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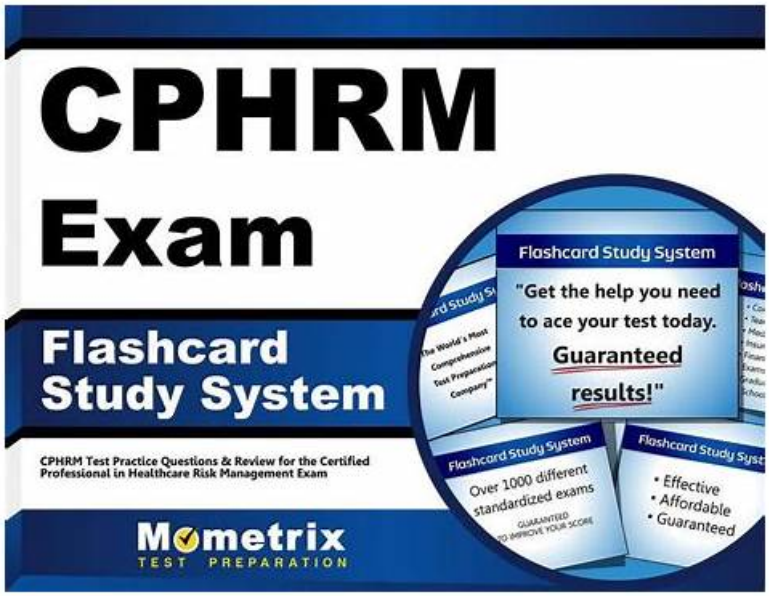

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ASHRM CPHRM Exam Syllabus Topics:

Topic	Details
Topic 1	• Healthcare Operations: This domain involves managing operational risk activities such as conducting risk assessments, developing policies, coordinating risk programs, supervising staff, and supporting patient safety initiatives.
Topic 2	• Claims and Litigation: This domain focuses on handling potential claims and legal cases, including claim reporting, litigation support, legal documentation management, and analyzing claims data to understand risk exposure.

Topic 3	• Legal and Regulatory: This domain focuses on ensuring compliance with healthcare laws and regulations, protecting patient information, managing reporting requirements, and supporting accreditation and regulatory responses.
Topic 4	• Risk Financing: This domain covers managing financial risks through insurance programs, claims coordination, loss analysis, and developing strategies to reduce financial exposure.
Topic 5	• Clinical • Patient Safety: This domain focuses on improving patient safety by promoting a safety culture, managing incident reporting, educating staff and patients, addressing ethical concerns, and implementing corrective actions to reduce risks and prevent harm.

ASHRM Certified Professional in Health Care Risk Management (CPHRM) Sample Questions (Q107-Q112):

NEW QUESTION # 107
What is one advantage of avoluntaryerror reporting system over amandatoryerror reporting system?

- A. Voluntary systems typically elicit more frontline reports and near-misses
- B. Voluntary systems guarantee legal privilege in all states
- C. Voluntary systems eliminate the need for root cause analysis
- D. Voluntary systems replace peer review and credentialing

Answer: A

Explanation:
Voluntary reporting systems often generatemore reports, especially ofnear-misses and low-harm events, because staff perceive less punitive risk and greater learning value. This is crucial for proactive risk management: near-misses expose weak signals and system vulnerabilities before a patient is harmed. A robust voluntary culture supports a "just culture" approach-encouraging reporting while still holding people accountable for reckless behavior. Compared with mandatory systems (typically limited to defined serious events), voluntary systems improve the organization's ability to identify patterns (communication failures, workflow traps, labeling issues, staffing risks), prioritize interventions, and measure improvement over time.
Risk management objectives include earlier hazard detection, better trend analysis, and stronger safety culture. To maximize effectiveness, leadership must provide feedback loops ("you reported, we improved"), protect confidentiality where permitted, and couple reporting with structured analysis (RCA/FMEA). While voluntary reporting does not automatically confer legal privilege, it is a foundational learning system in high- reliability healthcare operations.

NEW QUESTION # 108
What significantly impacts whether incident reports are discoverable?

- A. The patient's insurance plan
- B. State statutes, federal statutes, and case law
- C. The color of the incident form
- D. Staff seniority

Answer: B

Explanation:
Discoverability of incident reports varies substantially by jurisdiction and depends on how state and federal laws define peer review privilege, quality improvement protections, and confidentiality-plus how courts interpret those protections. Risk management objectives include structuring reporting and investigation workflows to maximize protected quality review where legally available: routing analyses through designated committees, labeling and handling documents per policy, limiting distribution, and avoiding mixing risk/peer review materials with ordinary business records. However, privilege is not automatic; mishandling (broad email distribution, using reports for disciplinary actions outside protected structures, inconsistent committee practices) can weaken protections. A defensible program uses legal counsel guidance, staff training, and clear documentation rules so the organization learns from events while reducing unnecessary legal exposure.

NEW QUESTION # 109
Root Cause Analyses most often reveal that mistakes are a result of:

- A. A single reckless person in most cases
- B. A series of small events and system flaws aligning
- C. Only equipment malfunction
- D. Random chance with no patterns

Answer: B

Explanation:
RCA and systems safety models (e.g., Swiss Cheese) emphasize that adverse events typically requiremultiple contributing factors-small process breakdowns, latent conditions, and active failures-to align. This is why focusing only on the last person who touched the patient ("sharp end blame") rarely prevents recurrence. Risk management objectives are to identify and strengthen defenses: policies, training, equipment design, staffing models, communication standards, and redundancy where needed. A series-of-events understanding enables targeted corrective actions (forcing functions, standardization, automation with safeguards, independent double checks for high-alert processes). It also supports just culture: accountability is preserved for reckless behavior, but most improvement comes from redesigning systems that make errors more likely. This approach improves reliability, reduces repeat harm, and provides defensible evidence of organizational learning and corrective action.

NEW QUESTION # 110
A patient has been declared brain dead as a result of injuries sustained during a criminal act. His driver's license states that he is an organ donor. The attending physician is planning to remove the life-support equipment. A risk manager should recommend

- A. coordinating the organ retrieval.
- B. notifying authorities to determine if an autopsy is required.
- C. determining the family's wishes regarding organ donation.
- D. following the patient's wishes and notify the organ retrieval team.

Answer: B

Explanation:
According to Health Care Risk Management standards established by ASHRM and the American Hospital Association Certification Center, deaths resulting from criminal acts fall under medico-legal jurisdiction and are typically subject to coroner or medical examiner review. Even when a patient is a documented organ donor, as indicated on a driver's license under the Uniform Anatomical Gift Act framework, the circumstances of death may require legal investigation.
When a death is associated with trauma from a criminal act, it is generally considered a reportable death. The medical examiner or coroner has statutory authority to determine whether an autopsy is required and to ensure preservation of forensic evidence. Organ procurement activities must not interfere with legal investigation obligations. Therefore, prior to organ retrieval or withdrawal of life support, the appropriate legal authorities must be notified.
While honoring the patient's documented donation wishes is important, compliance with state statutes governing reportable deaths and forensic investigations takes precedence. The family's wishes do not override a valid donor designation, but coordination must occur within the legal framework.
Thus, the most appropriate action for the risk manager is to ensure that authorities are notified to determine autopsy requirements before proceeding.

NEW QUESTION # 111
Whenever possible, medication orders should be by:

- A. Color coding
- B. Brand name
- C. Dose (explicit numeric dose and units)
- D. Verbal shorthand

Answer: C

Explanation:
Ordering by cleardose(with units, route, frequency, and indication when needed) reduces ambiguity and prevents common medication errors such as wrong concentration, wrong formulation, or misunderstood shorthand. Risk management objectives

emphasize "closed-loop" medication communication: standardized ordering, read-back for limited verbal orders, and minimizing abbreviations that cause confusion (sound-alike drug names, numeric mishearing like 15 vs 50). Patient safety frameworks consistently identify unclear orders as a high-frequency contributor to adverse drug events; therefore, explicit dosing is a core reliability practice.
When dose is specified precisely and entered via CPOE (preferred), organizations reduce transcription errors, improve pharmacy verification, and enable automated safety checks. Clear dosing also supports legal defensibility by documenting rational prescribing aligned with standards of care.

NEW QUESTION # 112
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