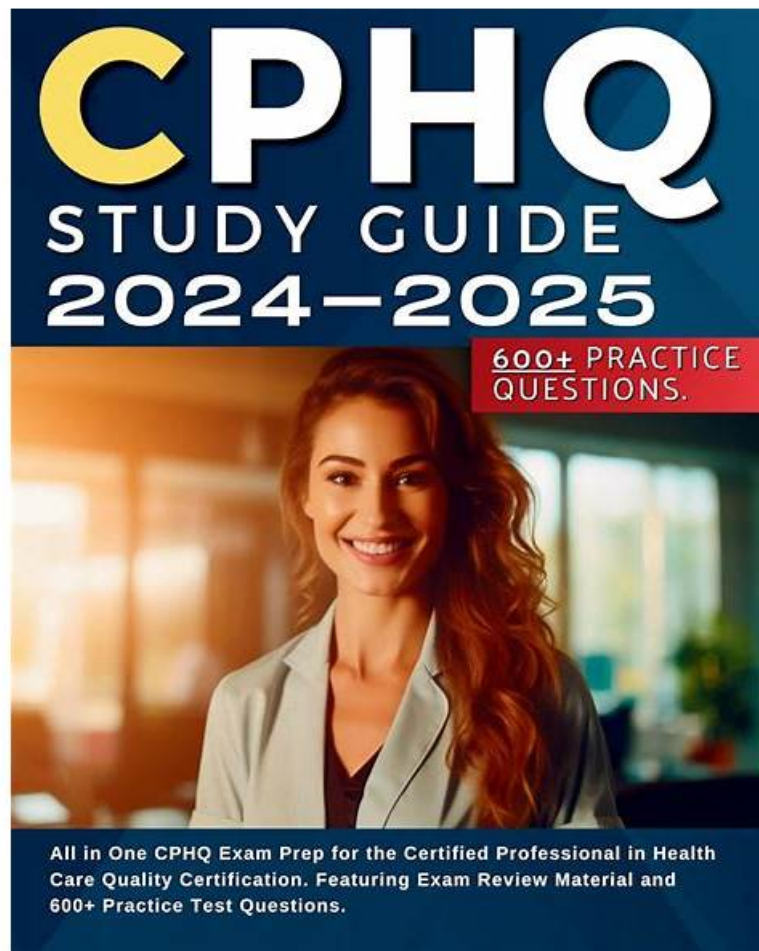


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NAHQ Certified Professional in Healthcare Quality Examination Sample Questions (Q577-Q582):

NEW QUESTION # 577

An internal customer of the admission process in a skilled nursing facility is the

- A. patient being admitted.
- **B. nurse completing the initial assessment.**
- C. insurance company.
- D. patient's spouse and family.

Answer: B

Explanation:

An internal customer is someone within the organization who relies on the output of a process or service to perform their duties. In the context of a skilled nursing facility, the nurse completing the initial assessment is considered an internal customer of the admission process. The nurse depends on the accurate and timely completion of the admission process to assess the patient's condition and plan care accordingly.

* Patient's spouse and family (A): They are external customers who interact with the facility but are not part of its internal processes.

* Insurance company (C): This is an external entity involved in the payment process, not an internal customer.

* Patient being admitted (D): The patient is the end-user of the services provided but is considered an external customer.

References

* NAHQ Body of Knowledge: Customer Identification and Management

* NAHQ CPHQ Exam Preparation Materials: Internal and External Customers in Healthcare

NEW QUESTION # 578

The performance improvement team developed a prioritization matrix based on the identified improvement opportunities. Based on the information below, what would be the first improvement effort implemented?

- A. Modify the check-in process for patients
- B. Send education to all possible patients
- C. Create a sign-in sheet
- **D. Create a paper checklist**

Answer: D

Explanation:

Detailed Explanation:

The prioritization matrix suggests selecting high-impact, low-effort actions first, as they provide the most benefit with minimal resources.

Option A: Create a paper checklist

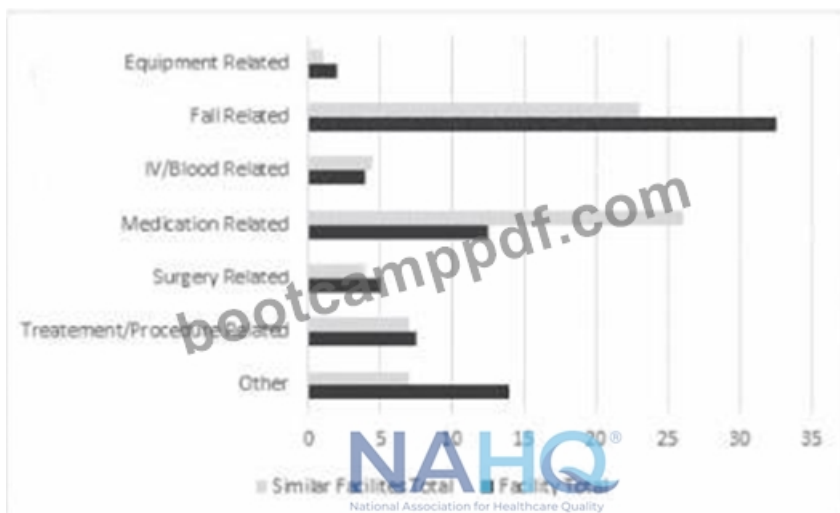
This is a high-impact, low-effort task, making it the most efficient improvement effort to implement first.

References:

Using prioritization matrices, as taught in CPHQ resources, guides quality professionals to choose high- impact, low-effort options first for quick wins.

NEW QUESTION # 579

Data from an Incident reporting system compares Incident rates for one facility to similar facilities:



After reviewing the graph, which of the following should be done first?

- A. perform additional analysis on falls data.
- B. Research best practices.
- C. Share data with the governing body.
- D. Review medication processes.

Answer: A

Explanation:

* Incident reporting systems are tools to collect and analyze data on patient safety incidents, such as medication errors, falls, infections, and adverse events¹².

* Incident reporting systems can help identify patterns, trends, and areas of improvement for patient safety and quality of care¹²³.

* The graph shows the incident rates for one facility compared to similar facilities in four categories: medication, falls, infection, and adverse events. The graph indicates that the facility has a higher incident rate for falls than the average of similar facilities, while the other categories are comparable or lower⁴.

* Therefore, the first step after reviewing the graph should be to perform additional analysis on falls data, such as the types, causes, consequences, and contributing factors of falls incidents, and compare them with the best practices and standards for falls prevention and management⁵⁶⁷.

* This will help the facility to understand the root causes of the high falls incident rate, and to develop and implement appropriate interventions to reduce the risk and harm of falls for patients⁵⁶⁷.

* Reviewing medication processes, researching best practices, and sharing data with the governing body are also important steps, but they should be done after the additional analysis on falls data, as they are more general and less specific to the problem identified by the graph⁴. References: 1: Patient Safety Incident Reporting and Learning Systems | WHO 2: Incident Reporting: Key to Successful Healthcare Organizations | SafeQual 3: Report a patient safety incident | NHS England 4: Data from an Incident reporting system compares Incident rates for one facility to similar facilities | User-uploaded image 5: Falls Prevention and Management | NAHQ 6: Preventing Falls in Hospitals | Agency for Healthcare Research and Quality 7: Falls Prevention and Management | Institute for Healthcare Improvement

NEW QUESTION # 580

Systematic sampling is achieved by numbering or ordering each element in the population (e.g., time order, alphabetical order, and medical order) and then selecting every kth element. The key point that most people ignore when doing a systematic sample is that:

- A. The starting point for selecting every kth element should be guaranteed through a random process and should be equal to or greater than zero.
- B. The starting point for selecting every kth element should be guaranteed through a random process and should be less than k but greater than zero.
- C. The starting point for selecting every kth element should be guaranteed through a random process and should be greater than zero.
- D. The starting point for selecting every kth element should be guaranteed through a random process and should be equal to or less than k but greater than zero.

Answer: D

NEW QUESTION # 581

Which of the following most accurately describes medication reconciliation?

- **A. identifying and resolving medication discrepancies**
- B. creating a list of a patient's prescription medications
- C. monitoring patient adherence to medication regimens
- D. sharing responsibility between pharmacy and nursing

Answer: A

Explanation:

Medication reconciliation is the process of identifying and resolving medication discrepancies to ensure that patients receive the correct medications. This process involves comparing the patient's current medications with new prescriptions, ensuring that there are no omissions, duplications, or interactions that could lead to adverse effects.

* Steps in Medication Reconciliation: The process typically involves:

* Collecting an accurate list of the patient's current medications (including prescription, over-the-counter, and herbal supplements).

* Comparing this list with new medication orders or prescriptions.

* Identifying discrepancies, such as omitted medications, incorrect dosages, or potentially harmful drug interactions.

* Resolving these discrepancies by consulting with the prescribing physician, pharmacist, or other healthcare providers.

* Comparison to Other Options:

* B. creating a list of a patient's prescription medications: While creating a medication list is a part of the reconciliation process, the primary goal is to resolve discrepancies, not just to list medications.

* C. monitoring patient adherence to medication regimens: Monitoring adherence is important, but it is not the primary focus of medication reconciliation.

* D. sharing responsibility between pharmacy and nursing: While collaboration between pharmacy and nursing is essential, medication reconciliation is specifically about identifying and addressing discrepancies.

References: NAHQ guidelines on medication safety stress the importance of medication reconciliation as a critical process for preventing errors and ensuring patient safety, focusing on the identification and resolution of discrepancies as the core objective.

NEW QUESTION # 582

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