

CCDM Valid Real Test - Valid CCDM Test Question

CCDM Test 2023-2024 Questions and Answers 100% Correct

A Certified Dietary Manager is dissatisfied with prices from current vendors. The Manager should first:

- ask vendors to lower their prices.
- ask the consultant to recommend other vendors.
- complete a comparison study of vendors.
- discontinue purchasing from the current vendors. - ANSWER-c. complete a comparison study of vendors.

The best way to prepare frozen peas is to: a. slowly cook the peas at 200°F (93.3°C) so they do not dry out.

- cook them rapidly until they reach an internal temperature of 140°F (60.0°C).
- cook them to 120°F (48.9°C) and hold them in the steam table to come up to temperature.
- cook them in batches throughout the service time. - ANSWER-d. cook them in batches throughout the service time.

Beans and legumes are essential protein substitutes for clients who are:

Choose one answer.

- lactose intolerant.
- vegan.
- ovo-lacto-vegetarian.
- lacto vegetarian. - ANSWER-b. vegan.

When preparing goals for the foodservice department, a Certified Dietary Manager must show that the goals are:

Choose one answer.

- narrow.
- broad.
- listed on the bulletin board.
- transferrable to other departments. - ANSWER-b. broad.

When purchasing food, a Certified Dietary Manager must develop specifications to ensure that:

Choose one answer.

- government commodities are used when available.
- eggs are delivered in a timely manner.
- milk arrives at a temperature below 41°F (5°C).
- canned fruits are packed in water or juice. - ANSWER-c. milk arrives at a temperature below 41°F (5°C).

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SCDM CCDM Exam Syllabus Topics:

Topic	Details
Topic 1	Design Tasks: This section of the CCDM exam measures skills of Data Managers and covers how to design and document data collection instruments, develop workflows and data flows, specify data elements, CRF forms, edit checks, reports, database structure, and define standards and procedures for traceability and auditability.
Topic 2	Data Processing Tasks: This section measures skills of Clinical Systems Analysts and focuses on handling, transforming, integrating, reconciling, coding, querying, updating, and archiving study data while maintaining quality, consistency, and proper privileges over the data lifecycle.

Topic 3	• Coordination and Project Management Tasks: This domain evaluates the skills of a Clinical Systems Analyst in coordinating data management workload, vendor selection, scheduling, cross-team communication, project timeline management, risk handling, metric tracking, and preparing for audits.
Topic 4	• Testing Tasks: This section measures the skills of Data Managers and involves creating test plans, generating test data, executing validation and user acceptance testing, and documenting results to ensure systems and processes perform reliably and according to specifications.
Topic 5	• Review Tasks: This section measures the skills of Data Managers and involves reviewing protocols, CRFs, data tables, listings, figures, and clinical study reports (CSRs) for consistency, accuracy, and alignment with data handling definitions and regulatory requirements.

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Pass Guaranteed Quiz 2025 Efficient CCDM: Certified Clinical Data Manager Valid Real Test

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SCDM Certified Clinical Data Manager Sample Questions (Q39-Q44):

NEW QUESTION # 39

Which database table structure is most appropriate for vital signs data collected at every-other visit for each patient in a study?

- A. One record per visit
- B. One record per patient
- **C. One record per patient per visit**
- D. One record per patient per study

Answer: C

Explanation:

In a relational clinical database, the most efficient and normalized structure for data collected repeatedly over time-such as vital signs-is one record per patient per visit.

Each patient will have multiple records, one for each visit when vital signs are assessed. This structure supports:

Time-based analysis (e.g., trends across visits),

Accurate data linkage with visit-level metadata, and

Efficient querying for longitudinal data.

According to the GCDMP (Chapter: Database Design and Build), the relational design principle dictates that data should be stored at the lowest unique level of observation. Since vital signs vary by both patient and visit, the combination of patient ID + visit ID forms a unique key for each record.

Option A (per visit) lacks patient identification, while options B and D aggregate data too broadly, losing temporal detail.

Thus, option C (One record per patient per visit) correctly represents the normalized design structure.

Reference (CCDM-Verified Sources):

SCDM GCDMP, Chapter: Database Design and Build, Section 4.2 - Normalization and Table Structure CDISC SDTM Implementation Guide, Section 5.3 - Visit-Level and Observation-Level Data Structures ICH E6(R2) GCP, Section 5.5.3 - Data Handling Principles

NEW QUESTION # 40

ePRO data are collected for a study using study devices given to subjects. Which is the most appropriate quality control method for the data?

- A. Data visualizations to look for site-to-site variation
- B. Manual review of data by the site study coordinator at the next visit

- C. Programmed edit checks to detect out of range values after submission to the database
- **D. Programmed edit checks to detect out of range values upon data entry**

Answer: D

Explanation:

When electronic patient-reported outcomes (ePRO) devices are used, data are captured directly by subjects through validated devices and transmitted electronically to the study database. To ensure real-time data quality control, programmed edit checks should be implemented at the point of data entry - that is, as subjects input data into the device.

According to Good Clinical Data Management Practices (GCDMP, Chapter: Data Validation and Cleaning), front-end programmed edit checks are the optimal method to prevent entry of invalid or out-of-range values in ePRO systems. This helps maintain data accuracy at the source, minimizing downstream queries and data cleaning workload.

Options A and B involve post-submission or manual review, which is less efficient and not compliant with the principle of first-pass data validation. Option C (visualization) is a valuable secondary QC method for trends, but not for immediate data validation.

Therefore, option D is correct - programmed edit checks upon data entry ensure immediate validation and higher data integrity.

Reference (CCDM-Verified Sources):

SCDM GCDMP, Chapter: Data Validation and Cleaning, Section 5.3 - Automated Edit Checks and Front-End Validation ICH E6(R2) GCP, Section 5.5.3 - Computerized System Controls and Validation FDA Guidance for Industry: Electronic Source Data in Clinical Investigations (2013), Section 6 - Real-Time Data Quality Control

NEW QUESTION # 41

Which competency is necessary for EDC system use in a study using the medical record as the source?

- A. Resolving discrepant data
- **B. Training on how to log into Medical Records system**
- C. Using ePRO devices
- D. Screening study subjects

Answer: B

Explanation:

In studies where the medical record serves as the source document, the Electronic Data Capture (EDC) system users (typically study coordinators or site personnel) must have appropriate training on how to access and log into the medical record system. This competency ensures that data abstracted from the electronic medical record (EMR) are complete, accurate, and verifiable in compliance with Good Clinical Practice (GCP) and Good Clinical Data Management Practices (GCDMP).

According to the GCDMP (Chapter: EDC Systems and Data Capture) and ICH E6(R2), all personnel involved in data entry and verification must be trained in both the EDC and the primary source systems (e.g., EMR). This ensures that the integrity of data flow-from source to EDC-is maintained, and that personnel understand system access controls, audit trails, and proper documentation of source verification.

While resolving discrepant data (C) and screening subjects (A) are part of study operations, the competency directly related to EDC system use in EMR-based studies is the ability to properly log into and navigate the medical records system to extract source data.

Reference (CCDM-Verified Sources):

SCDM GCDMP, Chapter: Electronic Data Capture (EDC), Section 5.1 - Source Data and System Access Requirements ICH E6(R2) Good Clinical Practice, Section 4.9 - Source Documents and Data Handling FDA Guidance: Use of Electronic Health Record Data in Clinical Investigations, Section 3 - Investigator Responsibilities

NEW QUESTION # 42

A protocol amendment adds three data elements to the vital signs screen and two additional data-collection time points. Which is best practice for handling changes to the form completion guidelines?

- A. Update the guidelines and post the new version on the trial portal
- B. Rely on the revised CRF to enforce the changes without updating guidelines or notifying sites
- **C. Update the guidelines and notify sites of changes prior to implementing the change**
- D. Notify sites of the change without a guideline update

Answer: C

Explanation:

The best practice when implementing a protocol amendment that affects CRF content or data collection timing is to update the

eCRF completion guidelines and notify sites before implementing the change.

According to the GCDMP (Chapter: CRF Design and Data Collection), the eCRF Completion Guidelines (eCRF CG) are an essential study tool that instructs site personnel on accurate and consistent data entry. When new data elements or collection time points are added, the guidelines must be revised, version-controlled, and communicated to all users prior to implementation to ensure sites collect and enter data correctly.

Simply relying on the revised CRF (option C) or updating the document without notification (option B) violates communication and training standards. Likewise, notifying sites without updating the documentation (option D) leaves insufficient reference material for data entry compliance.

Reference (CCDM-Verified Sources):

SCDM Good Clinical Data Management Practices (GCDMP), Chapter: CRF Design and Data Collection, Section 5.5 - Managing CRF Revisions and Site Communication ICH E6 (R2) GCP, Section 5.18.4 - Communication of Protocol Amendments and Documentation Updates FDA Guidance for Industry: Electronic Source Data in Clinical Investigations, Section 4.3 - Site Communication and Documentation Management

NEW QUESTION # 43

Which statement applies to the CRF Completion Guidelines (CCGs) for a multinational study?

- A. CCGs can instruct sites to use any abbreviations if they are documented in the subject source notes
- B. CCGs must be translated and back-translated in each local language used in the study
- C. CCGs can instruct sites to write in their local language as long as the CRA is fluent in this language
- **D. CCGs must contain the list of acceptable abbreviations to be used in the CRF**

Answer: D

Explanation:

The Case Report Form (CRF) Completion Guidelines (CCGs) are critical documents that guide site staff on how to accurately and consistently record data on CRFs across all participating sites, especially in multinational trials.

According to the Good Clinical Data Management Practices (GCDMP, Chapter: CRF Design and Data Collection), one of the key components of the CCGs is a list of acceptable abbreviations and conventions to be used during CRF entry. This standardization ensures data consistency across languages and countries, reduces ambiguity during data review, and facilitates database design and coding accuracy.

While translation (A) may be useful for training materials, it is not required for CCGs unless specified by regulatory bodies. Options C and D are incorrect because data collection should adhere to standardized terms in English (or the study's official language) - allowing free use of local languages or arbitrary abbreviations introduces inconsistencies.

Hence, option B - "CCGs must contain the list of acceptable abbreviations to be used in the CRF" - is correct.

Reference (CCDM-Verified Sources):

SCDM GCDMP, Chapter: CRF Design and Data Collection, Section 5.3 - CRF Completion Guidelines and Standardization ICH E6(R2) GCP, Section 5.5.3 - Consistency and Data Recording Requirements FDA Guidance for Industry: Computerized Systems Used in Clinical Investigations, Section 6.2 - Data Entry Conventions and Documentation

NEW QUESTION # 44

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