portal password
- D. Use emergency triage and arrange immediate evaluation

58. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action after reviewing an electronic message?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Assess for emergency warning signs and direct urgent evaluation
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

59. A patient with an implanted cardiac device reports repeated dizziness and near-fainting. What is the nurse's best initial action during a virtual follow-up?

- A. Obtain focused symptom information and escalate promptly
- B. Reassure the patient that dizziness is always benign
- C. Delay assessment until an annual device check
- D. Ask only about the preferred pharmacy

60. A patient with a new central line reports redness, tenderness, and fever. What is the nurse's best initial action after a transition of care?

- A. Suggest using a cosmetic topical product
- B. Tell the patient to wait for routine laboratory work
- C. Provide unrelated nutrition teaching
- D. Coordinate same-day urgent clinical assessment

61. A patient with COPD reports increasing breathlessness, fever, and a new inability to finish full sentences. What is the nurse's best initial action while coordinating same-day access?

- A. Schedule routine pulmonary education next month
- B. Recommend delaying care until the morning
- C. Use emergency triage and arrange immediate evaluation
- D. Focus only on the patient portal password

62. A patient calls after a fall and reports taking a blood thinner with a new severe headache. What is the nurse's best initial action during a routine reassessment?

- A. Recommend ordinary activity without further questions during this clinical encounter
- B. Assess for emergency warning signs and direct urgent evaluation
- C. Wait for the next scheduled refill request during this clinical encounter
- D. Provide fall-prevention education instead of triage during this clinical encounter

63. A patient is starting a complex medication regimen and has difficulty organizing doses. What is the nurse's best initial action during a telephone triage call?

- A. Tell the patient to follow the label without discussion
- B. Reconcile medications and develop a practical adherence plan
- C. Ask the patient to stop medications when confused
- D. Delay education until the next annual visit

64. A patient needs post-discharge follow-up but has no reliable internet access for virtual visits. What is the nurse's best initial action after reviewing an electronic message?

- A. Cancel follow-up because video is unavailable during this clinical encounter
- B. Assume a neighbor will provide technology during this clinical encounter
- C. Document the barrier without planning during this clinical encounter
- D. Arrange an accessible alternative and confirm follow-up details

65. A patient reports that home-monitoring equipment gives inconsistent readings. What is the nurse's best initial action during a virtual follow-up?

- A. Review technique and verify equipment use before acting on trends
- B. Make a diagnosis from the first unusual reading during this clinical encounter
- C. Tell the patient to discard all records during this clinical encounter
- D. Change the treatment plan without verification during this clinical encounter

66. A patient has difficulty obtaining prescribed supplies because coverage information changed. What is the nurse's best initial action after a transition of care?

- A. Tell the patient supplies are not part of care
- B. Instruct the patient to stop treatment until coverage returns
- C. Assess the access barrier and coordinate appropriate resources
- D. Wait for an emergency before responding during this clinical encounter

67. A patient is starting a complex medication regimen and has difficulty organizing doses. What is the nurse's best initial action while coordinating same-day access?

- A. Tell the patient to follow the label without discussion
- B. Reconcile medications and develop a practical adherence plan
- C. Ask the patient to stop medications when confused
- D. Delay education until the next annual visit

68. A patient needs post-discharge follow-up but has no reliable internet access for virtual visits. What is the nurse's best initial action during a routine reassessment?

- A. Cancel follow-up because video is unavailable during this clinical encounter
- B. Assume a neighbor will provide technology during this clinical encounter
- C. Document the barrier without planning during this clinical encounter
- D. Arrange an accessible alternative and confirm follow-up details

69. A patient reports that home-monitoring equipment gives inconsistent readings. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Make a diagnosis from the first unusual reading during this clinical encounter
- B. Tell the patient to discard all records during this clinical encounter
- C. Review technique and verify equipment use before acting on trends
- D. Change the treatment plan without verification during this clinical encounter

70. A patient has difficulty obtaining prescribed supplies because coverage information changed. What is the nurse's best initial action after reviewing the patient record?

- A. Assess the access barrier and coordinate appropriate resources
- B. Tell the patient supplies are not part of care
- C. Instruct the patient to stop treatment until coverage returns
- D. Wait for an emergency before responding during this clinical encounter

71. A patient is starting a complex medication regimen and has difficulty organizing doses. What is the nurse's best initial action during a telephone triage call?

- A. Tell the patient to follow the label without discussion
- B. Reconcile medications and develop a practical adherence plan
- C. Ask the patient to stop medications when confused
- D. Delay education until the next annual visit

72. A patient needs post-discharge follow-up but has no reliable internet access for virtual visits. What is the nurse's best initial action after reviewing an electronic message?

- A. Cancel follow-up because video is unavailable during this clinical encounter
- B. Assume a neighbor will provide technology during this clinical encounter
- C. Arrange an accessible alternative and confirm follow-up details
- D. Document the barrier without planning during this clinical encounter

73. A patient reports that home-monitoring equipment gives inconsistent readings. What is the nurse's best initial action during a virtual follow-up?

- A. Make a diagnosis from the first unusual reading during this clinical encounter
- B. Tell the patient to discard all records during this clinical encounter
- C. Change the treatment plan without verification during this clinical encounter
- D. Review technique and verify equipment use before acting on trends

74. A patient has difficulty obtaining prescribed supplies because coverage information changed. What is the nurse's best initial action after a transition of care?

- A. Assess the access barrier and coordinate appropriate resources
- B. Tell the patient supplies are not part of care
- C. Instruct the patient to stop treatment until coverage returns
- D. Wait for an emergency before responding during this clinical encounter

75. A patient is starting a complex medication regimen and has difficulty organizing doses. What is the nurse's best initial action while coordinating same-day access?

- A. Tell the patient to follow the label without discussion
- B. Reconcile medications and develop a practical adherence plan
- C. Ask the patient to stop medications when confused
- D. Delay education until the next annual visit

76. A patient needs post-discharge follow-up but has no reliable internet access for virtual visits. What is the nurse's best initial action during a routine reassessment?

- A. Cancel follow-up because video is unavailable during this clinical encounter
- B. Assume a neighbor will provide technology during this clinical encounter
- C. Document the barrier without planning during this clinical encounter
- D. Arrange an accessible alternative and confirm follow-up details

77. A patient reports that home-monitoring equipment gives inconsistent readings. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Make a diagnosis from the first unusual reading during this clinical encounter
- B. Tell the patient to discard all records during this clinical encounter
- C. Review technique and verify equipment use before acting on trends
- D. Change the treatment plan without verification during this clinical encounter

78. A patient has difficulty obtaining prescribed supplies because coverage information changed. What is the nurse's best initial action after reviewing the patient record?

- A. Assess the access barrier and coordinate appropriate resources
- B. Tell the patient supplies are not part of care
- C. Instruct the patient to stop treatment until coverage returns
- D. Wait for an emergency before responding during this clinical encounter

79. A patient is starting a complex medication regimen and has difficulty organizing doses. What is the nurse's best initial action during a telephone triage call?

- A. Reconcile medications and develop a practical adherence plan
- B. Tell the patient to follow the label without discussion
- C. Ask the patient to stop medications when confused
- D. Delay education until the next annual visit

80. A patient needs post-discharge follow-up but has no reliable internet access for virtual visits. What is the nurse's best initial action after reviewing an electronic message?

- A. Cancel follow-up because video is unavailable during this clinical encounter
- B. Arrange an accessible alternative and confirm follow-up details
- C. Assume a neighbor will provide technology during this clinical encounter
- D. Document the barrier without planning during this clinical encounter

81. A patient reports that home-monitoring equipment gives inconsistent readings. What is the nurse's best initial action during a virtual follow-up?

- A. Make a diagnosis from the first unusual reading during this clinical encounter
- B. Tell the patient to discard all records during this clinical encounter
- C. Review technique and verify equipment use before acting on trends
- D. Change the treatment plan without verification during this clinical encounter

82. A patient has difficulty obtaining prescribed supplies because coverage information changed. What is the nurse's best initial action after a transition of care?

- A. Tell the patient supplies are not part of care
- B. Instruct the patient to stop treatment until coverage returns
- C. Wait for an emergency before responding during this clinical encounter
- D. Assess the access barrier and coordinate appropriate resources

83. A patient is starting a complex medication regimen and has difficulty organizing doses. What is the nurse's best initial action while coordinating same-day access?

- A. Tell the patient to follow the label without discussion
- B. Reconcile medications and develop a practical adherence plan
- C. Ask the patient to stop medications when confused
- D. Delay education until the next annual visit

84. A patient needs post-discharge follow-up but has no reliable internet access for virtual visits. What is the nurse's best initial action during a routine reassessment?

- A. Cancel follow-up because video is unavailable during this clinical encounter
- B. Assume a neighbor will provide technology during this clinical encounter
- C. Arrange an accessible alternative and confirm follow-up details
- D. Document the barrier without planning during this clinical encounter

85. A patient reports that home-monitoring equipment gives inconsistent readings. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Make a diagnosis from the first unusual reading during this clinical encounter
- B. Tell the patient to discard all records during this clinical encounter
- C. Change the treatment plan without verification during this clinical encounter
- D. Review technique and verify equipment use before acting on trends

86. A patient has difficulty obtaining prescribed supplies because coverage information changed. What is the nurse's best initial action after reviewing the patient record?

- A. Assess the access barrier and coordinate appropriate resources
- B. Tell the patient supplies are not part of care
- C. Instruct the patient to stop treatment until coverage returns
- D. Wait for an emergency before responding during this clinical encounter

87. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action during a telephone triage call?

- A. Ignore it because no patient has been harmed yet
- B. Correct only the most recent record privately
- C. Report the pattern and participate in process improvement
- D. Discuss it outside approved professional channels during this clinical encounter

88. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action after reviewing an electronic message?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Ask untrained staff to make the decision during this clinical encounter
- C. Refuse without offering any next step during this clinical encounter
- D. Explain the limitation and route the request to the authorized clinician

89. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action during a virtual follow-up?

- A. Treat the complaint as a personal preference only
- B. Assess the process and address accessibility barriers equitably
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

90. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after a transition of care?

- A. Stop the sharing and follow the organization's privacy process
- B. Forward the screenshot to additional staff during this clinical encounter
- C. Assume it is acceptable because it is work related
- D. Keep the issue informal and undocumented during this clinical encounter

91. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action while coordinating same-day access?

- A. Ignore it because no patient has been harmed yet
- B. Correct only the most recent record privately
- C. Discuss it outside approved professional channels during this clinical encounter
- D. Report the pattern and participate in process improvement

92. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action during a routine reassessment?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Ask untrained staff to make the decision during this clinical encounter
- C. Explain the limitation and route the request to the authorized clinician
- D. Refuse without offering any next step during this clinical encounter

93. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Assess the process and address accessibility barriers equitably
- B. Treat the complaint as a personal preference only
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

94. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after reviewing the patient record?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Stop the sharing and follow the organization's privacy process
- C. Assume it is acceptable because it is work related
- D. Keep the issue informal and undocumented during this clinical encounter

95. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action during a telephone triage call?

- A. Report the pattern and participate in process improvement
- B. Ignore it because no patient has been harmed yet
- C. Correct only the most recent record privately
- D. Discuss it outside approved professional channels during this clinical encounter

96. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action after reviewing an electronic message?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Ask untrained staff to make the decision during this clinical encounter
- C. Explain the limitation and route the request to the authorized clinician
- D. Refuse without offering any next step during this clinical encounter

97. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action during a virtual follow-up?

- A. Treat the complaint as a personal preference only
- B. Assess the process and address accessibility barriers equitably
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

98. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after a transition of care?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Assume it is acceptable because it is work related
- C. Keep the issue informal and undocumented during this clinical encounter
- D. Stop the sharing and follow the organization's privacy process

99. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action while coordinating same-day access?

- A. Ignore it because no patient has been harmed yet
- B. Correct only the most recent record privately
- C. Discuss it outside approved professional channels during this clinical encounter
- D. Report the pattern and participate in process improvement

100. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action during a routine reassessment?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Ask untrained staff to make the decision during this clinical encounter
- C. Explain the limitation and route the request to the authorized clinician
- D. Refuse without offering any next step during this clinical encounter

101. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Treat the complaint as a personal preference only
- B. Assess the process and address accessibility barriers equitably
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

102. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after reviewing the patient record?

- A. Stop the sharing and follow the organization's privacy process
- B. Forward the screenshot to additional staff during this clinical encounter
- C. Assume it is acceptable because it is work related
- D. Keep the issue informal and undocumented during this clinical encounter

103. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action during a telephone triage call?

- A. Ignore it because no patient has been harmed yet
- B. Correct only the most recent record privately
- C. Report the pattern and participate in process improvement
- D. Discuss it outside approved professional channels during this clinical encounter

104. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action after reviewing an electronic message?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Explain the limitation and route the request to the authorized clinician
- C. Ask untrained staff to make the decision during this clinical encounter
- D. Refuse without offering any next step during this clinical encounter

105. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action during a virtual follow-up?

- A. Assess the process and address accessibility barriers equitably
- B. Treat the complaint as a personal preference only
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

106. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after a transition of care?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Assume it is acceptable because it is work related
- C. Keep the issue informal and undocumented during this clinical encounter
- D. Stop the sharing and follow the organization's privacy process

107. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action while coordinating same-day access?

- A. Ignore it because no patient has been harmed yet
- B. Report the pattern and participate in process improvement
- C. Correct only the most recent record privately
- D. Discuss it outside approved professional channels during this clinical encounter

108. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action during a routine reassessment?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Ask untrained staff to make the decision during this clinical encounter
- C. Explain the limitation and route the request to the authorized clinician
- D. Refuse without offering any next step during this clinical encounter

109. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Assess the process and address accessibility barriers equitably
- B. Treat the complaint as a personal preference only
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

110. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after reviewing the patient record?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Assume it is acceptable because it is work related
- C. Keep the issue informal and undocumented during this clinical encounter
- D. Stop the sharing and follow the organization's privacy process

111. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action during a telephone triage call?

- A. Report the pattern and participate in process improvement
- B. Ignore it because no patient has been harmed yet
- C. Correct only the most recent record privately
- D. Discuss it outside approved professional channels during this clinical encounter

112. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action after reviewing an electronic message?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Explain the limitation and route the request to the authorized clinician
- C. Ask untrained staff to make the decision during this clinical encounter
- D. Refuse without offering any next step during this clinical encounter

113. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action during a virtual follow-up?

- A. Treat the complaint as a personal preference only
- B. Offer changes only to patients who complain repeatedly
- C. Assess the process and address accessibility barriers equitably
- D. Avoid collecting information about the experience during this clinical encounter

114. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after a transition of care?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Assume it is acceptable because it is work related
- C. Keep the issue informal and undocumented during this clinical encounter
- D. Stop the sharing and follow the organization's privacy process

115. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action while coordinating same-day access?

- A. Ignore it because no patient has been harmed yet
- B. Correct only the most recent record privately
- C. Discuss it outside approved professional channels during this clinical encounter
- D. Report the pattern and participate in process improvement

116. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action during a routine reassessment?

- A. Complete the task without authorization during this clinical encounter during this clinical encounter
- B. Ask untrained staff to make the decision during this clinical encounter
- C. Explain the limitation and route the request to the authorized clinician
- D. Refuse without offering any next step during this clinical encounter

117. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Assess the process and address accessibility barriers equitably
- B. Treat the complaint as a personal preference only
- C. Offer changes only to patients who complain repeatedly
- D. Avoid collecting information about the experience during this clinical encounter

118. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after reviewing the patient record?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Stop the sharing and follow the organization's privacy process
- C. Assume it is acceptable because it is work related
- D. Keep the issue informal and undocumented during this clinical encounter

119. A nurse observes a recurring documentation omission that could affect follow-up. What is the nurse's best initial action during a telephone triage call?

- A. Ignore it because no patient has been harmed yet
- B. Report the pattern and participate in process improvement
- C. Correct only the most recent record privately
- D. Discuss it outside approved professional channels during this clinical encounter

120. A patient requests a task that requires prescriber authorization. What is the nurse's best initial action after reviewing an electronic message?

- A. Explain the limitation and route the request to the authorized clinician
- B. Complete the task without authorization during this clinical encounter during this clinical encounter
- C. Ask untrained staff to make the decision during this clinical encounter
- D. Refuse without offering any next step during this clinical encounter

121. A clinic team receives a complaint about long waits from patients with disabilities. What is the nurse's best initial action during a virtual follow-up?

- A. Treat the complaint as a personal preference only
- B. Offer changes only to patients who complain repeatedly
- C. Assess the process and address accessibility barriers equitably
- D. Avoid collecting information about the experience during this clinical encounter

122. A staff member shares a patient screenshot through an unapproved messaging channel. What is the nurse's best initial action after a transition of care?

- A. Forward the screenshot to additional staff during this clinical encounter
- B. Assume it is acceptable because it is work related
- C. Keep the issue informal and undocumented during this clinical encounter
- D. Stop the sharing and follow the organization's privacy process

123. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action during a telephone triage call?

- A. Use teach-back to identify gaps and reinforce the action plan
- B. Assume understanding because the patient agreed during this clinical encounter
- C. Repeat the same explanation without checking during this clinical encounter
- D. End the teaching session immediately during this clinical encounter

124. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action after reviewing an electronic message?

- A. Use technical terminology to save time during this clinical encounter
- B. Give written instructions without discussion during this clinical encounter
- C. Assume prior experience is sufficient during this clinical encounter
- D. Use plain language, demonstration, and confirmation of understanding

125. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action during a virtual follow-up?

- A. Speak louder without checking what helps during this clinical encounter
- B. Ask about communication preferences and provide accessible teaching
- C. Rely on another patient to interpret during this clinical encounter
- D. Skip discussion because printed material exists during this clinical encounter

126. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after a transition of care?

- A. Provide all details because the caregiver is concerned
- B. Refuse to speak with anyone without explanation during this clinical encounter
- C. Confirm authorization and involve the patient in the conversation
- D. Use a public area to discuss the plan

127. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action while coordinating same-day access?

- A. Assume understanding because the patient agreed during this clinical encounter
- B. Repeat the same explanation without checking during this clinical encounter
- C. End the teaching session immediately during this clinical encounter
- D. Use teach-back to identify gaps and reinforce the action plan

128. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action during a routine reassessment?

- A. Use plain language, demonstration, and confirmation of understanding
- B. Use technical terminology to save time during this clinical encounter
- C. Give written instructions without discussion during this clinical encounter
- D. Assume prior experience is sufficient during this clinical encounter

129. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Speak louder without checking what helps during this clinical encounter
- B. Ask about communication preferences and provide accessible teaching
- C. Rely on another patient to interpret during this clinical encounter
- D. Skip discussion because printed material exists during this clinical encounter

130. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after reviewing the patient record?

- A. Provide all details because the caregiver is concerned
- B. Refuse to speak with anyone without explanation during this clinical encounter
- C. Confirm authorization and involve the patient in the conversation
- D. Use a public area to discuss the plan

131. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action during a telephone triage call?

- A. Assume understanding because the patient agreed during this clinical encounter
- B. Repeat the same explanation without checking during this clinical encounter
- C. End the teaching session immediately during this clinical encounter
- D. Use teach-back to identify gaps and reinforce the action plan

132. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action after reviewing an electronic message?

- A. Use technical terminology to save time during this clinical encounter
- B. Use plain language, demonstration, and confirmation of understanding
- C. Give written instructions without discussion during this clinical encounter
- D. Assume prior experience is sufficient during this clinical encounter

133. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action during a virtual follow-up?

- A. Speak louder without checking what helps during this clinical encounter
- B. Rely on another patient to interpret during this clinical encounter
- C. Ask about communication preferences and provide accessible teaching
- D. Skip discussion because printed material exists during this clinical encounter

134. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after a transition of care?

- A. Confirm authorization and involve the patient in the conversation
- B. Provide all details because the caregiver is concerned
- C. Refuse to speak with anyone without explanation during this clinical encounter
- D. Use a public area to discuss the plan

135. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action while coordinating same-day access?

- A. Assume understanding because the patient agreed during this clinical encounter
- B. Repeat the same explanation without checking during this clinical encounter
- C. End the teaching session immediately during this clinical encounter
- D. Use teach-back to identify gaps and reinforce the action plan

136. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action during a routine reassessment?

- A. Use plain language, demonstration, and confirmation of understanding
- B. Use technical terminology to save time during this clinical encounter
- C. Give written instructions without discussion during this clinical encounter
- D. Assume prior experience is sufficient during this clinical encounter

137. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Speak louder without checking what helps during this clinical encounter
- B. Rely on another patient to interpret during this clinical encounter
- C. Ask about communication preferences and provide accessible teaching
- D. Skip discussion because printed material exists during this clinical encounter

138. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after reviewing the patient record?

- A. Provide all details because the caregiver is concerned
- B. Confirm authorization and involve the patient in the conversation
- C. Refuse to speak with anyone without explanation during this clinical encounter
- D. Use a public area to discuss the plan

139. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action during a telephone triage call?

- A. Assume understanding because the patient agreed during this clinical encounter
- B. Repeat the same explanation without checking during this clinical encounter
- C. End the teaching session immediately during this clinical encounter
- D. Use teach-back to identify gaps and reinforce the action plan

140. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action after reviewing an electronic message?

- A. Use technical terminology to save time during this clinical encounter
- B. Use plain language, demonstration, and confirmation of understanding
- C. Give written instructions without discussion during this clinical encounter
- D. Assume prior experience is sufficient during this clinical encounter

141. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action during a virtual follow-up?

- A. Ask about communication preferences and provide accessible teaching
- B. Speak louder without checking what helps during this clinical encounter
- C. Rely on another patient to interpret during this clinical encounter
- D. Skip discussion because printed material exists during this clinical encounter

142. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after a transition of care?

- A. Provide all details because the caregiver is concerned
- B. Refuse to speak with anyone without explanation during this clinical encounter
- C. Confirm authorization and involve the patient in the conversation
- D. Use a public area to discuss the plan

143. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action while coordinating same-day access?

- A. Assume understanding because the patient agreed during this clinical encounter
- B. Repeat the same explanation without checking during this clinical encounter
- C. End the teaching session immediately during this clinical encounter
- D. Use teach-back to identify gaps and reinforce the action plan

144. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action during a routine reassessment?

- A. Use technical terminology to save time during this clinical encounter
- B. Use plain language, demonstration, and confirmation of understanding
- C. Give written instructions without discussion during this clinical encounter
- D. Assume prior experience is sufficient during this clinical encounter

145. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action when the usual clinician is unavailable?

- A. Ask about communication preferences and provide accessible teaching
- B. Speak louder without checking what helps during this clinical encounter
- C. Rely on another patient to interpret during this clinical encounter
- D. Skip discussion because printed material exists during this clinical encounter

146. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after reviewing the patient record?

- A. Provide all details because the caregiver is concerned
- B. Confirm authorization and involve the patient in the conversation
- C. Refuse to speak with anyone without explanation during this clinical encounter
- D. Use a public area to discuss the plan

147. A patient says, 'I understand,' but cannot describe how to respond to worsening symptoms. What is the nurse's best initial action during a telephone triage call?

- A. Assume understanding because the patient agreed during this clinical encounter
- B. Repeat the same explanation without checking during this clinical encounter
- C. Use teach-back to identify gaps and reinforce the action plan
- D. End the teaching session immediately during this clinical encounter

148. A patient has limited health literacy and needs instruction about a new monitoring routine. What is the nurse's best initial action after reviewing an electronic message?

- A. Use plain language, demonstration, and confirmation of understanding
- B. Use technical terminology to save time during this clinical encounter
- C. Give written instructions without discussion during this clinical encounter
- D. Assume prior experience is sufficient during this clinical encounter

149. A patient with hearing impairment is preparing for a medication change. What is the nurse's best initial action during a virtual follow-up?

- A. Speak louder without checking what helps during this clinical encounter
- B. Rely on another patient to interpret during this clinical encounter
- C. Skip discussion because printed material exists during this clinical encounter
- D. Ask about communication preferences and provide accessible teaching

150. A family caregiver asks for information, but the patient has not indicated permission to share details. What is the nurse's best initial action after a transition of care?

- A. Provide all details because the caregiver is concerned
- B. Refuse to speak with anyone without explanation during this clinical encounter
- C. Confirm authorization and involve the patient in the conversation
- D. Use a public area to discuss the plan

Practice Exam 11: Answer Key and Explanations

- 1. D** — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.
- 2. C** — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.
- 3. A** — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.
- 4. C** — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.
- 5. D** — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.
- 6. B** — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.
- 7. B** — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.
- 8. C** — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

9. D — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

10. A — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

11. C — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

12. B — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

13. A — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

14. D — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

15. A — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

16. D — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

17. C — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

18. B — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

19. A — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

20. D — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

21. C — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

22. C — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

23. B — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

24. B — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

25. A — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

26. D — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

27. D — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

28. A — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

29. C — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

30. B — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

31. B — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

32. D — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

33. A — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

34. C — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

35. A — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

36. C — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

37. D — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

38. B — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

39. B — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

40. D — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

41. C — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

42. A — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

43. C — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

44. B — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

45. D — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

46. A — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

47. C — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

48. B — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

49. A — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

50. D — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

51. B — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

52. C — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

53. A — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

54. D — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

55. A — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

56. C — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

57. D — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

58. B — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

59. A — Repeated dizziness and near-syncope can reflect a clinically important cardiac issue and require focused assessment and timely escalation. The nurse should gather information about onset, symptoms, injury, and current status while following the approved pathway. Reassurance without assessment, delayed review, and administrative questions do not establish safety or an appropriate disposition.

60. D — Redness, tenderness, and fever associated with a central line may indicate infection requiring prompt assessment. The nurse should coordinate urgent review and reinforce safety instructions. Cosmetic treatment, delayed laboratory scheduling, and unrelated teaching can postpone needed care. Ambulatory nurses must recognize device-related warning signs and ensure that the patient reaches an appropriate clinician quickly.

61. C — Inability to speak in full sentences with worsening respiratory symptoms can indicate significant compromise. The nurse should use the emergency triage process, assess immediate safety, and arrange prompt evaluation. Routine education, delayed care, and administrative tasks do not address the potential for rapid deterioration. Ambulatory nursing priorities begin with safe disposition when red flags are present.

62. B — A fall with severe headache in a patient taking an anticoagulant warrants urgent assessment for possible bleeding or neurologic injury. The nurse should follow the emergency protocol rather than rely on routine advice. Activity guidance, refill timing, and education are secondary. Safe ambulatory triage identifies the high-risk combination and ensures timely access to definitive evaluation.

63. B — Medication management should begin with reconciliation, assessment of barriers, and a realistic plan that the patient can follow. Tools, schedules, caregiver support, and teach-back may be appropriate. Dismissive directions, unsupervised stopping, and delayed teaching increase the risk of errors. The ambulatory nurse helps translate prescribed treatment into safe daily routines.

64. D — Care coordination should account for access barriers and identify a workable alternative, such as telephone, in-person, or community-supported options. The patient needs clear instructions and confirmed follow-up. Cancelling necessary care, assuming informal support, or documenting without action does not prevent gaps after discharge or support equitable access to ambulatory services.

65. A — Reliable home data depend on appropriate technique, functioning equipment, and consistent measurement conditions. The nurse should review use, identify errors, and determine when repeat readings or clinical review are needed. Diagnosing from one value, discarding all information, or changing treatment without verification can produce unsafe decisions and fails to address the source of inconsistency.

66. C — Supply access can directly affect treatment adherence and safety. The nurse should clarify the barrier, engage appropriate pharmacy, financial, or care-management resources, and communicate with the clinical team. Dismissing the problem, recommending interrupted treatment, or waiting for an emergency does not implement a patient-centered plan or reduce preventable risk. This action supports clear communication and safe ambulatory care.

67. B — Medication management should begin with reconciliation, assessment of barriers, and a realistic plan that the patient can follow. Tools, schedules, caregiver support, and teach-back may be appropriate. Dismissive directions, unsupervised stopping, and delayed teaching increase the risk of errors. The ambulatory nurse helps translate prescribed treatment into safe daily routines.

68. D — Care coordination should account for access barriers and identify a workable alternative, such as telephone, in-person, or community-supported options. The patient needs clear instructions and confirmed follow-up. Cancelling necessary care, assuming informal support, or documenting without action does not prevent gaps after discharge or support equitable access to ambulatory services.

69. C — Reliable home data depend on appropriate technique, functioning equipment, and consistent measurement conditions. The nurse should review use, identify errors, and determine when repeat readings or clinical review are needed. Diagnosing from one value, discarding all information, or changing treatment without verification can produce unsafe decisions and fails to address the source of inconsistency.

70. A — Supply access can directly affect treatment adherence and safety. The nurse should clarify the barrier, engage appropriate pharmacy, financial, or care-management resources, and communicate with the clinical team. Dismissing the problem, recommending interrupted treatment, or waiting for an emergency does not implement a patient-centered plan or reduce preventable risk. This action supports clear communication and safe ambulatory care.

71. B — Medication management should begin with reconciliation, assessment of barriers, and a realistic plan that the patient can follow. Tools, schedules, caregiver support, and teach-back may be appropriate. Dismissive directions, unsupervised stopping, and delayed teaching increase the risk of errors. The ambulatory nurse helps translate prescribed treatment into safe daily routines.

72. C — Care coordination should account for access barriers and identify a workable alternative, such as telephone, in-person, or community-supported options. The patient needs clear instructions and confirmed follow-up. Cancelling necessary care, assuming informal support, or documenting without action does not prevent gaps after discharge or support equitable access to ambulatory services.

73. D — Reliable home data depend on appropriate technique, functioning equipment, and consistent measurement conditions. The nurse should review use, identify errors, and determine when repeat readings or clinical review are needed. Diagnosing from one value, discarding all information, or changing treatment without verification can produce unsafe decisions and fails to address the source of inconsistency.

74. A — Supply access can directly affect treatment adherence and safety. The nurse should clarify the barrier, engage appropriate pharmacy, financial, or care-management resources, and communicate with the clinical team. Dismissing the problem, recommending interrupted treatment, or waiting for an emergency does not implement a patient-centered plan or reduce preventable risk. This action supports clear communication and safe ambulatory care.

75. B — Medication management should begin with reconciliation, assessment of barriers, and a realistic plan that the patient can follow. Tools, schedules, caregiver support, and teach-back may be appropriate. Dismissive directions, unsupervised stopping, and delayed teaching increase the risk of errors. The ambulatory nurse helps translate prescribed treatment into safe daily routines.

76. D — Care coordination should account for access barriers and identify a workable alternative, such as telephone, in-person, or community-supported options. The patient needs clear instructions and confirmed follow-up. Cancelling necessary care, assuming informal support, or documenting without action does not prevent gaps after discharge or support equitable access to ambulatory services.

77. C — Reliable home data depend on appropriate technique, functioning equipment, and consistent measurement conditions. The nurse should review use, identify errors, and determine when repeat readings or clinical review are needed. Diagnosing from one value, discarding all information, or changing treatment without verification can produce unsafe decisions and fails to address the source of inconsistency.

78. A — Supply access can directly affect treatment adherence and safety. The nurse should clarify the barrier, engage appropriate pharmacy, financial, or care-management resources, and communicate with the clinical team. Dismissing the problem, recommending interrupted treatment, or waiting for an emergency does not implement a patient-centered plan or reduce preventable risk. This action supports clear communication and safe ambulatory care.

79. A — Medication management should begin with reconciliation, assessment of barriers, and a realistic plan that the patient can follow. Tools, schedules, caregiver support, and teach-back may be appropriate. Dismissive directions, unsupervised stopping, and delayed teaching increase the risk of errors. The ambulatory nurse helps translate prescribed treatment into safe daily routines.

80. B — Care coordination should account for access barriers and identify a workable alternative, such as telephone, in-person, or community-supported options. The patient needs clear instructions and confirmed follow-up. Cancelling necessary care, assuming informal support, or documenting without action does not prevent gaps after discharge or support equitable access to ambulatory services.

81. C — Reliable home data depend on appropriate technique, functioning equipment, and consistent measurement conditions. The nurse should review use, identify errors, and determine when repeat readings or clinical review are needed. Diagnosing from one value, discarding all information, or changing treatment without verification can produce unsafe decisions and fails to address the source of inconsistency.

82. D — Supply access can directly affect treatment adherence and safety. The nurse should clarify the barrier, engage appropriate pharmacy, financial, or care-management resources, and communicate with the clinical team. Dismissing the problem, recommending interrupted treatment, or waiting for an emergency does not implement a patient-centered plan or reduce preventable risk. This action supports clear communication and safe ambulatory care.

83. B — Medication management should begin with reconciliation, assessment of barriers, and a realistic plan that the patient can follow. Tools, schedules, caregiver support, and teach-back may be appropriate. Dismissive directions, unsupervised stopping, and delayed teaching increase the risk of errors. The ambulatory nurse helps translate prescribed treatment into safe daily routines.

84. C — Care coordination should account for access barriers and identify a workable alternative, such as telephone, in-person, or community-supported options. The patient needs clear instructions and confirmed follow-up. Cancelling necessary care, assuming informal support, or documenting without action does not prevent gaps after discharge or support equitable access to ambulatory services.

85. D — Reliable home data depend on appropriate technique, functioning equipment, and consistent measurement conditions. The nurse should review use, identify errors, and determine when repeat readings or clinical review are needed. Diagnosing from one value, discarding all information, or changing treatment without verification can produce unsafe decisions and fails to address the source of inconsistency.

86. A — Supply access can directly affect treatment adherence and safety. The nurse should clarify the barrier, engage appropriate pharmacy, financial, or care-management resources, and communicate with the clinical team. Dismissing the problem, recommending interrupted treatment, or waiting for an emergency does not implement a patient-centered plan or reduce preventable risk. This action supports clear communication and safe ambulatory care.

87. C — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

88. D — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

89. B — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

90. A — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

91. D — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

92. C — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

93. A — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

94. B — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

95. A — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

96. C — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

97. B — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

98. D — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

99. D — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

100. C — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

101. B — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

102. A — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

103. C — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

104. B — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

105. A — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

106. D — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

107. B — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

108. C — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

109. A — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

110. D — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

111. A — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

112. B — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

113. C — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

114. D — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

115. D — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

116. C — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

117. A — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

118. B — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

119. B — Recurring documentation omissions can create continuity and safety risks. The nurse should use approved reporting and improvement processes to examine the system and prevent recurrence. Ignoring the pattern, correcting only one record, or discussing it outside professional channels does not address the underlying process or support a culture of accountability and learning.

120. A — Scope of practice requires the nurse to recognize authorization limits while ensuring that the patient's need reaches the appropriate decision-maker. Completing the task without authority or asking untrained staff to decide can be unsafe. A refusal without guidance abandons the concern. Clear explanation and timely routing protect the patient and support professional accountability.

121. C — Accessibility concerns should be evaluated as a systems issue using patient input, workflow review, and equitable standards. The nurse leader should identify barriers and support feasible improvements. Dismissing the concern, favoring persistent complainants, or avoiding data undermines inclusive care. Professional advocacy includes helping the organization provide access that respects functional needs and dignity.

122. D — Patient screenshots and other electronic information require the same privacy protections as any clinical record. The nurse should stop unapproved sharing, secure the information, and use the established reporting process. Forwarding it, assuming work purpose removes restrictions, or keeping the issue informal can expand exposure and compromise confidentiality, trust, and organizational compliance.

123. A — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

124. D — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

125. B — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

126. C — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.

127. D — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

128. A — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

129. B — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve

comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

130. C — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.

131. D — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

132. B — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

133. C — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

134. A — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.

135. D — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

136. A — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

137. C — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

138. B — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.

139. D — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

140. B — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

141. A — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

142. C — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.

143. D — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

144. B — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

145. A — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

146. B — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private

setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.

147. C — Teach-back asks the patient to explain the plan in their own words and reveals whether teaching was understood. Agreement alone does not demonstrate comprehension. Repeating information without assessment or ending the session can leave important gaps. The nurse should clarify warning signs, next steps, and contact instructions until the patient can describe safe action.

148. A — Effective education for limited health literacy uses clear language, short instructions, demonstration, and confirmation through teach-back or return demonstration. Technical wording, handouts alone, and assumptions about experience can hide misunderstandings. The nurse should focus on what the patient must do, how to recognize problems, and when to contact the care team.

149. D — Accessible education begins by asking the patient what communication methods are effective, then using appropriate supports and confirming understanding. Speaking louder may not improve comprehension, other patients should not interpret clinical information, and printed material alone may be inadequate. The nurse should adapt teaching so the patient can participate meaningfully in decisions and self-management.

150. C — Family involvement can support care, but patient privacy and preferences guide what may be shared. The nurse should confirm authorization, involve the patient when possible, and use a private setting. Providing unrestricted details, refusing without guidance, or using a public area can undermine trust and fails to balance supportive caregiving with confidentiality obligations.