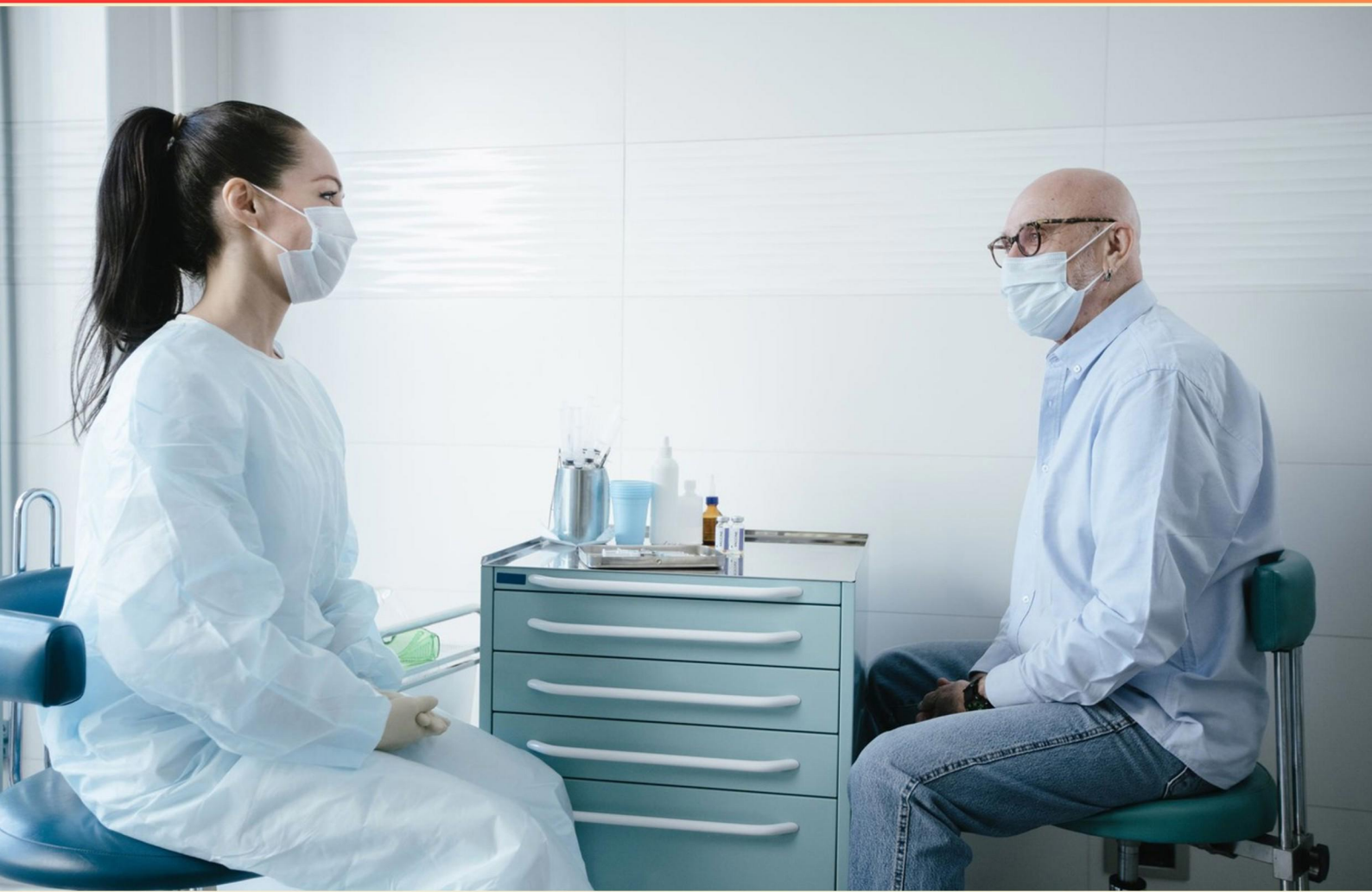


CONTINUITY OF CARE EXAM 2 PRACTICE (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://continuityofcare2.examzify.com>



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. In a root cause analysis, when confusing medication labels contribute to an error, the team should focus on**
 - A. Blaming the nurse
 - B. Fixing the system
 - C. Punishing the staff
 - D. Reassigning patients

- 2. What is the purpose and typical timing of a post-discharge follow-up call?**
 - A. A call within 6 weeks to confirm insurance changes.
 - B. A call only to schedule adult vaccination appointments.
 - C. A call to collect data for research; no patient care purpose.
 - D. A call to check patient status within 48-72 hours, address concerns, verify medications, and encourage adherence and timely follow-up.

- 3. A patient has hypertension, smokes, and has a family history of heart disease. Which factor can the nurse help change?**
 - A. Smoking
 - B. Hypertension
 - C. Family History
 - D. Age

- 4. When using digital tools for education, which practice ensures information quality?**
 - A. Use reliable resources
 - B. Use unverified sources
 - C. Copy patient data
 - D. Ignore credibility

- 5. What are the five RCA steps?**
 - A. Define goal, brainstorm, implement, monitor, escalate.
 - B. Plan, Do, Study, Act.
 - C. Identify problem, collect data, identify resource constraints, recommend actions, and measure effectiveness.
 - D. Observe, hypothesize, test, conclude, report.

- 6. Which term describes a physiological alteration in body structure or function?**
- A. Wellness.
 - B. Illness.
 - C. Health.
 - D. Disease.
- 7. How do interoperability and standardized terminologies support continuity of care?**
- A. They slow data sharing but improve privacy.
 - B. They require identical software platforms for all providers.
 - C. They enable consistent data sharing, reduce misinterpretation, and improve data exchange across systems.
 - D. They are only relevant for billing and not clinical care.
- 8. How should a discharge summary be delivered to ensure timely communication with the primary care provider?**
- A. Mailed paper copy to the primary care provider within a week.
 - B. Hand-delivered to the patient at discharge.
 - C. Electronically and securely to the primary care provider, with copies to the patient, within 24–48 hours per policy.
 - D. Faxed to the patient within 24 hours without PCP copy.
- 9. How does documentation quality impact continuity of care between inpatient and outpatient settings?**
- A. It has minimal impact
 - B. Increases duplication and errors
 - C. Requires only patient signatures
 - D. High-quality, timely, complete documentation ensures accurate knowledge transfer, reduces duplication and errors, and supports safe post-discharge care

10. Which metrics are commonly used to measure the quality of continuity of care?

- A. Number of clinic visits, physician age, medication costs, number of labs drawn.
- B. Staff turnover, device uptime, etc.
- C. Readmission rates, follow-up within 7-14 days, medication reconciliation accuracy, patient satisfaction, and timely discharge summaries.
- D. Time to first appointment universally within 1 day, patient zip code, hospital size, provider gender.

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Answers

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1. B
2. D
3. A
4. A
5. C
6. D
7. C
8. C
9. D
10. C

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Explanations

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1. In a root cause analysis, when confusing medication labels contribute to an error, the team should focus on

- A. Blaming the nurse
- B. Fixing the system**
- C. Punishing the staff
- D. Reassigning patients

When a labeling mix-up leads to an error, the important idea is that safety relies on system design, not on blaming a single person. A root cause analysis aims to uncover how the process allowed the mistake to occur and how to prevent it in the future. This means examining the labeling system itself, the workflow for prescribing and dispensing medications, handoffs from pharmacy to nursing, the clarity of the labels, and how interruptions or look-alike/sound-alike drugs contribute to risk. By making systemic improvements—such as standardizing label formats, using clearer typography, implementing barcode verification, adopting safe prescribing and dispensing workflows, and reducing interruptions—you add multiple layers of protection that reduce reliance on perfect human performance. This approach fosters a safer culture, where learning from errors strengthens processes rather than punishing individuals. Blaming the nurse, punishing staff, or reassigning patients don't address the underlying design flaws and can undermine safety culture.

2. What is the purpose and typical timing of a post-discharge follow-up call?

- A. A call within 6 weeks to confirm insurance changes.
- B. A call only to schedule adult vaccination appointments.
- C. A call to collect data for research; no patient care purpose.
- D. A call to check patient status within 48–72 hours, address concerns, verify medications, and encourage adherence and timely follow-up.**

The main idea here is that a post-discharge follow-up call is a patient-care activity timed to occur soon after leaving the hospital, with the goal of ensuring a safe transition back home. The best choice emphasizes checking on the patient's status within 48–72 hours, addressing any concerns, verifying the medication list and any changes made during the hospital stay, encouraging adherence to the treatment plan, and prompting attendance at timely follow-up appointments. This timing matters because problems often arise soon after discharge—signs of complications, misunderstandings about medications, or lapses in following the plan can lead to readmission if not caught early. A well-structured call helps catch these issues early, provides reassurance, and reinforces what the patient needs to do next. The other options don't fit the typical purpose or timing: calling within 6 weeks to confirm insurance changes focuses on administrative details rather than patient safety, and is not the immediate post-discharge care touchpoint. Scheduling adult vaccination appointments is not the primary purpose of a post-discharge call, which is about recovery and care transitions. Collecting data for research with no patient care purpose misses the essential aim of safeguarding the patient's health and coordinating ongoing care.

3. A patient has hypertension, smokes, and has a family history of heart disease. Which factor can the nurse help change?

- A. Smoking**
- B. Hypertension
- C. Family History
- D. Age

The main idea here is identifying what the patient can change. Some cardiovascular risk factors are modifiable, meaning they can be altered through behavior, treatment, or lifestyle changes, and the nurse plays a key role in guiding those changes. Smoking is a behavior the nurse can directly address with the patient—offer brief counseling, help set a quit date, connect them with cessation programs, and consider nicotine replacement or other medications. Quitting smoking can quickly improve cardiovascular risk and make other factors (like hypertension) easier to control over time. Age and family history are non-modifiable; they cannot be changed by nursing intervention. Hypertension is modifiable too, but it often requires ongoing treatment and adherence rather than a single, immediate change, so the factor most clearly and directly changeable through nursing support in this scenario is smoking.

4. When using digital tools for education, which practice ensures information quality?

- A. Use reliable resources**
- B. Use unverified sources
- C. Copy patient data
- D. Ignore credibility

Relying on reliable resources is the way to ensure information quality when using digital tools for education. Credible sources come from authors or organizations with qualifications, transparent authorship, up-to-date content, and, ideally, peer review or official guidelines. This combination helps guarantee accuracy, reduces bias, and provides evidence you can verify and cite. Unverified sources can spread errors or outdated information, copying patient data is unethical and unsafe, and ignoring credibility leads to weak learning and potentially harmful decisions. So the best practice is to choose resources that are reputable, clearly sourced, and current.

5. What are the five RCA steps?

- A. Define goal, brainstorm, implement, monitor, escalate.
- B. Plan, Do, Study, Act.
- C. Identify problem, collect data, identify resource constraints, recommend actions, and measure effectiveness.**
- D. Observe, hypothesize, test, conclude, report.

Root Cause Analysis is about moving from identifying a problem to implementing fixes and confirming they work. The best five-step sequence here follows that logical path: first clearly identify the problem so everyone agrees on what needs to be fixed; next gather data to understand what happened and what evidence points to underlying causes; then consider resource constraints to ensure proposed solutions are feasible and won't create new barriers; next develop and propose actions aimed at addressing the root causes discovered; finally measure the effectiveness of those actions to verify the issue is resolved and to prevent recurrence. This structure keeps the focus on understanding causes, planning concrete, feasible remedies, and validating their impact. The other options mix in elements from project management, the classic PDCA cycle, or the scientific method, but they don't emphasize a five-step RCA flow that centers on problem definition, data-driven analysis of root causes (including feasibility), concrete corrective actions, and verification of results.

6. Which term describes a physiological alteration in body structure or function?

- A. Wellness.
- B. Illness.
- C. Health.
- D. Disease.**

A physiological alteration in body structure or function is best described as disease. Disease refers to a deviation from normal biology that affects the body's structure or function and is often accompanied by signs, symptoms, or measurable pathology. It captures the idea of an abnormal process that disrupts homeostasis and can arise from infection, injury, genetic factors, or other disease processes. Illness, by contrast, is the patient's subjective experience of feeling unwell, which may occur with or without a defined disease. Health and wellness describe a state of functioning well and absence of disease. So disease is the term that specifically designates an abnormal, measurable alteration in the body's structure or function.

7. How do interoperability and standardized terminologies support continuity of care?

- A. They slow data sharing but improve privacy.
- B. They require identical software platforms for all providers.
- C. They enable consistent data sharing, reduce misinterpretation, and improve data exchange across systems.**
- D. They are only relevant for billing and not clinical care.

Interoperability and standardized terminologies enable data to move between different health IT systems in a way that each system can interpret correctly. When systems share information using common codes and formats, clinicians see the same patient data—diagnoses, labs, medications, and care plans—across settings. This reduces misinterpretation and makes data exchange across networks smoother and faster, which supports safer, more coordinated care during transitions. Standards like SNOMED CT for problems, LOINC for labs, RxNorm for meds, and FHIR for data exchange provide the semantic glue that keeps meaning intact even when the originating system differs. It's not about using identical software platforms; it's about agreeing on common languages and interfaces so information flows reliably.

8. How should a discharge summary be delivered to ensure timely communication with the primary care provider?

- A. Mailed paper copy to the primary care provider within a week.
- B. Hand-delivered to the patient at discharge.
- C. Electronically and securely to the primary care provider, with copies to the patient, within 24–48 hours per policy.**
- D. Faxed to the patient within 24 hours without PCP copy.

Getting discharge information to the primary care provider quickly and securely is essential for safe and coordinated transitions of care. Delivering the discharge summary electronically to the PCP, with copies sent to the patient, within 24–48 hours per policy, ensures the clinician who will manage follow-up has timely access to the hospitalization details, medications, and care plan. This rapid, secure transmission supports prompt adjustments to treatment, reduces the risk of gaps in care, and maintains an audit trail for privacy and accountability. Mailed paper copies within a week can miss critical follow-up windows and delay needed actions. Hand-delivering to the patient at discharge fails to notify the PCP promptly, hindering continuity of care. Faxing to the patient without providing a PCP copy omits the clinician responsible for ongoing management and may not meet privacy or policy requirements.

9. How does documentation quality impact continuity of care between inpatient and outpatient settings?

- A. It has minimal impact
- B. Increases duplication and errors
- C. Requires only patient signatures
- D. High-quality, timely, complete documentation ensures accurate knowledge transfer, reduces duplication and errors, and supports safe post-discharge care**

High-quality documentation is essential for how care information moves from hospital to the next care setting. When the inpatient record is timely, complete, and accurate, the outpatient clinicians receive a clear picture of what happened during the hospitalization: why the patient was admitted, what diagnoses were made, what treatments and medications were started or changed, any test results or pending issues, and a precise discharge plan with follow-up steps. This seamless transfer allows the outpatient team to continue care safely, avoids repeating tests or duplicating orders, and minimizes medication errors or conflicting instructions. It also supports patient safety after discharge by making sure the plan for ongoing monitoring, follow-up appointments, and patient education is understood and actionable. If documentation is incomplete or delayed, teams may duplicate tests, miss important medication changes, or misinterpret the current care plan, increasing the risk of errors and readmissions. Discharge summaries, updated med lists, problem lists, and clear follow-up instructions are all part of this transfer of knowledge, and they empower safe, coordinated care. So the best choice reflects that high-quality, timely, complete documentation ensures accurate knowledge transfer, reduces duplication and errors, and supports safe post-discharge care.

10. Which metrics are commonly used to measure the quality of continuity of care?

- A. Number of clinic visits, physician age, medication costs, number of labs drawn.
- B. Staff turnover, device uptime, etc.
- C. Readmission rates, follow-up within 7-14 days, medication reconciliation accuracy, patient satisfaction, and timely discharge summaries.**
- D. Time to first appointment universally within 1 day, patient zip code, hospital size, provider gender.

Continuity of care quality is about how well care is coordinated across encounters and settings, ensuring information, medications, and follow-up plans move smoothly with the patient. The best measures reflect that coordination: readmission rates signal whether gaps in care or communication led to problems after discharge; follow-up within 7-14 days shows ongoing monitoring and engagement with the patient after an visit or discharge; medication reconciliation accuracy reduces discrepancies as patients move between providers and settings; patient satisfaction captures the patient's experience of communication and continuity; and timely discharge summaries ensure the next care team has complete, up-to-date information to continue care. Other options include factors like visit counts, age, costs, device uptime, or demographics, which don't directly assess how well care is coordinated across transitions.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://continuityofcare2.examzify.com>

We wish you the very best on your exam journey. You've got this!

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