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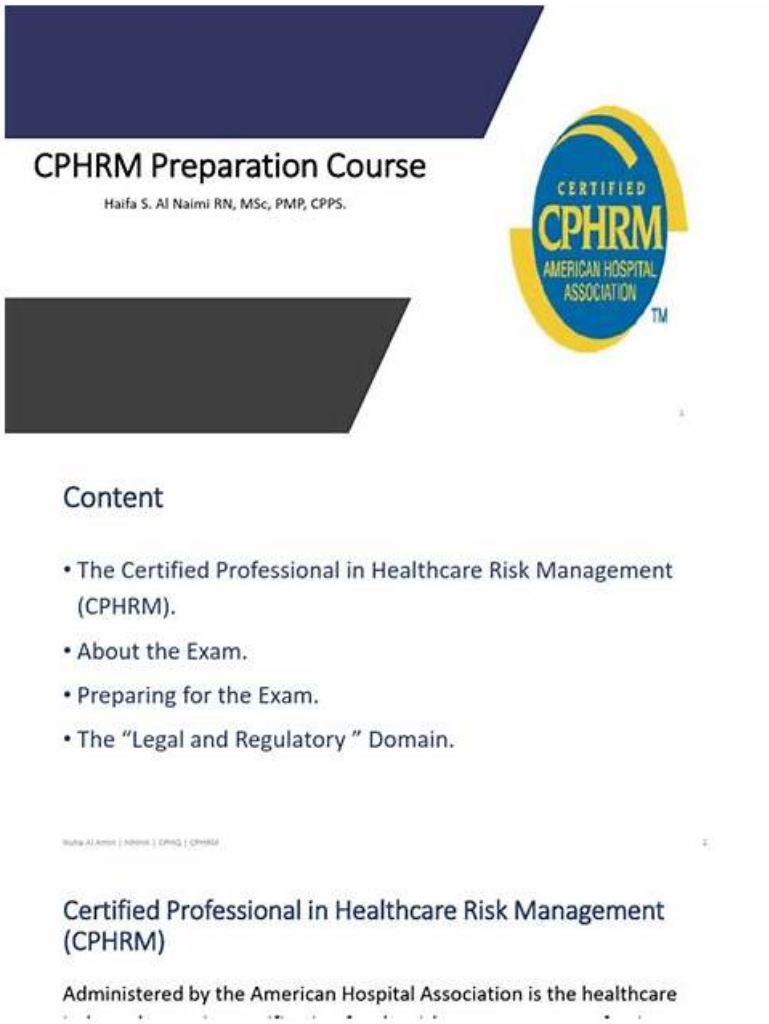

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ASHRM CPHRM Exam Syllabus Topics:

Topic	Details
Topic 1	• 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.
Topic 2	• Risk Financing: This domain covers managing financial risks through insurance programs, claims coordination, loss analysis, and developing strategies to reduce financial exposure.
Topic 3	• 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 4	• 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 5	• 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.

ASHRM Certified Professional in Health Care Risk Management (CPHRM) Sample Questions (Q101-Q106):

NEW QUESTION # 101
The reporting requirements of the Safe Medical Devices Act SMDA apply to which of the following?
* nursing homes
* physician offices
* ambulatory surgery
* hospitals

- A. 1, 3, and 4 only
- B. 2, 3, and 4 only
- C. 1, 2, and 3 only
- D. 1, 2, and 4 only

Answer: A

Explanation:
According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, the Safe Medical Devices Act SMDA establishes mandatory reporting requirements for certain healthcare facilities when a medical device has or may have caused or contributed to a patient death or serious injury. These requirements apply to device user facilities, which include hospitals, nursing homes, and ambulatory surgical facilities.
Hospitals are explicitly required to report device-related deaths to both the FDA and the manufacturer, and serious injuries to the manufacturer or the FDA if the manufacturer is unknown. Nursing homes and ambulatory surgery centers are also considered device user facilities under the Act and must comply with similar reporting obligations.
Physician offices, however, are generally not classified as device user facilities under SMDA reporting rules and therefore are not subject to the same mandatory reporting requirements, although voluntary reporting is encouraged.
Legal and regulatory objectives emphasize timely compliance with FDA reporting mandates, maintenance of documentation, and coordination with manufacturers and regulatory authorities to mitigate risk and enhance patient safety. Therefore, the SMDA reporting requirements apply to nursing homes, ambulatory surgery facilities, and hospitals.

NEW QUESTION # 102
If an at-risk patient is left unattended and has an adverse response to medication, this is best classified as:

- A. A marketing defect
- B. A financial risk transfer
- C. An active error at the sharp end (frontline lapse)
- D. A harmless variance

Answer: C

Explanation:
Leaving an at-risk patient unattended during/after medication administration is typically anactive failure occurring at thesharp end-the point of direct care delivery. Active errors are the observable actions
/omissions by frontline personnel that can immediately contribute to harm (e.g., failure to monitor sedation, failure to reassess after opioids). Risk management objectives, however, require looking beyond the individual act: Was staffing insufficient? Was monitoring policy unclear? Were alarms ineffective? Was there inadequate training or workload overload? Those "blunt end" conditions create latent risk that increases the likelihood of sharp-end failures. Proper classification helps organizations respond with systems fixes (monitoring standards, escalation triggers, staffing acuity tools, continuous pulse oximetry/capnography policies where appropriate) rather than blaming individuals alone.

NEW QUESTION # 103
For a liability claim to succeed, the claimant must establish duty owed, duty breached, proximate cause, and

- A. contributory negligence.
- B. injury sustained.
- C. gross negligence.
- D. punitive damages.

Answer: B

Explanation:
Under Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, a successful negligence claim requires proof of four essential legal elements: duty, breach of duty, causation, and damages. Duty refers to the legal obligation owed by the healthcare provider to the patient. Breach occurs when the provider fails to meet the applicable standard of care. Proximate cause establishes the direct link between the breach and the harm suffered.
The final required element is actual injury or damages sustained by the claimant. Without demonstrable harm, a negligence claim cannot succeed, even if duty and breach are proven. The injury may include physical harm, emotional distress, or financial loss, but it must be measurable and attributable to the breach.
Contributory negligence is a defense that may reduce or bar recovery but is not an element the claimant must prove. Punitive damages are awarded in exceptional cases involving egregious misconduct and are not required to establish liability. Gross negligence represents a higher degree of negligence but is not a required element in standard malpractice claims.
Therefore, proof of injury sustained is essential for a liability claim to succeed.

NEW QUESTION # 104
People make fewer errors when:

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

Answer: D

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 # 105
Per The Joint Commission and CMS patient visitation standards, a hospital may restrict an individual's ability to visit a patient if the visitor

- A. administered the patient an unknown drug via IV.
- B. is not the patient's designated healthcare surrogate.
- C. is known to be a drug seeker in the community.
- D. is not the patient's immediate family member.

Answer: A

Explanation:
According to Health Care Risk Management standards supported by ASHRM, CMS Conditions of Participation, and The Joint Commission patient visitation standards, hospitals must have written visitation policies that respect patient rights. Patients generally have the right to designate visitors of their choosing, including individuals who are not immediate family members. Visitation cannot be restricted based on non- clinical factors such as relationship status or surrogate designation.
However, facilities may impose clinically reasonable or safety-based restrictions. If a visitor administers an unknown drug intravenously to a patient, this presents a clear and immediate threat to patient safety. Such conduct justifies restricting visitation to protect the patient from harm, maintain clinical control of treatment, and prevent unsafe interference with care.
Being known as a drug seeker in the community, without evidence of disruptive or harmful behavior during the visit, does not alone justify restriction under patient rights standards. Similarly, visitation cannot be denied solely because the individual is not the designated healthcare surrogate.
Legal and regulatory objectives emphasize balancing patient rights with safety and security. Therefore, a hospital may restrict visitation when a visitor's actions pose a direct threat to patient safety.

NEW QUESTION # 106
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