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ASHRM Certified Professional in Health Care Risk Management (CPHRM) Sample Questions (Q31-Q36):

NEW QUESTION # 31

A clear directive to a nurse is:

- A. "Be careful."
- B. "Monitor the infusion pump's operation at defined intervals and document checks."
- C. "If you have time, look at it."
- D. "Do your best."

Answer: B

Explanation:

Clear directives are specific, measurable, and time-bound-reducing ambiguity and variability that drive frontline error. "Monitor every so often" becomes safer when translated into a defined interval (e.g., every 15 minutes for the first hour, then hourly), with documentation requirements and escalation triggers. Risk management objectives emphasize standard work and reliable monitoring for high-risk equipment such as infusion pumps because device malfunction or programming errors can rapidly cause harm. Clear directives also support accountability and defensibility: they demonstrate the organization defined expectations and trained staff accordingly. Vague instructions ("be careful") do not reliably change behavior or outcomes. In high-reliability care, clarity is a safety

barrier: it reduces cognitive load, prevents missed steps, and improves handoffs between staff by making the plan visible and verifiable.

NEW QUESTION # 32

In preparing next year's budget, the hospital CFO has contacted the risk manager for a projected contribution to the hospital's professional and general liability self-insured retention fund. To respond to this request, the risk manager should refer to which of the following?

- A. frequency and severity analyses of pending claims
- B. total incurred losses for the current year
- C. professional and general liability premiums
- D. actuarial reports and loss runs

Answer: D

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, projecting contributions to a self-insured retention fund requires actuarially sound financial forecasting. Actuarial reports use historical claims data, trend analyses, loss development factors, and exposure projections to estimate future liabilities and required funding levels. Loss run reports provide detailed historical claims information, including paid losses, reserves, and claim status, which serve as foundational data for actuarial modeling.

Professional and general liability premiums are relevant to insured layers above the retention but do not determine funding requirements for the retained portion. Frequency and severity analyses of pending claims are important components of actuarial evaluation but, standing alone, may not capture long-tail development or incurred but not reported claims. Total incurred losses for the current year provide limited insight without considering historical patterns and future projections.

Risk financing objectives emphasize accurate funding of retained risk to ensure financial stability, regulatory compliance, and protection of organizational assets. Therefore, actuarial reports, supported by comprehensive loss run data, provide the most reliable basis for determining projected contributions to a self-insured retention fund.

NEW QUESTION # 33

Which of the following is the BEST reason for the selection of defense counsel?

- A. percentage of defense verdicts
- B. fee schedule
- C. proximity to the facility
- D. area of expertise

Answer: D

Explanation:

According to Health Care Risk Management standards outlined by ASHRM and the American Hospital Association Certification Center, the selection of defense counsel should be based primarily on demonstrated expertise in the relevant area of law. Medical malpractice litigation involves complex clinical issues, evolving standards of care, expert witness coordination, and familiarity with healthcare regulations. Counsel with specialized experience in healthcare liability defense is better equipped to manage case strategy, assess exposure, and navigate jurisdiction-specific procedural rules.

Proximity to the facility may offer logistical convenience but does not ensure competency in complex medical litigation. Percentage of defense verdicts can be misleading, as case mix, settlement strategy, and jurisdictional tendencies influence outcomes. A high defense verdict rate does not necessarily reflect effective risk management or cost control. Fee schedule is an important financial consideration; however, cost alone should not override qualifications and experience.

Claims and litigation objectives emphasize effective case management, accurate evaluation of liability exposure, and protection of organizational reputation. Selecting counsel based on specialized expertise supports stronger legal defense, strategic settlement evaluation, and improved coordination with clinical experts. Therefore, area of expertise is the best reason for selecting defense counsel.

NEW QUESTION # 34

People make fewer errors when:

- A. Staff work as a coordinated team with shared communication tools
- B. Speed is prioritized over verification
- C. Individuals work alone to avoid distraction
- D. Errors are hidden to protect reputations

Answer: A

Explanation:

Team-based care reduces errors by improving communication, cross-monitoring, workload distribution, and escalation when risk increases. TeamSTEPPS and related patient safety evidence show teamwork training can improve safety culture and reduce clinical error rates by creating predictable behaviors—briefs, huddles, check-backs, and mutual support. From a risk management standpoint, teamwork is a high-leverage control because many serious adverse events involve coordination failures (handoffs, unclear ownership, missed deterioration). Effective teams also reduce "single-point-of-failure" risk; when one clinician misses something, another can catch it. Organizations operationalize this through standardized communication (SBAR), structured handoffs, simulation, and leadership support for psychological safety so staff speak up.

Team functioning is therefore not "soft skill"—it is a measurable safety barrier that reduces preventable harm and strengthens reliability in complex, high-acuity environments.

NEW QUESTION # 35

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:

According to Health Care Risk Management standards outlined by ASHRM and the American Hospital Association Certification Center, the governing board has ultimate responsibility for organizational oversight, quality of care, and patient safety. As part of its fiduciary and governance duties, the board approves high-level policies that establish the organization's philosophy, strategic direction, and commitment to safety and risk management.

A philosophy regarding medical error management reflects the organization's approach to disclosure, reporting, just culture principles, accountability, and system improvement. Because this philosophy sets the tone for organizational culture and impacts patient safety, legal exposure, and regulatory compliance, it requires board-level approval to ensure alignment with governance expectations and accreditation standards.

In contrast, the risk management department's annual budget is typically approved through financial governance processes rather than as a policy document. Risk analyses are operational tools conducted by management and do not require board approval. Departmental personnel job descriptions are administrative documents managed at the executive or human resources level. Health Care Operations objectives emphasize board engagement in safety culture and oversight of enterprise risk management. Therefore, the philosophy regarding medical error management should be approved by the organization's board of directors.

NEW QUESTION # 36

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