COORDINATOR OF CARE EXAM 5 PRACTICE (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://coordinatorofcare5.examzify.com

Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright 1

Table of Contents 2

Introduction 3

How to Use This Guide 4

Questions 5

Answers 8

Explanations 10

Next Steps 15

SAMPLE

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.

SAMPLE

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!

SAMPLE

Questions

SAMPLE

1. Describe a care coordination metric to monitor care transitions.

A. Time to first post-discharge follow-up (within 7 days) or 30-day readmission rate for target conditions.

B. Number of patient admissions per month.

C. Average hospital length of stay.

D. Total number of emails sent to the care team.

2. Which statement best describes indirect care?

A. Interventions performed through interaction with the client

B. Interventions performed away from but on behalf of the client

C. Nursing actions that require patient consent

D. Activities done only in emergency situations

3. Which is NOT a typical telehealth component in care coordination?

A. Remote monitoring.

B. Virtual visits.

C. Improved access.

D. Home safety checks.

4. What term best describes the process of recognizing a patient problem, analyzing clinical data, evaluating information, and drawing conclusions?

A. Memorization

B. Documentation

C. Critical Thinking

D. Routine Care

5. In a nursing diagnosis, which of the following is an etiological factor?

A. Diagnostic label

B. Etiology

C. Cues

D. Interventions

SAMPLE

6. What should documenting care coordination activities include?

A. Dates, participants, interventions, outcomes, follow-up plans, and standardized templates for audit trails.

B. Only billing codes.

C. Personal opinions of staff.

D. Narratives without templates.

7. Which statement best describes a time-limited goal in care planning?

A. It must have a time frame for completion.

B. It must be decided by the physician.

C. It has no deadline.

D. It is always long-term.

8. Which two tasks can nurses NEVER delegate?

A. Medication administration and evaluation

B. Teaching and assessment

C. Documentation and monitoring

D. Patient education and care planning

9. Which statement illustrates a single, specific action?

A. The client will walk

B. The client will ambulate

C. The client will move around

D. The client will walk 20 feet down the hall with a walker

10. Assessment in nursing is defined as?

A. Systemic and continuous collection of data including history, physical exam, and lab/diagnostic tests

B. Planning patient care

C. Implementing interventions

D. Evaluating outcomes

SAMPLE

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Describe a care coordination metric to monitor care transitions.

A. Time to first post-discharge follow-up (within 7 days) or 30-day readmission rate for target conditions.

B. Number of patient admissions per month.

C. Average hospital length of stay.

D. Total number of emails sent to the care team.

Effective care transitions are supported by measuring whether patients get timely follow-up after discharge. Tracking time to the first post-discharge follow-up within a short window (like seven days) directly assesses whether a patient is connected to ongoing care after leaving the hospital, a critical moment where gaps can lead to problems. Pairing that process measure with an outcome like the 30-day readmission rate for targeted conditions gives a fuller view of transition quality: timely follow-up should help prevent preventable readmissions, so lower readmission rates indicate better coordination of post-discharge care. The other options don't focus on what happens as patients move from hospital to home. The number of patient admissions per month is a volume metric and doesn't reflect transition quality. The average hospital length of stay is an inpatient efficiency metric, not about post-discharge care. The total number of emails sent to the care team is a process detail that isn't standardized or tied to patient outcomes.

2. Which statement best describes indirect care?

A. Interventions performed through interaction with the client

B. Interventions performed away from but on behalf of the client

C. Nursing actions that require patient consent

D. Activities done only in emergency situations

Indirect care means nursing actions done away from the patient that support care on the patient's behalf. This covers coordinating with other health professionals, planning and organizing resources, documenting care, advocating for the patient, and arranging referrals or discharge planning. These tasks enable and improve the patient's care without the nurse being directly at the bedside with the patient. This is why the statement describing interventions performed away from the client but on behalf of the client is the best fit. It contrasts with direct care, which involves hands-on activities with the patient. Actions that require the patient's consent relate to direct involvement, and activities limited to emergencies often involve immediate direct interaction with the patient.

3. Which is NOT a typical telehealth component in care coordination?

A. Remote monitoring.

B. Virtual visits.

C. Improved access.

D. Home safety checks.

Telehealth in care coordination centers on delivering clinical services and coordinating care through technology that enables remote data exchange and communication. Remote monitoring fits this because devices can continuously send patient data to the care team for ongoing management. Virtual visits align with telehealth by allowing video encounters that replace or supplement in-person visits. Improved access is a natural outcome of telehealth, reducing barriers like travel time and scheduling delays so patients receive timely care. Home safety checks, however, focus on inspecting the patient's living environment for hazards. That type of assessment is typically done in person by home health or occupational therapy professionals. While telehealth can support education and counseling about home safety, the actual safety-check process is not a standard telehealth service in care coordination.

SAMPLE

4. What term best describes the process of recognizing a patient problem, analyzing clinical data, evaluating information, and drawing conclusions?

A. Memorization

B. Documentation

C. Critical Thinking

D. Routine Care

Critical thinking is the process described here. It's about applying reasoned judgment to patient data: first recognizing that something isn't right, then analyzing the gathered information (history, exam findings, labs, imaging), evaluating the relevance and quality of that information, and drawing informed conclusions about the patient's problem. This reasoning leads to a thoughtful plan of care based on evidence and clinical context. Memorization is just recalling facts without integrating new data. Documentation is about recording information. Routine care involves performing standard tasks and procedures, not necessarily engaging in analytical decision-making.

5. In a nursing diagnosis, which of the following is an etiological factor?

A. Diagnostic label

B. Etiology

C. Cues

D. Interventions

In a nursing diagnosis, the piece that explains why the problem exists is the etiology. It identifies the cause or contributing factors that link the problem to its origin. Nursing diagnoses are typically framed with Problem, Etiology, and Defining Characteristics (cues). The etiologic factor is not the problem label, nor the cues (which are the observable manifestations), nor the interventions. For example, in a statement like "Acute pain related to tissue injury from surgery," the etiologic factor is the tissue injury from surgery—the cause that explains why the patient is experiencing pain. The cues would be the patient's pain reports, facial grimacing, guarding, restlessness, etc., and the interventions would be actions to relieve the pain. So the etiologic factor corresponds to the etiology—the underlying cause or contributing factor.

6. What should documenting care coordination activities include?

A. Dates, participants, interventions, outcomes, follow-up plans, and standardized templates for audit trails.

B. Only billing codes.

C. Personal opinions of staff.

D. Narratives without templates.

Documentation of care coordination should capture when actions occurred, who was involved, what interventions were performed, the outcomes observed, and the planned follow-up, using standardized templates to create a clear audit trail. Dates establish timing and sequence across providers; noting participants clarifies roles and responsibilities; recording interventions details the concrete steps taken; documenting outcomes shows the impact on the patient's care; outlining follow-up plans guides future care and accountability. Standardized templates ensure consistency, enable efficient review, and support interoperability and quality improvement. Focusing only on billing codes misses the clinical coordination details, personal opinions lack objectivity, and free-text narratives without templates can be inconsistent and hard to audit or share.

SAMPLE

7. Which statement best describes a time-limited goal in care planning?

A. It must have a time frame for completion.

B. It must be decided by the physician.

C. It has no deadline.

D. It is always long-term.

Time-limited goals in care planning are defined by having a specific time frame for completion. That deadline lets the care team and the patient track progress, evaluate whether interventions are working, and adjust the plan if needed. It also creates accountability and helps organize follow-up actions and resources. In practice, goals are a collaborative decision, not driven solely by the physician. A goal isn't without a deadline—that would contradict the idea of being time-limited. And a time-limited goal isn't necessarily long-term; it can be short-term or long-term as long as there is a defined deadline to reach the target. For example, "increase ambulation distance to 150 feet within 3 weeks" has a clear timeframe and can be measured.

8. Which two tasks can nurses NEVER delegate?

A. Medication administration and evaluation

B. Teaching and assessment

C. Documentation and monitoring

D. Patient education and care planning

The key idea here is that some nursing tasks require independent professional judgment and accountability that cannot be shifted to others. Teaching and assessment fit this requirement because they involve deciding what the patient needs to learn, tailoring information to the individual, and evaluating whether learning and understanding have occurred. When you teach, you're not just delivering facts—you're assessing the patient's baseline knowledge, learning needs, and readiness, and you must ensure comprehension and safety. When you assess, you're interpreting data, forming nursing judgments, and determining the next steps in the care plan; that interpretive work cannot be delegated to someone without nursing authority. Other tasks can be delegated under proper supervision and within scope, such as routine data collection or monitoring, but the responsibility for making clinical judgments and providing individualized education remains with the nurse.

9. Which statement illustrates a single, specific action?

A. The client will walk

B. The client will ambulate

C. The client will move around

D. The client will walk 20 feet down the hall with a walker

In care planning, goals should be specific, observable, and measurable. The statement that describes walking a defined distance with an assistive device meets that need because it spells out exactly what the patient will do, how far, and with what aid. This makes the action observable and assessable—you can watch the patient walk 20 feet down the hall using a walker and determine whether the goal was achieved. The other options are too vague or broad: simply saying "walk" or "ambulate" lacks distance and method, and "move around" is unclear and not easily measured. By specifying both distance and assistive device, the chosen statement provides a single, concrete action that can be observed in a single session.

SAMPLE

10. Assessment in nursing is defined as?

A. Systemic and continuous collection of data including history, physical exam, and lab/diagnostic tests

B. Planning patient care

C. Implementing interventions

D. Evaluating outcomes

Assessment is the systematic, ongoing collection of data about a patient, including history, physical examination, and lab/diagnostic tests. This phase establishes the patient's current health status, identifies problems and risks, and provides the information needed to diagnose, plan, implement, and evaluate care. It combines subjective data (what the patient reports) with objective data (what you observe or measure) and is repeated as conditions change to keep the care plan accurate. Planning, implementing, and evaluating are separate steps that follow the assessment.

SAMPLE

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://coordinatorofcare5.examzify.com

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

SAMPLE