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>> CPHRM Key Concepts <<

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At TrainingDumps, we strive hard to offer a comprehensive Certified Professional in Health Care Risk Management (CPHRM) (CPHRM) exam questions preparation material bundle pack. The product available at TrainingDumps includes ASHRM CPHRM Real Dumps pdf and mock tests (desktop and web-based). Practice exams give an experience of taking the Certified Professional in Health Care Risk Management (CPHRM) (CPHRM) actual exam.

ASHRM Certified Professional in Health Care Risk Management (CPHRM) Sample Questions (Q48-Q53):

NEW QUESTION # 48

The source of many medication errors is:

- A. Patient wristbands
- B. Radiology scheduling
- C. Elevator delays
- D. Verbal/telephone orders (when avoidable and not properly verified)

Answer: D

Explanation:

Verbal/telephone orders are widely recognized as error-prone because they can be misheard, misunderstood, or transcribed incorrectly—especially with sound-alike drug names, confusing numerals (15 vs 50), background noise, accents, and interruptions. ISMP and patient safety advisories recommend minimizing verbal orders whenever possible and using safeguards such as read-

back/confirm-back, spelling drug names, stating digits individually, and documenting promptly. Risk management objectives include reducing reliance on memory and imperfect communication by prioritizing written or electronic orders (CPOE), standardizing when verbal orders are permitted (true emergencies), and auditing compliance to prevent unsafe normalization. Because medication errors can cause severe harm, controlling verbal order risk is a high-yield safety intervention and improves legal defensibility by aligning practice with recognized safety recommendations.

NEW QUESTION # 49

In a failure mode and effects analysis, the risk priority number is calculated by

- A. adding the severity, occurrence, and detection scores.
- B. multiplying the severity and detection scores.
- C. multiplying the severity, occurrence, and detection scores.
- D. adding the severity and occurrence scores.

Answer: C

Explanation:

According to Health Care Risk Management standards endorsed by ASHRM and the American Hospital Association Certification Center, Failure Mode and Effects Analysis FMEA is a proactive patient safety tool used to identify and prioritize potential process failures before harm occurs. Within FMEA methodology, each potential failure mode is evaluated using three separate scoring components: severity, occurrence, and detection.

Severity measures the potential impact of the failure if it occurs. Occurrence assesses the likelihood that the failure will happen.

Detection evaluates the probability that the failure will be identified before causing harm.

Each component is typically assigned a numerical value based on predefined criteria.

The Risk Priority Number RPN is calculated by multiplying the three scores: severity multiplied by occurrence multiplied by detection. This multiplication approach produces a composite score that reflects both the seriousness of potential harm and the likelihood that the event will occur and escape detection. Higher RPN values indicate higher-priority risks requiring mitigation. Clinical and patient safety objectives emphasize systematic risk prioritization to allocate resources effectively and reduce preventable adverse events. Therefore, the RPN is calculated by multiplying severity, occurrence, and detection scores.

NEW QUESTION # 50

Which of the following concerns meets the CMS Hospital Conditions of Participation 42 CFR §482.12 classification as a grievance?

- A. a verbal complaint that cannot be solved by current staff, and the resolution of which is postponed for later
- B. a patient calling regarding a billing issue requesting for adjustment to the charges
- C. information obtained with a patient satisfaction survey
- D. post-hospital verbal communication regarding a care issue that could have been handled by the staff during visit but was not reported

Answer: A

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, the CMS Hospital Conditions of Participation define a grievance as a formal or informal written or verbal complaint made by a patient or representative regarding care, abuse, neglect, compliance with regulations, or patient rights that is not resolved at the time of the complaint by staff present.

A verbal complaint that cannot be resolved immediately by current staff and whose resolution is postponed qualifies as a grievance under 42 CFR §482.12. Such grievances require formal investigation, documentation, and written response within established timeframes.

Billing issues generally fall outside the grievance definition unless they involve quality of care or patient rights concerns. Information from patient satisfaction surveys is not automatically classified as a grievance unless the patient specifically requests investigation or follow-up. Post-discharge verbal concerns may constitute grievances depending on context, but the key CMS criterion is whether the complaint could not be resolved at the time it was expressed.

Legal and regulatory objectives emphasize proper classification, timely response, documentation, and board oversight of grievance processes. Therefore, a verbal complaint that cannot be resolved immediately and is deferred meets CMS grievance criteria.

NEW QUESTION # 51

Which of the following is the MOST likely root cause of medication errors in healthcare entities?

- A. system or process failure
- B. illegible physician handwriting
- C. manual medication delivery systems
- D. look-alike, sound-alike drugs

Answer: A

Explanation:

According to Health Care Risk Management standards supported by ASHRM and patient safety principles endorsed by The Joint Commission, the most likely root cause of medication errors is system or process failure. Modern patient safety frameworks emphasize that errors rarely result from isolated individual mistakes. Instead, they typically arise from weaknesses in processes, workflow design, communication systems, technology integration, or inadequate safeguards.

Illegible handwriting, manual systems, and look-alike or sound-alike drugs are recognized contributing factors. However, these elements represent components within a broader system. For example, illegible handwriting becomes problematic when standardized order entry systems are lacking. Look-alike medications pose risks when storage, labeling, or verification processes are insufficient. Manual medication delivery systems increase risk when redundancy and double-check mechanisms are absent.

Root cause analysis methodologies consistently demonstrate that unsafe system design, poor communication processes, lack of standardized procedures, and inadequate training contribute to medication errors. A systems-based approach aligns with just culture principles and focuses on improving processes rather than assigning individual blame.

Clinical and patient safety objectives emphasize system redesign, standardization, and continuous quality improvement. Therefore, system or process failure is the most likely root cause of medication errors.

NEW QUESTION # 52

Which of the following documents will an insurance underwriter use to provide an insurance quote?

- A. certificate of need
- B. application
- C. declaration page
- D. certificate of insurance

Answer: B

Explanation:

Under Health Care Risk Management principles supported by ASHRM and the American Hospital Association Certification Center, the insurance application is the primary document used by an underwriter to evaluate risk and generate a premium quote. The application provides detailed information about the organization's operations, services, patient volume, claims history, risk control measures, governance structure, and prior insurance coverage. This information enables the underwriter to assess exposure, determine eligibility, and calculate appropriate pricing and coverage terms.

A certificate of insurance is issued after a policy is in force to verify coverage to third parties and does not serve as a quoting document. The declaration page is part of an existing insurance policy and summarizes coverage limits, deductibles, and endorsements; it reflects finalized terms rather than information used to generate a quote. A certificate of need is a regulatory document related to state approval of healthcare facilities or services and is unrelated to underwriting.

Risk financing objectives emphasize accurate disclosure and thorough completion of insurance applications, as misrepresentation or omission may affect coverage validity. Therefore, the application is the document used by an underwriter to provide an insurance quote.

NEW QUESTION # 53

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











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