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CPHQ Exam Outline

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Time limit: 3 hours

Total questions: 140

Question format: Multiple-choice

Delivery format: Computer-delivered

Mometrix TEST PREPARATION

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NAHQ Certified Professional in Healthcare Quality Examination Sample Questions (Q444-Q449):

NEW QUESTION # 444

The design of a piece of equipment contributes to an error. Which of the following types of errors has occurred?

- A. Negligent
- **B. Latent**
- C. Active
- D. Organizational

Answer: B

Explanation:

Detailed Explanation:

Errors resulting from equipment design are considered latent errors, which are underlying system issues rather than direct, immediate actions.

Option B: Latent

Latent errors are "hidden" in processes or systems, often stemming from poor design or organizational factors. Equipment design issues fall under this category.

Option A: Organizational

Organizational errors are broader systemic failures within policies or processes but are not specifically related to equipment design.

Option C: Active

Active errors occur due to immediate actions by individuals, such as mistakes in task execution.

Option D: Negligent

Negligence implies failure to exercise proper care, which is not specific to design-related issues.

References:

CPHQ materials and human factors engineering literature describe latent errors as root causes often embedded within systems, including design flaws in equipment.

NEW QUESTION # 445

This example shows the relationship between:

Concept: *Patient safety*

What aspect of patient safety do we want to measure? *Medication errors*

What specific measures could we track?

- Number of medication orders that had an error
- Total number of errors caught each day
- Percentage of orders with an error
- Medication error rate
- Number of wasted IVs
- Percentage of administration errors

Which specific indicator will you select?

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- A. Specific measures and specific indicators
- B. Effectiveness and concept
- C. Specific indicator and milestone
- **D. A concept and specific measures**

Answer: D

NEW QUESTION # 446

Which of the following actions target social determinants of health in an improvement project on asthma control?

- A. scheduling follow-up visits at time of discharge for high-risk asthmatic patients
- **B. mapping asthma patient zip codes against environmental air quality data**
- C. stratifying prevalence of asthma in the community by age and gender
- D. measuring medication adherence to asthma treatment guidelines

Answer: B

Explanation:

Explanation: Social determinants of health (SDOH) are non-medical factors that influence health outcomes, such as environmental conditions, socioeconomic status, and access to resources. In an asthma control improvement project, targeting SDOH involves addressing external factors like air quality or geographic disparities that exacerbate asthma. Mapping asthma patient zip codes against environmental air quality data (B) directly addresses SDOH by identifying correlations between environmental factors and asthma prevalence or severity, enabling targeted interventions. Options A, C, and D focus on clinical or demographic factors, not SDOH.

NAHQ CPHQ Study Guide, Population Health and Care Transitions Section, "Social Determinants of Health and Population Health Strategies"; NAHQ CPHQ Practice Questions, Population Health Concepts.

NEW QUESTION # 447

Once you have resolved these issues, the data collection should go smoothly. Unfortunately, many quality improvement teams do not spend sufficient time discussing their data collection plans. They want to move immediately to data collection step. This haste usually guarantees that the team will:

- A. Reschedule the time and cost

- B. Collect the wrong data
- C. Collect too much (or too little) data
- D. Become frustrated with the entire measurement journey

Answer: B,C,D

NEW QUESTION # 448

Which of the following quality improvement tools is best for risk assessment of a new or modified process?

- A. 5 whys
- B. SWOT analysis
- C. failure mode and effects analysis (FMEA)
- D. force field analysis

Answer: C

Explanation:

Failure Mode and Effects Analysis (FMEA) is a systematic method for evaluating a process to identify where and how it might fail, to assess the relative impact of different failures, and to identify the parts of the process that are most in need of change. FMEA includes review of the following:

- * Steps in the process: Identify what could go wrong during each step.
- * Failure modes: Identify potential failure modes for each step.
- * Failure effects: For each failure mode, identify potential effects.
- * Severity: Assign a severity rating for each effect of failure.
- * Occurrence: Assign an occurrence rating for each failure mode.
- * Detection: Assign a detection rating for each failure mode and effect.
- * Risk Priority Number (RPN): Calculate the RPN for each effect.

FMEA is particularly useful in healthcare for risk assessment of a new or modified process because it not only identifies potential failures, but also prioritizes them based on their impact, frequency of occurrence, and detectability, allowing for targeted and efficient process improvement.



References:

- * Quality improvement tools are standalone strategies or processes that can help you better understand, analyze, or communicate your QI efforts¹.
- * The 7 Basic Quality Tools for Process Improvement².
- * A guide to quality improvement tools³.

NEW QUESTION # 449

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