

Certified Professional in Patient Safety (CPPS) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

Copyright © 2026 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 accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	17

SAMPLE

Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

SAMPLE

- 1. Which event provides the best opportunity for conducting a root cause analysis (RCA)?**
 - A. A post-operative patient removes his own IV, causing a skin tear from the tape.**
 - B. A patient with no known allergies experiences an anaphylactic reaction to an antibiotic.**
 - C. The biopsy samples from a colonoscopy are never received by pathology after the procedure.**
 - D. Depressed respirations related to sedation in the same department.**

- 2. Which safety tool includes practices such as bedside shift report and medication reconciliation?**
 - A. Patient and family engagement**
 - B. Standardization**
 - C. Medication administration safety**
 - D. Patient safety themes**

- 3. Which method is a scientific approach to process improvement in real work settings?**
 - A. Root cause analysis (RCA)**
 - B. Event analysis**
 - C. Plan-Do-Study-Act (PDSA) cycle**
 - D. Failure mode and effects analysis (FMEA)**

- 4. Who are "patient safety champions"?**
 - A. Patients who have experienced errors**
 - B. Individuals who advocate for safety initiatives within their organizations**
 - C. Healthcare workers who do not support safety protocols**
 - D. Administrators who manage safety budgets**

- 5. The scenario where a nurse gives the wrong medication to a patient due to distraction is an example of which type of error?**
 - A. Sentinel event.**
 - B. Human error.**
 - C. Behavioral choice.**
 - D. System failure.**

6. What is the definition of a sentinel event?

- A. An unexpected occurrence involving financial loss**
- B. An expected outcome from a routine procedure**
- C. An unexpected occurrence involving death or serious physical or psychological injury**
- D. A minor incident that requires intervention**

7. What percentage of respondents agreed that "we have patient safety problems in this unit," according to the survey results?

- A. 75%**
- B. 60%**
- C. 25%**
- D. 20%**

8. What is the primary goal of implementing patient safety WalkRounds?

- A. To increase the number of safety reports filed by staff.**
- B. To educate the board about safety data.**
- C. To empower frontline staff to identify safety risks.**
- D. To standardize safety protocols across departments.**

9. When creating a checklist, how many tasks should ideally be kept to match working memory limits?

- A. 1 and 5**
- B. 3 and 10**
- C. 5 and 9**
- D. 10 and 15**

10. What should be the focus of a gap analysis when assessing a replacement for a safety reporting system?

- A. Existing software capabilities**
- B. Staff training needs**
- C. Stakeholder requirements**
- D. Financial estimates for software**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

- 1. Which event provides the best opportunity for conducting a root cause analysis (RCA)?**
 - A. A post-operative patient removes his own IV, causing a skin tear from the tape.**
 - B. A patient with no known allergies experiences an anaphylactic reaction to an antibiotic.**
 - C. The biopsy samples from a colonoscopy are never received by pathology after the procedure.**
 - D. Depressed respirations related to sedation in the same department.**

The correct answer identifies a scenario that involves a clear systemic failure that warrants a comprehensive investigation to understand underlying factors and processes. In the case of biopsy samples not being received by pathology after a procedure, this event indicates a breakdown in communication and workflow that could affect patient outcomes significantly. Such a situation not only impacts the current patient's care but could also pose risks for future patients, emphasizing the importance of understanding how such an error occurred to prevent reoccurrence. Root cause analysis is most effectively conducted on events where there is potential for serious harm or where processes fail, leading to adverse outcomes. The scenario concerning the biopsy samples highlights a specific and factual issue—a tangible failure in protocol that can be dissected and analyzed. The RCA aims to determine not just what went wrong, but why it went wrong, enabling the development of preventive strategies. Other events, while also serious, may not reflect systemic issues as clearly as the one concerning the biopsy samples. For example, the anaphylactic reaction to an antibiotic pertains to individual patient risk factors or potential gaps in allergy screening, which might not indicate a systematic flaw. Similarly, the other scenarios focus more on situational errors rather than widespread process failures that need to be addressed through an RCA. The case of the biopsy samples

SAMPLE

2. Which safety tool includes practices such as bedside shift report and medication reconciliation?

- A. Patient and family engagement**
- B. Standardization**
- C. Medication administration safety**
- D. Patient safety themes**

The correct answer focuses on the concept of medication administration safety, which encompasses practices specifically designed to ensure that medications are administered accurately and safely to patients. Bedside shift report and medication reconciliation are two critical strategies implemented within healthcare settings that contribute to enhancing the safety and effectiveness of medication management. Bedside shift report encourages direct communication between outgoing and incoming healthcare providers at the patient's bedside. This practice ensures that all critical information regarding the patient's medication regimen is communicated directly, which promotes accountability and patient involvement in their own care. Patients are often better informed and can verify that their medications are being managed correctly, reducing the likelihood of errors. Medication reconciliation, on the other hand, is a systematic process that involves comparing a patient's medication orders to all of the medications that the patient has been taking. This practice aims to identify and resolve any discrepancies, ensuring that patients receive the correct medications at the right dosages and times throughout their care transitions, such as from hospitalization to home care or from one facility to another. Both practices play a fundamental role in medication administration safety by supporting clear communication and thorough review of medication regimens, ultimately safeguarding patients from potential medication errors.

3. Which method is a scientific approach to process improvement in real work settings?

- A. Root cause analysis (RCA)**
- B. Event analysis**
- C. Plan-Do-Study-Act (PDSA) cycle**
- D. Failure mode and effects analysis (FMEA)**

The Plan-Do-Study-Act (PDSA) cycle is recognized as a scientific approach to process improvement in real work settings because it provides a structured framework for testing changes in processes and assessing their impact in a practical environment. The PDSA cycle consists of four repeated steps: 1. ****Plan****: Identify a goal or aim and develop a plan for testing a change that will lead to improvement. 2. ****Do****: Implement the plan on a small scale to test the change. 3. ****Study****: Analyze the data gathered during the test to evaluate the impact of the change and compare the results to the expected outcomes. 4. ****Act****: Based on what was learned from the study phase, decide whether to adopt, adapt, or abandon the change. This iterative process enables ongoing refinement and helps organizations progressively improve their practices based on evidence and feedback from real-world applications. It fosters a culture of continuous improvement, allowing teams to adapt and innovate effectively. Though the other methods like root cause analysis, event analysis, and failure mode and effects analysis have their specific roles in safety and quality improvement, they do not inherently provide the same cycle of experimentation and continuous learning offered by the PDSA framework. Root cause analysis

4. Who are "patient safety champions"?

- A. Patients who have experienced errors**
- B. Individuals who advocate for safety initiatives within their organizations**
- C. Healthcare workers who do not support safety protocols**
- D. Administrators who manage safety budgets**

Patient safety champions are individuals who advocate for safety initiatives within their organizations, making them crucial advocates for fostering a culture of safety. These champions are often involved in implementing safety protocols, promoting best practices, and raising awareness about patient safety issues. They work to engage other staff and leadership, encouraging a collective effort towards reducing errors and improving patient outcomes. This role is essential in driving organizational change and influencing policies that prioritize patient safety. By being proactive about safety measures, these champions can inspire others in the healthcare setting to prioritize safety, ultimately leading to a more effective and supportive environment for both patients and healthcare providers.

5. The scenario where a nurse gives the wrong medication to a patient due to distraction is an example of which type of error?

- A. Sentinel event.**
- B. Human error.**
- C. Behavioral choice.**
- D. System failure.**

The scenario where a nurse gives the wrong medication to a patient due to distraction is best categorized as a human error. This type of error is a mistake made by an individual, resulting from factors such as lapses in attention, memory failures, or misjudgments during the execution of their duties. In this case, the nurse's distraction directly led to the incorrect administration of medication. Human errors often stem from cognitive overload, fatigue, or environmental distractions, as seen here. Understanding this distinction is crucial for developing strategies to minimize such errors in healthcare settings, emphasizing the importance of maintaining focus and implementing safe medication practices. Other options, while relevant to different contexts, do not represent this specific scenario accurately. Sentinel events are significant incidents that result in death or serious injury, and behavioral choice refers more to decisions made based on a willingness to act or not act in a particular way. System failures pertain to broader organizational issues that might create an environment conducive to error, rather than the direct actions of an individual.

6. What is the definition of a sentinel event?

- A. An unexpected occurrence involving financial loss
- B. An expected outcome from a routine procedure
- C. An unexpected occurrence involving death or serious physical or psychological injury**
- D. A minor incident that requires intervention

A sentinel event is defined as an unexpected occurrence that results in death or serious physical or psychological injury. This definition highlights the critical nature of these events, which serve as indicators of underlying safety issues within a healthcare system. Sentinel events prompt thorough investigation and analysis to prevent future occurrences, making them vital to patient safety and quality of care. The key aspect of this definition is the element of unexpectedness, indicating that these events are not anticipated outcomes of care. When a sentinel event occurs, it usually uncovers significant problems within healthcare practices, such as flaws in processes, communication failures, or inadequate training. Recognizing and responding appropriately to sentinel events is essential for improving patient safety and ensuring high-quality care. In contrast, the other options describe circumstances that do not align with the definition of a sentinel event. Financial loss, expected outcomes from routine procedures, and minor incidents do not carry the same gravity or implications for patient safety as sentinel events do. Understanding this distinction is crucial for healthcare professionals dedicated to enhancing safety and quality within their practices.

7. What percentage of respondents agreed that "we have patient safety problems in this unit," according to the survey results?

- A. 75%**
- B. 60%
- C. 25%
- D. 20%

The assertion that 75% of respondents agreed that "we have patient safety problems in this unit" indicates a significant recognition of safety issues among staff within that unit. This substantial percentage underscores the importance of awareness and acknowledgment in improving patient safety. Recognizing existing safety problems is a critical first step toward fostering a culture of safety and initiating necessary interventions to address and mitigate these issues. A high level of agreement, such as 75%, can serve as a compelling impetus for leadership to implement changes and prioritize patient safety initiatives. It reflects a widespread consensus that safety challenges exist, which can lead to more focused actions on enhancing safety practices, training, and resources within the healthcare environment.

8. What is the primary goal of implementing patient safety WalkRounds?

- A. To increase the number of safety reports filed by staff.
- B. To educate the board about safety data.
- C. To empower frontline staff to identify safety risks.**
- D. To standardize safety protocols across departments.

The primary goal of implementing patient safety WalkRounds is to empower frontline staff to identify safety risks. WalkRounds serve as a structured approach for leaders and staff to engage collaboratively in discussions about safety concerns and challenges encountered in day-to-day operations. By involving frontline staff, who have direct experience and insight into safety issues, these rounds provide an opportunity for staff to voice their concerns, share observations, and suggest solutions. This empowerment encourages a culture of safety where employees feel valued and recognized for their contributions, ultimately leading to improved patient safety outcomes. While increasing the number of safety reports filed, educating the board about safety data, and standardizing protocols are important aspects of an overall patient safety strategy, they do not capture the essence of what WalkRounds primarily aim to achieve. The focus on frontline empowerment distinctly highlights the interactive nature of WalkRounds and their role in fostering open communication about safety within the organization.

9. When creating a checklist, how many tasks should ideally be kept to match working memory limits?

- A. 1 and 5
- B. 3 and 10
- C. 5 and 9**
- D. 10 and 15

The ideal number of tasks in a checklist aligns with cognitive psychology research on working memory limits, which suggest that individuals can effectively manage between 5 and 9 items at one time. This range allows for optimal cognitive load, ensuring that users can recall and execute each task without becoming overwhelmed or confused. When creating checklists, it is critical to stay within this range because exceeding it can lead to decreased performance and an increased likelihood of errors. This consideration is particularly important in high-stakes environments, such as healthcare, where precision is vital for patient safety. By keeping the number of tasks between 5 and 9, checklists can support the user's ability to dutifully follow the prescribed steps without cognitive overload, thereby enhancing adherence and improving outcomes. This practice is grounded in understanding human cognitive capabilities, especially when those tasks require attention and memory recall simultaneously.

10. What should be the focus of a gap analysis when assessing a replacement for a safety reporting system?

- A. Existing software capabilities**
- B. Staff training needs**
- C. Stakeholder requirements**
- D. Financial estimates for software**

The focus of a gap analysis when assessing a replacement for a safety reporting system should be on stakeholder requirements. This approach is essential because understanding the needs and expectations of all parties involved—such as healthcare providers, safety officers, administrators, and patients—ensures that the new system effectively addresses the key concerns and challenges currently faced. Engaging with stakeholders helps identify critical functions and features that are necessary for improving safety reporting, thereby enhancing the overall effectiveness of the system. By prioritizing stakeholder requirements, a healthcare organization can ensure that the replacement system not only meets regulatory standards but also aligns with practical operational needs, ultimately leading to better patient safety outcomes and user satisfaction. This strategic focus on collaboration and communication allows for a comprehensive understanding of what stakeholders require to successfully report and analyze safety incidents, which is crucial for the ongoing improvement of patient safety initiatives.

SAMPLE

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://certifiedprofessionalinfoodsafety-cpps.examzify.com>

We wish you the very best on your exam journey. You've got this!

SAMPLE