

# **Certified Professional in Patient Safety (CPPS) Practice Exam Sample Study Guide**



**EVERYTHING you need from our exam experts!**

**Featuring practice questions, answers, and explanations  
for each question.**

**This study guide is a SAMPLE. Visit  
<https://certifiedprofessionalinfoodsafety-cpps.examzify.com>  
to get the full version available exclusively to  
Examzify Plus pass holders .**

**Copyright © 2025 by Examzify - A Kaluba Technologies Inc. product.**

**ALL RIGHTS RESERVED.**

**No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.**

**Notice: Examzify makes every reasonable effort to obtain from reliable sources accurate, complete, and timely information about this product.**

**SAMPLE**

## **Questions**

- 1. What principle of high reliability focuses on investigating beyond surface-level explanations?**
  - A. Resiliency.**
  - B. Reluctance to accept simple explanations.**
  - C. Deference to expertise.**
  - D. Sensitivity to operations.**
- 2. In case of equipment variance in a hospital, which human factors engineering solution should be prioritized?**
  - A. Resilience.**
  - B. Forcing functions.**
  - C. Usability tests.**
  - D. Standardization.**
- 3. Which of the following statements best describes the science of human factors?**
  - A. It is applied to address problems by modifying the design of the system to better aid the people in it.**
  - B. It is about eliminating human error.**
  - C. It consists of a set of principles that can be learned during training.**
  - D. It represents the intersection of medicine and engineering.**
- 4. Which tool is best suited for assessing risks before implementing robotic surgery technology?**
  - A. Meaningful use evaluation**
  - B. Failure modes and effects analysis (FMEA)**
  - C. Root cause analysis (RCA)**
  - D. Patient safety leadership WalkRounds**
- 5. According to the Institute for Safe Medication Practices (ISMP), why should manual independent double checks (IDCs) be used selectively?**
  - A. Given the workload, staff do not have time for IDCs on all high-alert medications.**
  - B. Research has shown that IDCs are not effective.**
  - C. Reversal agents for medication overdoses are widely available.**
  - D. Computerized prescriber order entry has greatly reduced medication errors.**

- 6. What is a common barrier to effective communication in healthcare?**
- A. Advanced technology**
  - B. Hierarchical structures within care teams**
  - C. Abundant resources**
  - D. Comprehensive training programs**
- 7. What does the term "psychological safety" refer to in a healthcare setting?**
- A. A belief that one will not be punished or humiliated for speaking up.**
  - B. A supportive system of shared accountability.**
  - C. A system designed for reporting adverse events.**
  - D. A method to ensure compliance with regulations.**
- 8. What is the relationship between burnout and patient safety?**
- A. Burnout can enhance communication among providers**
  - B. Burnout can lead to decreased attention and higher error rates among healthcare workers**
  - C. Burnout has no impact on patient safety**
  - D. Burnout results in more thorough patient examinations**
- 9. Which tool is commonly used for risk assessment in healthcare?**
- A. SWOT Analysis**
  - B. Fishbone Diagram**
  - C. Failure Mode and Effects Analysis (FMEA)**
  - D. Brainstorming Sessions**
- 10. What does a "whole system" approach mean in patient safety?**
- A. Focusing solely on clinical outcomes**
  - B. Considering all elements of care delivery to identify risks and solutions**
  - C. Emphasizing individual provider accountability**
  - D. Ignoring external factors influencing patient care**

## **Answers**

SAMPLE

1. B
2. D
3. A
4. B
5. A
6. B
7. A
8. B
9. C
10. B

SAMPLE

## **Explanations**



**1. What principle of high reliability focuses on investigating beyond surface-level explanations?**

- A. Resiliency.
- B. Reluctance to accept simple explanations.**
- C. Deference to expertise.
- D. Sensitivity to operations.

The principle of high reliability that emphasizes investigating beyond surface-level explanations is the reluctance to accept simple explanations. This principle directs practitioners to delve deeper into issues rather than settling for initial, superficial justifications for problems or failures. By encouraging a comprehensive analysis, this approach helps to uncover the more complex underlying causes of incidents or adverse events in patient safety, leading to more effective solutions and improved outcomes. This principle fosters a culture of inquiry where team members are trained to critically assess situations, recognizing that the initial explanation may not capture the full picture. The aim is to prevent complacency and promote thorough investigation, ensuring that all contributing factors are identified and addressed. This understanding is crucial for healthcare professionals, as it aligns with the need for continuous improvement and learning in safety practices. It underscores the importance of not only addressing immediate concerns but also understanding their broader implications to prevent recurrence. Other principles, while important in high-reliability organizations, focus on different aspects of safety and operational effectiveness. Resiliency, for instance, emphasizes the capacity to anticipate, adapt, and respond effectively to unexpected challenges. Deference to expertise involves recognizing and valuing the input of individuals with relevant knowledge in decision-making processes. Sensitivity to operations pertains to heightened awareness of the day-to-day

**2. In case of equipment variance in a hospital, which human factors engineering solution should be prioritized?**

- A. Resilience.
- B. Forcing functions.
- C. Usability tests.
- D. Standardization.**

Prioritizing standardization in the case of equipment variance within a hospital is essential for ensuring consistent processes and enhancing patient safety. Standardization refers to creating uniform protocols and practices that reduce variations in equipment use and operational procedures. This consistency is vital as it minimizes the risk of errors that can occur when healthcare providers encounter multiple versions of equipment or different protocols. By implementing standardized equipment and procedures, hospitals can improve communication among staff, enhance training effectiveness, and streamline workflows. This leads to improved efficiency and a reduction in potential mistakes associated with equipment variance, ultimately resulting in better patient outcomes. While the other options, such as usability tests, forcing functions, and resilience, each have their importance in addressing human factors, standardization significantly impacts safety and effectiveness in a hospital environment. Ensuring that all staff are familiar with the same equipment and protocols allows for clearer expectations and smoother operations, and therefore is prioritized in situations of equipment variance.

**3. Which of the following statements best describes the science of human factors?**

**A. It is applied to address problems by modifying the design of the system to better aid the people in it.**

**B. It is about eliminating human error.**

**C. It consists of a set of principles that can be learned during training.**

**D. It represents the intersection of medicine and engineering.**

The statement that best describes the science of human factors is that it is applied to address problems by modifying the design of the system to better aid the people in it. This perspective is central to human factors engineering, which emphasizes the importance of understanding how people interact with various systems, tools, and environments. By focusing on optimizing the design of these systems, human factors science aims to enhance usability, improve performance, and reduce the risk of errors. The goal of human factors is not solely to eliminate human error, but rather to create systems that anticipate human capabilities and limitations. While it's true that human factors can contribute to reducing errors, the broader scope involves enhancing overall system design to make it more effective and user-friendly. Furthermore, while there are principles within human factors that can be learned through training, the essence of the field lies in practical application rather than solely theoretical knowledge. It also spans beyond just training into a comprehensive approach that involves research, design, and iterative improvement. Lastly, while there is an intersection of medicine and engineering in human factors, the science itself is broader, encompassing psychology, sociology, and design fields, thereby focusing on how to create systems that work better for human users in various contexts.

**4. Which tool is best suited for assessing risks before implementing robotic surgery technology?**

**A. Meaningful use evaluation**

**B. Failure modes and effects analysis (FMEA)**

**C. Root cause analysis (RCA)**

**D. Patient safety leadership WalkRounds**

The best tool for assessing risks before implementing robotic surgery technology is Failure Modes and Effects Analysis (FMEA). FMEA is a proactive risk assessment method that helps healthcare organizations identify potential failures in processes, products, or systems before they occur. It takes into account various failure modes, the likelihood of their occurrence, their potential effects on patient safety, and how they could impact the overall success of a new technology like robotic surgery. Using FMEA for this situation allows healthcare teams to evaluate all aspects of implementing robotic surgery, including technical, operational, and human factors. By identifying potential complications or issues in advance, the organization can develop strategies to mitigate those risks and enhance patient safety. Other tools mentioned, such as root cause analysis (RCA), are more appropriate for investigating incidents after they have occurred, rather than assessing potential risks before implementation. Meaningful use evaluation focuses on the effective use of technology in improving healthcare delivery and outcomes, but it does not specifically assess risks. Patient safety leadership WalkRounds aim to engage leadership with staff regarding safety issues but do not systematically analyze risks associated with new technologies. Thus, FMEA stands out for its comprehensive approach to proactively identifying and mitigating risks prior to the introduction of robotic surgery technology.

**5. According to the Institute for Safe Medication Practices (ISMP), why should manual independent double checks (IDCs) be used selectively?**

**A. Given the workload, staff do not have time for IDCs on all high-alert medications.**

**B. Research has shown that IDCs are not effective.**

**C. Reversal agents for medication overdoses are widely available.**

**D. Computerized prescriber order entry has greatly reduced medication errors.**

The use of manual independent double checks (IDCs) should be approached selectively primarily due to the consideration of healthcare staff workload and the practicalities of clinical practice. High-alert medications, which are medications associated with a higher risk of causing significant harm when used incorrectly, certainly warrant careful scrutiny; however, requiring IDCs on all of these medications can lead to inefficiencies and increased workload. When staff are overwhelmed with tasks, there's a risk that they may become distracted or rushed, which could unintentionally lead to errors despite the presence of IDCs. Therefore, implementing selective IDCs allows healthcare providers to focus their efforts on those high-alert medications that pose the greatest risk, while also maintaining their capacity to provide safe and effective care overall. This strategic approach helps ensure that double checks are used judiciously where they are most needed, thereby enhancing patient safety without unnecessarily burdening the staff. In this context, other choices do not provide as compelling a rationale for the selective use of IDCs. For instance, the effectiveness of IDCs is not discounted in the same way by researched findings, and while computerized systems certainly contribute to reducing errors, they do not eliminate the need for vigilance in medication administration.

**6. What is a common barrier to effective communication in healthcare?**

**A. Advanced technology**

**B. Hierarchical structures within care teams**

**C. Abundant resources**

**D. Comprehensive training programs**

Hierarchical structures within care teams can significantly impede effective communication in healthcare settings. In many organizations, traditional roles and positions can create barriers where team members may hesitate to speak up or share concerns, especially if they feel that their input may not carry the same weight as that of higher-ranking individuals. When communication flows predominantly from the top down, it can lead to misunderstandings, lack of engagement, and missed opportunities for collaborative problem-solving. The dynamics of hierarchy may also result in those at the lower levels feeling undervalued or intimidated, thus further stifling open dialogue. Fostering an environment where every team member, regardless of their position, feels comfortable and empowered to communicate can enhance safety and the quality of patient care. This underscores the importance of addressing hierarchical barriers to cultivate a culture of safety within healthcare teams.

7. What does the term "psychological safety" refer to in a healthcare setting?

- A. A belief that one will not be punished or humiliated for speaking up.**
- B. A supportive system of shared accountability.
- C. A system designed for reporting adverse events.
- D. A method to ensure compliance with regulations.

The term "psychological safety" in a healthcare setting primarily refers to the environment where individuals feel secure in expressing their thoughts, ideas, and concerns without fear of negative repercussions. This concept is crucial for fostering open communication among healthcare workers, as it encourages team members to speak up about patient safety issues, share innovative ideas, or report errors without worry of punishment or ridicule. When healthcare professionals operate in a psychologically safe environment, they are more likely to engage in candid discussions about potential problems and collaborate effectively, leading to improved patient outcomes and enhanced organizational culture. This supportive atmosphere is foundational for continuous learning and quality improvement within healthcare teams, as it cultivates trust and promotes active participation in safety initiatives. While the other options address important aspects of healthcare operations, they do not encapsulate the essence of psychological safety as effectively. Shared accountability is more about responsibility among team members, reporting systems focus on the formal channels for incident reporting, and compliance methods pertain specifically to adhering to regulatory standards—all of which, while critical, do not capture the fundamental notion of creating an open and trusting environment for communication and dialogue.

8. What is the relationship between burnout and patient safety?

- A. Burnout can enhance communication among providers
- B. Burnout can lead to decreased attention and higher error rates among healthcare workers**
- C. Burnout has no impact on patient safety
- D. Burnout results in more thorough patient examinations

The relationship between burnout and patient safety significantly highlights the negative impact that burnout can have on healthcare providers and the quality of care they deliver. When healthcare workers experience burnout, they often face emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. This state can lead to decreased attention and vigilance in their work, which in turn increases the likelihood of errors. Healthcare providers who are burned out may struggle with concentration, critical thinking, and decision-making, all of which are essential for maintaining patient safety. As a result, the risk of making mistakes, overlooking important details, or failing to communicate effectively with colleagues and patients escalates. This direct correlation explains why burnout is considered a significant concern in the realm of patient safety, emphasizing the need for effective interventions to support healthcare workers' well-being. Other options, while they may reflect misconceptions about the effects of burnout, do not capture the established understanding of its adverse consequences on the safety and quality of patient care.

**9. Which tool is commonly used for risk assessment in healthcare?**

**A. SWOT Analysis**

**B. Fishbone Diagram**

**C. Failure Mode and Effects Analysis (FMEA)**

**D. Brainstorming Sessions**

Failure Mode and Effects Analysis (FMEA) is a structured approach to identifying and prioritizing potential failures in a system, process, or product, particularly within healthcare settings. It systematically evaluates what might go wrong, assesses the impact of those failures, and identifies the causes and potential effects. This method is particularly relevant to healthcare risk assessment as it not only helps in understanding the various ways healthcare processes or systems may fail, but it also promotes preventive measures by prioritizing risks based on their severity, occurrence, and detectability. FMEA is widely recognized for its systematic approach and focus on proactive risk management, making it a preferred tool among healthcare professionals aiming to enhance patient safety and improve overall healthcare quality. By utilizing FMEA, organizations can implement strategies to mitigate risks before they happen, ultimately enhancing patient care and safety outcomes.

**10. What does a "whole system" approach mean in patient safety?**

**A. Focusing solely on clinical outcomes**

**B. Considering all elements of care delivery to identify risks and solutions**

**C. Emphasizing individual provider accountability**

**D. Ignoring external factors influencing patient care**

A "whole system" approach in patient safety refers to the practice of considering all elements of care delivery to identify risks and solutions holistically. This approach recognizes that patient safety is influenced by a multitude of factors, including processes, environments, communication, teamwork, organizational culture, and systems that all interact with one another. By taking this comprehensive view, healthcare organizations can better understand the interconnectedness of various components, allowing for more effective identification of potential hazards, barriers to patient safety, and opportunities for improvement. This approach goes beyond just examining isolated clinical outcomes or focusing solely on the actions of individual providers. Instead, it encourages collaborative efforts and systemic changes that can lead to safer care environments. This perspective is fundamental in developing strategies that enhance safety across all levels of the healthcare system, rather than simply addressing isolated incidents or areas.