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## HIMSS Certified Professional in Healthcare Information and Management Systems Sample Questions (Q21-Q26):

### NEW QUESTION # 21

To improve patient safety and reduce the rate of medication administration errors, implementation of which of the following types of clinical systems or modules should have the GREATEST immediate impact?

- A. CPOE.
- B. EMR.
- C. BCMA.
- D. CDSS.

**Answer: C**

Explanation:

Bar coded medication administration (BCMA) has the greatest immediate impact on reducing medication administration errors because it places an electronic safety check directly at the point where the medication is given to the patient. BCMA requires scanning the patient identifier (e.g., wristband) and the medication barcode, then automatically verifying the match against the active medication order and the scheduled administration time. This creates a real-time "stop-and-check" mechanism that prevents or interrupts common administration errors such as wrong patient, wrong drug, wrong dose, wrong time, and in many implementations, wrong route. Because the control is applied at bedside (or point of administration), improvements are often seen quickly once workflows and scanning compliance stabilize.

An EMR is a broad record platform that can contain many tools, but by itself it does not guarantee bedside verification. CPOE primarily reduces prescribing and transcription errors earlier in the medication-use process; its benefits are substantial but are not as directly tied to administration errors as BCMA. CDSS can reduce errors via alerts and guidance, yet its effectiveness depends heavily on rule design and can be limited by alert fatigue; it also does not inherently verify the medication in-hand at the bedside. Therefore, BCMA is the best choice for the greatest immediate reduction in medication administration errors.

### NEW QUESTION # 22

Patient safety is best promoted when

- A. traditional standards are implemented.
- B. vendor agreements are in place.
- C. prescriptions for scheduled medications are written electronically.
- D. physician input is sought after workflows are designed, built, and tested.

**Answer: A**

Explanation:

Patient safety is best promoted when traditional standards are implemented because standards create consistent, evidence-based expectations for how care and supporting information systems should function. In clinical informatics, "standards" include established clinical and safety practices (e.g., medication safety processes, verification steps, standardized order sets), as well as consistent documentation and workflow rules that reduce unwanted variation. When standards are embedded into clinical operations and health IT (such as standardized clinical protocols, medication administration safeguards, and consistent data definitions), they reduce preventable errors, improve reliability of care, and support measurable quality improvement.

Option B (vendor agreements) is important for governance and accountability, but contractual arrangements do not inherently improve bedside safety unless translated into operational controls and effective system design. Option C is explicitly late involvement of physicians; engaging clinicians only after workflows are designed and built is a common cause of poor usability and workarounds, which can increase safety risk.

Option D (electronic prescribing for scheduled medications) can improve security and reduce certain prescribing errors, but it is a narrower intervention than implementing broad safety standards across clinical practice and system workflows. Therefore, implementing traditional standards is the most comprehensive and foundational approach to promoting patient safety.

### NEW QUESTION # 23

Which of the following is an example of EHR training that integrates workflow?

- A. Intensive Care Unit nurse reviewing Emergency Department patient handover reports.
- B. Pharmacist evaluating medication errors.
- C. Radiologist reviewing error messages received when viewing x-rays.
- D. Privacy Officer determining appropriate access related to patient confidentiality.

**Answer: A**

Explanation:

EHR training that integrates workflow is role-based and scenario-driven, meaning it teaches end users how to perform their real clinical tasks in the system in the same sequence, context, and timing they experience in practice. This approach emphasizes end-to-end processes (handoffs, ordering, documentation, medication administration, discharge) rather than isolated features or generic navigation. The example that best reflects workflow-integrated training is the ICU nurse reviewing Emergency Department patient handover reports, because it mirrors a common, time-sensitive clinical transition of care. In this scenario, the nurse must locate the correct patient, review ED documentation, reconcile current status and interventions, confirm orders, and prepare for ongoing ICU management-steps that directly match actual bedside workflow and support safe continuity of care.

Option A focuses on troubleshooting system error messages, which is more technical than workflow training.

Option B relates to governance and access control decision-making, not frontline EHR workflow use. Option D (evaluating medication errors) is primarily a quality/safety analysis activity; while important, it does not clearly represent a hands-on EHR

workflow task sequence for routine care delivery. Workflow-integrated training improves adoption, efficiency, and patient safety because users practice exactly how the EHR supports their daily work.

#### NEW QUESTION # 24

Which is an example of scope creep in an EHR implementation?

- A. The IT team has found that additional servers are required for the system to operate.
- B. The pharmacy system fails to print medication labels when ordered from the Operating Room.
- C. The hospital administration requests that additional facilities be included in the system.
- D. The respiratory therapists require additional training.

**Answer: C**

Explanation:

Scope creep is the uncontrolled expansion of a project's scope after the scope baseline has been approved- typically through adding new requirements, sites, departments, features, or deliverables without corresponding adjustments to time, budget, resources, and formal change control. In an EHR implementation, the original scope usually defines which entities (hospitals, clinics, departments), which modules (CPOE, eMAR, results review), and which interfaces or conversions will be delivered by a target go-live date.

Option A is a classic example of scope creep because adding additional facilities expands the project boundaries and increases complexity (build, training, workflow alignment, data conversion, integration testing, support staffing, and cutover planning). If this addition is requested midstream and not handled through a structured governance and change management process, it can derail timelines, increase costs, and introduce risk to patient care operations at go-live.

By contrast, option B is a technical capacity discovery (resource planning), option C is a training/readiness need, and option D is a defect or integration issue that must be fixed to meet existing requirements- none of which inherently expands scope. Therefore, A is the best example of scope creep.

#### NEW QUESTION # 25

A healthcare facility needs to connect with an external agency to send financial billing information from the electronic health record (EHR) system. Which of the following protocols would BEST facilitate this?

- A. VPN and HL7.
- B. HTTPS and SSL.
- C. VPN and RDP.
- D. HTTPS and DICOM.

**Answer: A**

Explanation:

The best choice is VPN and HL7 because it combines a secure transport method with a healthcare messaging standard suited to exchanging administrative and financial transactions. A VPN (Virtual Private Network) creates an encrypted tunnel between organizations, supporting secure connectivity over public networks and helping protect sensitive data (including billing-related patient information) during transmission. HL7 - commonly HL7 v2 in many environments- provides standardized message structures used by hospitals to exchange patient demographics (ADT), charges, billing events, and related administrative data with external systems such as clearinghouses, payers, or revenue-cycle partners. Using HL7 reduces interface ambiguity by defining consistent fields and event triggers, which is critical for accurate billing and reconciliation.

Option A (VPN and RDP) is not ideal because RDP is for remote screen access, not structured data interchange; it also introduces operational and security risks when used as a substitute for interfaces. Option B (HTTPS and SSL) focuses on transport security, but does not specify a healthcare data format for billing;

"SSL" is also a legacy term often replaced by TLS, and HTTPS alone doesn't ensure standardized billing content. Option D (HTTPS and DICOM) is incorrect because DICOM is primarily for medical imaging, not financial billing transactions.

#### NEW QUESTION # 26

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