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PRACTICE QUESTIONS

Certification Board for Professionals in Patient Safety (CBPPS)

FMB9686W

Certified Professional in Human Factors in Health Care
(CPHFH)[™] Examination

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for Certification Board for Professionals in Patient Safety (CBPPS) **FMB9686W**, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, **FMB9686W**
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

SINGLE CHOICE

Which statement best describes the fundamental premise of the human factors approach to patient safety?

- ☐ A Human error is the primary cause of adverse events and must be eliminated through individual accountability.
- ☐ B Humans are inherently unreliable components that should be replaced by automation wherever possible.
- ☒ C Humans are integral components of systems; safety is improved by designing systems that account for human capabilities and limitations.
- ☐ D Adverse events are caused solely by system failures, so individual behavior is not relevant to safety improvement.

ANSWER C

WHY Human factors is grounded in the systems view that humans are part of the work system. Safety improves by designing processes, tools, and environments that fit human capabilities and limitations, rather than by blaming individuals or relying solely on replacement by technology. Options A and D reflect inaccurate extremes, and option B ignores the reality that automation introduces its own human-factors challenges.

QUESTION 2

SINGLE CHOICE

A nurse misreads a medication order because two look-alike drug names are stored on adjacent screens in the electronic health record. Which human factors concept best explains this error?

- ☐ A Confirmation bias
- ☐ B Situational awareness failure
- ☒ C Visual perception influenced by display design
- ☐ D Authority gradient

ANSWER C

WHY Adjacency and visual similarity in a display exploit known limitations of visual perception, such as the difficulty of distinguishing near-identical stimuli presented close together. This is a display-design human factors issue rather than a motivational, social, or higher-order cognitive bias.

QUESTION 3

SINGLE CHOICE

According to the Swiss Cheese Model of accident causation, an adverse event typically occurs when:

- ☐ A A single layer of defense fails and the responsible individual is not retrained.
- ☒ B Latent failures and active failures align across multiple layers of defense so that hazards reach the patient.
- ☐ C Organizational culture is too punitive, causing staff to hide near misses.
- ☐ D Automated decision support is unavailable in the clinical workflow.

ANSWER B

WHY Reason's Swiss Cheese Model posits that each defensive layer has holes (latent conditions and active failures). An adverse event occurs when the holes in multiple layers align, allowing a hazard trajectory to reach the patient. The model emphasizes the cumulative interaction of system failures rather than any single cause.

QUESTION 4

SINGLE CHOICE

Structured communication tools such as SBAR (Situation–Background–Assessment–Recommendation) are recommended in health care primarily because they:

- ☐ A Eliminate the need for verbal handoffs between clinicians.
- ☒ B Standardize information transfer and reduce omissions across disciplines and levels of hierarchy.
- ☐ C Replace documentation in the electronic health record.
- ☐ D Are required by law for all patient encounters.

ANSWER B

WHY SBAR and similar structured communication tools standardize the content and sequence of clinical communication, which reduces omissions and the impact of hierarchy on information sharing. They do not replace verbal exchange, documentation, or legal requirements; they augment reliable communication.

QUESTION 5

SINGLE CHOICE

Which workplace design intervention is most consistent with human factors principles for reducing medication administration errors at a busy nursing station?

- ☐ A Requiring nurses to repeat a manual double-check for every dose.
- ☐ B Posting additional policy reminders at the workstation.
- ☒ C Reducing ambient noise, improving lighting, and providing a dedicated, uncluttered preparation area.
- ☐ D Increasing the number of patients assigned to each nurse to improve focus.

ANSWER C

WHY Human factors and ergonomic evidence show that noise, poor lighting, clutter, and interruptions contribute to cognitive overload and slips in medication preparation. Modifying the physical work environment is a higher-leverage, system-level intervention than adding rules, reminders, or workload.

QUESTION 6

SINGLE CHOICE

A well-designed clinical decision support (CDS) alert in an electronic health record should generally be:

- ☐ A Triggered for every possible drug interaction so that no risk is missed.
- ☒ B Specific, actionable, and delivered at a point in the workflow where the clinician can respond.
- ☐ C Displayed only after the order has been finalized.
- ☐ D Wording-identical to vendor default alerts to ensure consistency.

ANSWER B

WHY Human factors literature on CDS emphasizes that alerts should be specific, actionable, and timely. Alerts that are too frequent, non-actionable, or appear too late in the workflow contribute to alert fatigue and override behavior. Accepting vendor defaults verbatim typically reflects usability and workflow problems.

QUESTION 7

SINGLE CHOICE

Which characteristic distinguishes a Healthcare Failure Mode and Effects Analysis (HFMEA) from a Root Cause Analysis (RCA)?

- ☐ A HFMEA is used only after a sentinel event has harmed a patient.
- ☒ B HFMEA is a prospective analysis designed to identify and mitigate potential failures before they occur.
- ☐ C RCA focuses on redesigning physical workspaces, while HFMEA focuses on staff training.
- ☐ D RCA relies exclusively on quantitative data, while HFMEA relies exclusively on qualitative data.

ANSWER B

WHY HFMEA is a prospective, proactive risk-assessment method that identifies potential failure modes in a process and prioritizes interventions before harm occurs. RCA is reactive, performed after an adverse event or near miss to identify underlying causes and recommend system changes.

QUESTION 8

SINGLE CHOICE

A Just Culture differentiates between behaviors in an organization primarily by:

- ☐ A Assigning blame based on the severity of the outcome.
- ☐ B Punishing all individuals involved in any error regardless of intent.
- ☒ C Distinguishing human error, at-risk behavior, and reckless behavior when designing responses to events.
- ☐ D Focusing exclusively on system causes and ignoring individual accountability.

ANSWER C

WHY A Just Culture framework (associated with Reason and Marx) distinguishes among human error (unintentional slips/lapses), at-risk behavior (drift into shortcuts), and reckless behavior (conscious disregard of substantial risk). Responses differ for each category, balancing system improvement with appropriate accountability. It does not judge by outcome severity, nor does it absolve reckless conduct.

QUESTION 9

MULTIPLE CHOICE

Which of the following are recognized human factors methods used to evaluate health care processes and devices? (Choose two.)

- ☒ **A** Task analysis
- ☒ **B** Cognitive walkthrough / heuristic evaluation
- ☐ **C** Kaplan-Meier survival analysis
- ☐ **D** Failure Modes and Effects Analysis (FMEA)

ANSWER A • B

WHY Task analysis and heuristic evaluation (often supported by cognitive walkthroughs) are core human factors methods used to describe work, identify demands on users, and evaluate interfaces against usability principles. While FMEA is widely used in health care safety work, in its classic form it is a risk-assessment method rather than a human factors evaluation method; Kaplan-Meier is a biostatistical survival analysis, not a human factors tool.