ASHRM CPHRM Practice Test

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Question 1

Question Type: MultipleChoice

Which sentinel event type has been reported among the most frequent categories in Joint Commission-related analyses (noting year-to-year variation)?

Options:

A- Falls (recent years show high frequency)
B- Cafeteria food complaints
C- Parking disputes
D- Gift shop inventory loss

Answer:

A

Explanation:

Sentinel event ''most common'' can change by reporting year and classification approach. Recent summaries of 2023 sentinel event reporting indicate falls were the most frequently reported category in that dataset, with wrong surgery and unintended retention also high-ranking. Risk management objectives treat this as a dynamic signal: the organization should use current event data, internal trends, and unit-specific hazards to prioritize controls. Falls prevention requires layered interventions---risk stratification, mobility support, medication review, environmental controls, and post-fall huddles to learn and redesign. Leaders should avoid over-fixating on one historical ''most common'' event type and instead use current surveillance to target the biggest preventable harm burdens.

Question 2

Question Type: MultipleChoice

If a practitioner requests a telemedicine consult with another practitioner in another state, the consultant:

Options:

A- May need to hold a valid license in the patient's state (requirements vary by state)
B- Never needs any license
C- Can practice under the patient's insurance plan only
D- Can rely on verbal permission from the ED nurse

Answer:

A

Explanation:

Telemedicine licensure is largely state-based in the U.S., and many states require the consulting clinician to be licensed in the state where the patient is located (with exceptions such as specific compacts, special telehealth registrations, or emergency provisions). Risk management objectives include verifying licensure/credentialing before services, ensuring privileging-by-proxy processes where applicable, confirming malpractice coverage for telehealth and cross-state practice, and ensuring informed consent/privacy safeguards. Failure to comply can trigger regulatory penalties, payer issues, and liability exposure if care is delivered without proper authorization.

Question 3

Question Type: MultipleChoice

A hospital's Ethics Committee is seeking advice on a case involving the elective sterilization of an adolescent patient who is developmentally disabled. One of the parents is refusing consent. The risk manager should evaluate which of the following?

who has consent authority

competency level of the patient

diagnosis of the patient

state statutes and laws

Options:

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

Answer:

B

Explanation:

Under Health Care Risk Management principles outlined by ASHRM and the American Hospital Association Certification Center, cases involving sterilization of minors, particularly those who are developmentally disabled, raise significant legal and regulatory concerns. The risk manager's primary responsibility is to ensure compliance with applicable consent laws and protect patient rights while minimizing organizational liability.

First, determining who has legal consent authority is essential. When parents disagree, state law typically governs whether both parents must consent, whether one parent's consent is sufficient, or whether court involvement is required. Second, evaluating the competency level of the patient is critical because decision-making capacity influences whether the patient can participate in consent or assent processes. Capacity assessments may require clinical and legal evaluation.

Third, state statutes and laws are highly relevant, as many jurisdictions impose strict legal requirements or court approval for sterilization of minors or individuals with developmental disabilities. These laws are designed to protect vulnerable populations.

The patient's diagnosis alone is not the determining legal factor; rather, decision-making capacity and statutory requirements are central. Therefore, the risk manager must evaluate consent authority, competency, and applicable state laws to ensure regulatory compliance and ethical integrity.

Question 4

Question Type: MultipleChoice

An appropriate way to complete the verification read-back of a complete order, as required by The Joint Commission National Patient Safety Goals, is to have the person receiving the order

Options:

A- write the information down before reading it back.
B- immediately repeat the information.
C- have a witness verify that the information is repeated back correctly.
D- document the date and time the order was received.

Answer:

A

Explanation:

According to Health Care Risk Management standards supported by ASHRM and The Joint Commission National Patient Safety Goals, the read-back process is designed to ensure accurate communication of verbal or telephone orders. The correct process requires the person receiving the order to first write down the complete order and then read it back to the prescribing practitioner for verification.

Writing the order down before reading it back reduces reliance on memory and decreases the risk of omission or transcription errors. The practitioner who gave the order must then confirm that the read-back is accurate. This closed-loop communication process enhances patient safety and reduces medication and treatment errors associated with miscommunication.

Immediately repeating the information without documenting it does not meet the full verification requirement, as the written record must be confirmed. A witness is not required under the standard. Documenting the date and time is necessary for proper charting but does not constitute completion of the read-back verification itself.

Clinical and patient safety objectives emphasize clear, structured communication processes. Therefore, writing the information down before reading it back is the appropriate method to complete the verification process.

Question 5

Question Type: MultipleChoice

Which option best is the BEST reason for the selection of defense counsel?

Options:

A- proximity to the facility
B- percentage of defense verdicts
C- area of expertise
D- fee schedule

Answer:

C

Explanation:

According to Health Care Risk Management standards outlined by ASHRM and the American Hospital Association Certification Center, the selection of defense counsel should be based primarily on demonstrated expertise in the relevant area of law. Medical malpractice litigation involves complex clinical issues, evolving standards of care, expert witness coordination, and familiarity with healthcare regulations. Counsel with specialized experience in healthcare liability defense is better equipped to manage case strategy, assess exposure, and navigate jurisdiction-specific procedural rules.

Proximity to the facility may offer logistical convenience but does not ensure competency in complex medical litigation. Percentage of defense verdicts can be misleading, as case mix, settlement strategy, and jurisdictional tendencies influence outcomes. A high defense verdict rate does not necessarily reflect effective risk management or cost control. Fee schedule is an important financial consideration; however, cost alone should not override qualifications and experience.

Claims and litigation objectives emphasize effective case management, accurate evaluation of liability exposure, and protection of organizational reputation. Selecting counsel based on specialized expertise supports stronger legal defense, strategic settlement evaluation, and improved coordination with clinical experts. Therefore, area of expertise is the best reason for selecting defense counsel.

Question 6

Question Type: MultipleChoice

Which of the following should be the primary consideration when designing a new risk management program for a facility?

Options:

A- size of the facility
B- type of insurance the facility carries
C- history of the facility
D- mission and vision of the facility

Answer:

D

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, the primary consideration in designing a risk management program is alignment with the organization's mission and vision. A risk management program must support the strategic goals, values, and patient care objectives of the facility. This ensures that risk identification, mitigation strategies, and reporting structures are integrated into the broader organizational framework.

While facility size, insurance structure, and historical claims experience are important operational factors, they are secondary to strategic alignment. The mission and vision guide priorities such as patient safety, quality improvement, regulatory compliance, and financial stewardship. Risk management activities should be structured to advance these priorities, reinforce leadership commitment, and support governance oversight.

An effective program reflects organizational culture, scope of services, and community role. It establishes reporting mechanisms to leadership, integrates enterprise risk management principles, and promotes collaboration across departments.

Health Care Operations objectives emphasize governance integration, strategic alignment, and organizational accountability. Therefore, the mission and vision of the facility should be the primary consideration when designing a new risk management program.

Question 7

Question Type: MultipleChoice

Which of the following risk management documents in a policy and procedure manual should be approved by an organization's board of directors?

Options:

A- philosophy regarding medical error management
B- risk management department's annual budget
C- risk analysis
D- departmental personnel job descriptions

Answer:

A

Explanation:

According to Health Care Risk Management standards outlined by ASHRM and the American Hospital Association Certification Center, the governing board has ultimate responsibility for organizational oversight, quality of care, and patient safety. As part of its fiduciary and governance duties, the board approves high-level policies that establish the organization's philosophy, strategic direction, and commitment to safety and risk management.

A philosophy regarding medical error management reflects the organization's approach to disclosure, reporting, just culture principles, accountability, and system improvement. Because this philosophy sets the tone for organizational culture and impacts patient safety, legal exposure, and regulatory compliance, it requires board-level approval to ensure alignment with governance expectations and accreditation standards.

In contrast, the risk management department's annual budget is typically approved through financial governance processes rather than as a policy document. Risk analyses are operational tools conducted by management and do not require board approval. Departmental personnel job descriptions are administrative documents managed at the executive or human resources level.

Health Care Operations objectives emphasize board engagement in safety culture and oversight of enterprise risk management. Therefore, the philosophy regarding medical error management should be approved by the organization's board of directors.

Question 8

Question Type: MultipleChoice

The Joint Commission requires that after a healthcare organization becomes aware of a sentinel event, it must complete a root cause analysis and action plan within how many days?

Options:

A- 30
B- 45
C- 60
D- 75

Answer:

B

Explanation:

According to Health Care Risk Management standards supported by ASHRM and the American Hospital Association Certification Center, The Joint Commission's sentinel event policy requires organizations to complete a thorough root cause analysis and develop an action plan within 45 days of becoming aware of the sentinel event.

The root cause analysis must identify underlying system failures and contributing factors rather than focusing solely on individual performance. The resulting action plan must outline specific corrective measures, assign responsibility, establish implementation timelines, and include mechanisms to monitor effectiveness. The emphasis is on sustainable system improvement to reduce the likelihood of recurrence.

Failure to complete the analysis and action plan within the required timeframe may result in additional review, accreditation consequences, or other follow-up actions by The Joint Commission. Timely completion demonstrates organizational accountability, leadership oversight, and commitment to patient safety.

Clinical and patient safety objectives emphasize structured investigation processes, documentation of corrective actions, and alignment with accreditation standards. Therefore, the required timeframe for completion of the root cause analysis and action plan following awareness of a sentinel event is 45 days.

Question 9

Question Type: MultipleChoice

Based on Joint Commission findings, what is a main cause of wrong-site surgery?

Options:

A- Communication failure
B- Laundry delays
C- Weather conditions
D- Pharmacy stock-outs

Answer:

A

Explanation:

Wrong-site surgery is a high-severity, preventable event. Joint Commission analyses repeatedly identify communication failures as a leading root cause---breakdowns in scheduling, consent/site verification, handoffs, and intraoperative confirmation. Risk management objectives therefore emphasize standardized verification systems: correct patient/procedure/site documentation, pre-op verification, surgical site marking, and a robust time-out performed with full team engagement. Communication failures can include ambiguous documentation, incorrect or incomplete handoff information, and hierarchy barriers that prevent speaking up. Improving communication reduces reliance on memory and individual vigilance and increases system reliability. In addition, organizations must audit compliance, address workarounds, and strengthen team empowerment so any member can stop the line if a mismatch is detected.

Question 10

Question Type: MultipleChoice

A patient who has suffered a stroke is aphasic and unable to swallow. The physician would like to place a PEG tube for feeding. The patient is considered incapacitated and his wife consents to the treatment. The patient's adult children do not. The wife and oldest daughter each present a power of attorney document identifying them as the designated decision makers. To support the ethical principle of patient autonomy, which of the following should the risk manager recommend?

Options:

A- Check the dates on the documents; the one with the older date is the valid power of attorney.
B- Check the dates on the documents; the one with the more recent date is the valid power of attorney.
C- Tell the family to contact their respective counsel and return when they have worked this issue out.
D- Refer the matter to the Ethics Committee for resolution.

Answer:

B

Explanation:

Under Health Care Risk Management principles supported by ASHRM and the American Hospital Association Certification Center, patient autonomy is upheld by honoring valid advance directives and durable powers of attorney for healthcare. When multiple documents are presented that designate different decision makers, the most recent properly executed document typically

supersedes earlier versions, unless state law provides otherwise.

Durable powers of attorney for healthcare may be revoked or replaced by executing a newer document. Therefore, determining the effective document requires reviewing execution dates and ensuring validity under applicable state statutes, including witnessing and notarization requirements. The document with the more recent date generally reflects the patient's latest expressed wishes and controls decision-making authority.

Referring immediately to an ethics committee may be appropriate in unresolved value conflicts, but first establishing legal authority is essential. Asking the family to resolve the dispute independently delays necessary medical decisions and does not clarify legal standing. Selecting the older document would contradict the principle that later directives replace earlier ones.

Legal and regulatory objectives emphasize verification of surrogate authority, compliance with state advance directive laws, and protection of patient autonomy. Therefore, the risk manager should confirm which document is most recent and legally valid.

Question 11

Question Type: MultipleChoice

Which option best has been proven to reduce costs of workers' compensation programs?

Options:

A- early return-to-work programs
B- comprehensive departmental safety analyses
C- employee assistance programs
D- employee disciplinary actions

Answer:

A

Explanation:

Within Health Care Risk Management frameworks endorsed by ASHRM and the American Hospital Association Certification Center, early return-to-work programs are recognized as one of the most effective strategies for controlling workers' compensation costs. These programs facilitate the safe and timely return of injured employees to modified or transitional duty consistent with medical restrictions.

Workers' compensation costs are significantly influenced by wage replacement benefits and duration of disability. By reducing the length of time an employee remains off work, early return-to-work initiatives directly decrease indemnity payments, lower claim severity, and improve overall claim outcomes. Additionally, such programs support employee morale, maintain productivity, and reduce the likelihood of prolonged disability or litigation.

While comprehensive safety analyses contribute to injury prevention and long-term risk reduction, their direct cost impact is preventive rather than immediately measurable in claim severity. Employee assistance programs focus primarily on behavioral health and personal support, not claim cost containment. Disciplinary actions do not constitute a structured risk financing strategy and may negatively affect organizational culture.

Therefore, from a risk financing perspective, early return-to-work programs have demonstrated measurable effectiveness in reducing workers' compensation program costs.

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