PassQueen
a.k.a dumpsqueen.com

Certified Professional in Health Care Risk Management ()

ASHRM CPHRM

Version Demo

Total Demo Questions: 14

Total Premium Questions: 140

Buy Premium PDF

https://passqueen.com

support@passqueen.com

Topic Break Down

Topic	No. of Questions
Topic 1, Risk Management Professionalism	27
Topic 2, Healthcare Operations	24
Topic 3, Clinical/Patient Safety	44
Topic 4, Claims and Litigation	23
Topic 5, Risk Financing	19
Topic 6, Emergency Management	3
Total	140

QUESTION NO: 1

Which type of information was associated with the former HIPDB (now within NPDB) but not the original NPDB focus?

A. Fraud/abuse-related actions and exclusions involving providers/suppliers (HIPDB purpose)

B. Restaurant health inspections

C. Public voter registration files

D. School disciplinary actions

ANSWER: A

Explanation:

Fraud/abuse-related actions and exclusions involving providers/suppliers (HIPDB purpose) is correct because the Healthcare Integrity and Protection Data Bank was created under Section 1128E of the Social Security Act to support efforts against health care fraud and abuse. Its reporting scope included specified final adverse actions and exclusions imposed against health care providers, suppliers, and practitioners, including actions connected to fraud, abuse, licensing, certification, and program participation. This focus extended beyond the original National Practitioner Data Bank's central purpose of improving health care quality by making certain information concerning practitioners' professional competence and conduct available to eligible entities conducting credentialing and privileging activities. In 2013, the separate HIPDB was merged into the NPDB. The NPDB now receives and discloses the applicable reports through one system, but risk managers should recognize the historical distinction because it explains why the modern database includes both practitioner-quality information and integrity-related actions involving a broader range of health care entities. Appropriate querying and reporting help organizations make informed credentialing, employment, contracting, and compliance decisions. HRSA describes the NPDB and its reporting framework at https://www.npdb.hrsa.gov/; the statutory basis for the former HIPDB is available at https://www.govinfo.gov/content/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap7-subchapXI-partA-sec1320a-7e.pdf.

QUESTION NO: 2

Which of the following analyses is required as part of the sentinel event process of The Joint Commission?

A. fishbone diagram of the causal factors

B. Pareto chart outlining the problems identified and the priorities for improvement

C. action plan listing the steps for improvement and the dates of implementation for each step

D. flow chart listing the responsibilities for each of the departments involved

ANSWER: C

Explanation:

The Joint Commission's sentinel event process requires the organization to complete a thorough and credible comprehensive systematic analysis and to develop an action plan that responds to the identified root causes and contributing factors. Therefore, *action plan listing the steps for improvement and the dates of implementation for each step* is the required component represented by the available choices. A credible action plan translates the findings of the investigation into specific system-level improvements, identifies who is accountable for carrying out each intervention, and establishes implementation time frames. It also supports leadership oversight and follow-up monitoring to determine whether the changes have been implemented and are reducing the risk of recurrence. This emphasis ensures that the sentinel event review produces sustained patient-safety improvement rather than merely documenting what happened. The Joint Commission evaluates whether the submitted response includes an analysis that is sufficiently thorough and an action plan that addresses the vulnerabilities identified through that analysis. Its Sentinel Event Policy and Procedures describe the expectations for completing a comprehensive systematic analysis and an action plan after a reviewable sentinel event. See The Joint Commission Sentinel Event Policy and Procedures and The Joint Commission Sentinel Event resources.

QUESTION NO: 3

Information from the Data Bank (NPDB; includes former HIPDB content) can be requested by:

A. Any member of the public

B. Professional societies with formal peer review (as permitted)

C. Social media investigators

D. Patients requesting a clinician's full file

ANSWER: B

Explanation:

Professional societies with formal peer review (as permitted) is correct because the National Practitioner Data Bank permits certain professional societies to query information when they have a formal peer-review process and use the information for a statutorily authorized purpose related to the quality of health care. This access supports legitimate professional oversight by allowing an eligible society to obtain relevant reports about practitioners or entities when conducting peer review consistent with applicable federal requirements. The Data Bank is not a public-record system; its information is confidential and may be disclosed only to authorized entities and individuals for specifically permitted purposes. For risk-management professionals, this limitation is important because appropriate use of Data Bank information can support informed credentialing, professional review, and patient-safety activities, while improper access or disclosure can create compliance and confidentiality concerns. The Health Resources and Services Administration identifies professional societies with formal peer-review processes among the types of organizations eligible to query, subject to the applicable eligibility and use requirements. See the National Practitioner Data Bank and HRSA's NPDB Guidebook resources for current querying eligibility, registration, and confidentiality guidance.

QUESTION NO: 4

After an emergency exercise, a hospital identifies that its backup communication method cannot reliably reach off-duty clinical staff. Which action best demonstrates an effective emergency-management improvement process?

A. File the exercise report and revisit the issue during the next annual exercise.

B. Assign responsibility and deadlines for corrective actions, then test the revised communication process.

C. Provide a general reminder that staff should keep contact information current.

D. Purchase additional radios without evaluating how they will be used or tested.

ANSWER: B

Explanation:

Assign responsibility and deadlines for corrective actions, then test the revised communication process is correct because exercises are intended to identify gaps and drive measurable improvement. The organization should document the deficiency, identify accountable leaders, establish corrective actions and timeframes, implement the revised process, and evaluate whether the change works through testing or a subsequent exercise.

Simply filing the exercise report or repeating education does not establish that the communication failure has been corrected. Purchasing technology without a defined implementation and testing plan likewise does not demonstrate operational readiness. Emergency management requires an ongoing cycle of assessment, planning, training, testing, corrective action, and reassessment.

QUESTION NO: 5

A healthcare entity has a large fleet of vehicles driven by employees. What is the minimum required documentation the entity should obtain for each driver on an annual basis?

A. mileage log

B. driving record

C. driver training

D. proof of insurance

ANSWER: B

Explanation:

driving record is the appropriate annual documentation because an up-to-date motor vehicle record provides objective evidence of each employee-driver's current license status and driving history. For a healthcare entity operating a fleet, annual review supports a continuing driver-qualification process rather than relying only on information collected at hire. The record can identify license suspensions, revocations, disqualifying violations, or other changes that may affect whether a worker may safely operate an organization vehicle. This review helps risk management apply fleet eligibility standards consistently, document oversight, and take timely action when a driver's status no longer meets organizational requirements. Annual motor-vehicle-record checks are also a widely used fleet-safety control because motor-vehicle crashes are a significant occupational safety exposure, including for employees whose primary jobs are not transportation. OSHA recommends employer motor-vehicle safety programs that include selecting qualified drivers and managing safe driving risk. The National Highway Traffic Safety Administration likewise identifies driver screening and monitoring as core elements of employer traffic-safety programs. Maintaining the driving record in the driver qualification or personnel file establishes a defensible record of this ongoing review. See OSHA's Motor Vehicle Safety guidance and NHTSA employer traffic-safety resources.

QUESTION NO: 6

When CPOE is implemented, there is almost always a decline in:

A. Medication errors related to prescribing/transcription

B. Nurse staffing requirements

C. Patient acuity

D. The need for clinical decision-making

ANSWER: A

Explanation:

Medication errors related to prescribing/transcription is correct because computerized provider order entry (CPOE) replaces handwritten and verbally relayed orders with electronic orders that are legible, complete, time-stamped, and transmitted directly to the systems and staff responsible for carrying them out. This reduces common vulnerabilities in the prescribing and transcription stages, including misinterpretation of handwriting, omitted order details, duplicate manual entry, and communication errors during order transfer. CPOE can also standardize required fields and connect ordering to medication lists, allergies, laboratory results, and clinical decision support. These functions help clinicians identify and correct potentially unsafe orders before they reach dispensing or administration workflows. From a health care risk-management perspective, the principal patient-safety benefit of CPOE is therefore the reduction of preventable medication-order errors at their source, while also improving the traceability of who entered, changed, and acknowledged an order. Effective implementation requires workflow design, training, monitoring, and governance, but reducing prescribing and transcription-related medication errors is a well-established intended safety outcome. The Agency for Healthcare Research and Quality describes CPOE as a health IT intervention that can reduce medication errors, and the Joint Commission identifies electronic order processes as an important medication-management safety control. See AHRQ PSNet: Computerized Provider Order Entry and The Joint Commission: Medication Safety.

QUESTION NO: 7

Which of the following risk management documents in a policy and procedure manual should be approved by an organization's board of directors?

A. philosophy regarding medical error management

B. risk management department's annual budget

C. risk analysis

D. departmental personnel job descriptions

ANSWER: A

Explanation:

The **philosophy regarding medical error management** is the appropriate document for board approval because it is a high-level governance statement, rather than a departmental operating tool. A medical-error-management philosophy establishes the organization's fundamental commitments concerning patient safety, reporting and learning from adverse events, accountability, disclosure, and improvement of systems of care. These commitments set expectations for organizational culture and guide the development of more detailed policies, procedures, and operational practices throughout the enterprise.

Board approval is appropriate because a hospital's governing body is accountable for the overall conduct of the institution and for ensuring that the organization has effective policies supporting quality care and patient safety. In particular, the Medicare hospital Conditions of Participation assign the governing body responsibility for ensuring that care is provided in a safe environment and that the hospital has effective quality-assessment and performance-improvement arrangements. A board-approved philosophy gives executive leadership and the risk management function a clear, durable mandate for error prevention, transparent reporting, and organizational learning. It also demonstrates governance-level oversight of risks that affect patient harm, professional liability exposure, regulatory obligations, and public trust. See the CMS governing-body requirements at 42 CFR § 482.12 and ASHRM's overview of health care risk management at ASHRM: About Health Care Risk Management.

QUESTION NO: 8

Whenever possible, medication orders should be by:

A. Brand name

B. Dose (explicit numeric dose and units)

C. Color coding

D. Verbal shorthand

E. Generic name

ANSWER: E

Explanation:

Generic name is correct because medication orders should use a drug's established, nonproprietary name whenever feasible. Generic naming provides a single standardized identifier for the active medication ingredient, supporting clear communication among prescribers, pharmacists, nurses, and patients. This approach is particularly important when a medication may be marketed under multiple brand names or when a health care organization's formulary supplies a therapeutically equivalent product from a different manufacturer. Using the generic name promotes consistent formulary management, helps pharmacy verification and dispensing processes identify the intended active ingredient, and reduces the opportunity for confusion created by proprietary naming conventions.

The U.S. Food and Drug Administration describes a generic drug name as the established name associated with the drug's active ingredient and explains that generic medicines have the same active ingredient as their brand-name counterparts. In medication-safety practice, standardizing medication nomenclature is a foundational control because it improves the reliability of ordering and communication across transitions of care. The order must still contain all clinically necessary prescription elements, including the intended dose, route, frequency, and other applicable directions; however, the naming

convention requested by this question is the generic name. See the FDA's Generic Drug Facts and the Institute for Safe Medication Practices' medication-safety recommendations.

QUESTION NO: 9

An organization has recently changed insurance. The risk manager receives a claim from a former patient on July 3, 2004, claiming injury and alleging negligence by the surgery staff on September 5, 2003. Which of the following would apply to this claim?

a claims-made policy for the period 1/1/03 to 1/1/04 with a retro date of 1/1/02

an occurrence policy for the period 1/1/03 to 1/1/04

a claims-made policy for the period 1/1/03 to 1/1/04 with a 1-year tail coverage

an occurrence policy for the period 1/1/04 to 1/1/05

A. 1 and 2 only

B. 1 and 4 only

C. 2 and 3 only

D. 3 and 4 only

ANSWER: C

Explanation:

The correct response is **"2 and 3 only."** The alleged negligent surgical care occurred on September 5, 2003. An occurrence policy responds when the covered injury-causing event occurs during its policy period, regardless of the later date on which the patient presents the claim. Because the occurrence policy ran from January 1, 2003, through January 1, 2004, the September 2003 event falls within that coverage period. This reflects the fundamental occurrence-based coverage trigger used in health care professional liability risk financing.

The claims-made policy with a one-year tail also applies. The retroactive date of January 1, 2002, preserves coverage for the September 2003 alleged act because it occurred after that date. More importantly, the one-year extended reporting period, commonly called tail coverage, permits reporting of a claim after the claims-made policy expires. The claim was received on July 3, 2004, which is within one year after the policy's January 1, 2004 expiration. Therefore, the tail allows the organization to report this otherwise timely covered claim under the prior claims-made policy. ASHRM risk-financing education emphasizes evaluating both the policy's coverage trigger and reporting-period provisions when determining liability coverage. See ASHRM Academy and the NAIC insurance coverage terminology overview.

QUESTION NO: 10

Documentation that assists with defense of a malpractice claim

A. contains subjective comments about the patient.

B. describes the provider's clinical decision-making process.

C. is not important if the claim happened in prior years.

D. does not need to be complete or timely.

ANSWER: B

Explanation:

Documentation that *describes the provider's clinical decision-making process* best assists in defending a malpractice claim because the health record is the contemporaneous evidence of what was assessed, decided, communicated, and done

during care. A clear record connects relevant history and examination findings with the clinician's assessment, diagnostic or treatment choices, consultations, patient education, informed-consent discussion when applicable, and follow-up or escalation plan. This creates a reliable factual account from which the reasonableness of care can be evaluated against the applicable standard of care.

For risk-management purposes, the documentation should be accurate, objective, complete, timely, and attributable to the author. Recording the rationale for material clinical decisions is especially valuable when several reasonable care paths exist, when a patient declines a recommendation, or when a condition changes over time. It helps demonstrate that decisions were based on the information available at the time of the encounter rather than reconstructed after an adverse outcome. The American Health Information Management Association describes the legal health record as the organization's business record of patient care, while the Centers for Medicare & Medicaid Services emphasizes complete and accurate medical-record documentation. See AHIMA's guidance on the legal health record and CMS documentation guidance.

QUESTION NO: 11

A doctor fails to administer an indicated test, and the patient deteriorates and must be admitted. This is an example of:

A. Diagnostic error (delay/omission in diagnostic process)

B. Risk financing error

C. Contracting breach

D. Facility security event

ANSWER: A

Explanation:

Diagnostic error (delay/omission in diagnostic process) is correct because an indicated diagnostic test is a key part of gathering and interpreting clinical information needed to establish, confirm, or rule out a diagnosis. When the test is not performed, the diagnostic process is incomplete. That omission can prevent timely recognition of a worsening condition and delay appropriate treatment or escalation of care. In this scenario, the patient's deterioration and subsequent admission demonstrate patient harm associated with the missed diagnostic step, making the event particularly relevant for risk-management review. The National Academies defines diagnostic error as failure to establish an accurate and timely explanation of a patient's health problem or to communicate that explanation to the patient; omitted testing can directly contribute to such a failure. AHRQ's diagnostic-safety resources likewise identify breakdowns in testing processes, including failures to order, perform, follow up, or act on tests, as important sources of diagnostic harm. Risk management should evaluate the clinical decision-making, test-ordering and completion workflow, communication, documentation, and any system factors that allowed the indicated test to be missed. See the National Academies' Improving Diagnosis in Health Care report and AHRQ's Diagnostic Safety resources.

QUESTION NO: 12

What factors are included in a calculation of Risk Priority Number (RPN) in FMEA?

A. Severity, occurrence (probability), detection

B. Cost, staff satisfaction, marketing risk

C. Legal privilege, media attention, reputation

D. Insurance premiums, deductibles, coinsurance

ANSWER: A

Explanation:

Severity, occurrence (probability), detection is correct because the traditional Failure Modes and Effects Analysis method calculates a Risk Priority Number by multiplying ratings for severity, occurrence, and detection. Severity represents the

seriousness of the effect if a failure reaches the patient or other end user. Occurrence estimates how frequently or likely the failure mode is expected to happen. Detection evaluates the likelihood that existing process controls will identify the failure before it results in the anticipated effect; a lower likelihood of detection receives a higher detection rating. The resulting numerical score supports a structured, prospective comparison of failure modes so an interdisciplinary team can identify priorities for risk reduction. In health care, FMEA is used to examine vulnerable processes before an adverse event occurs, such as medication-use workflows, patient identification, or handoffs. Although organizations should not rely on the RPN alone and may give immediate attention to any catastrophic-severity risk, severity, occurrence, and detection are the established inputs to the conventional RPN calculation. The Institute for Healthcare Improvement describes FMEA as a proactive method for identifying and preventing process failures, while AHRQ provides health care tools and resources for applying this approach. See the Institute for Healthcare Improvement FMEA tool and AHRQ's health care FMEA resources.

QUESTION NO: 13

According to The Joint Commission, which of the following should be done to patient-owned electrical devices entering the facility?

A. inventory with patient belongings

B. sequester the electrical device

C. conduct an electrical safety inspection

D. tag by biomedical engineering

ANSWER: C

Explanation:

conduct an electrical safety inspection is correct because a healthcare organization must control the electrical-safety risks created when a patient brings personally owned electrical equipment into the facility. Before the device is permitted for use, the organization should inspect it under its established electrical-equipment safety process. This evaluation verifies that the device and its power cord, plug, insulation, and other accessible components are in safe condition and that its intended use will not introduce shock, fire, overheating, or other environmental risks in the patient-care setting. The process also enables the organization to identify devices that need to be removed from service, restricted, repaired, or replaced before they can create harm.

This approach is consistent with The Joint Commission's Environment of Care expectations that hospitals manage risks associated with the safety and use of equipment in the physical environment. It also aligns with CMS guidance applying the Life Safety Code and NFPA electrical-safety requirements, under which facilities must ensure electrical equipment used in the building is maintained and safe for use. The inspection may be performed by qualified personnel under the organization's policy, but the core action is the safety evaluation before use. See The Joint Commission's Environment of Care standards overview and CMS's State Operations Manual, Appendix Z.

QUESTION NO: 14

A risk manager is reviewing the professional liability insurance policy for the limits of liability. Which of the following should the risk manager review FIRST?

A. conditions

B. exclusions

C. declaration

D. insuring agreement

ANSWER: C

Explanation:

The declaration is the appropriate first document to review because it is the policy's schedule of individualized coverage information. For a professional liability policy, it ordinarily identifies the named insured, policy period, applicable coverage form, and—most importantly for this review—the stated limit of liability. The risk manager can use the declaration to promptly identify the per-claim or per-occurrence limit, the aggregate limit, and any deductible or self-insured retention that affects the organization's retained financial exposure. It also commonly identifies endorsements that may modify the basic policy terms and therefore should be examined after the limits have been located. Starting with the declaration gives the risk manager an efficient, high-level confirmation of the amount of insurance purchased before conducting a more detailed analysis of the operative policy language and endorsements. This is consistent with sound health care risk-financing practice: risk leaders need to verify that the stated limits align with the organization's exposure profile, contractual obligations, and risk-retention strategy. The Insurance Risk Management Institute describes declarations as the portion of the policy containing information specific to the particular insured and coverage, including policy limits. See IRMI's definition of declarations and ASHRM's CPHRM certification information.