Medical Errors FY 20-22 Quiz

Email completed test to Leila.filson@flhealth.gov to receive certificate for course

| Name_ | | | Date | License # | | |
|-------|--|--------------------------|---------------------------------|-----------|--|--|
| | | | | | | |
| 1. | Medical Errors are the leading cause of death in the United States. | | | | | |
| | a. | 1 st | | | | |
| | b. | 2 nd | | | | |
| | c. | 3 rd | | | | |
| | d. | 4 th | | | | |
| 2. | These medical errors occur during the time after the laboratory reports test results | | | | | |
| | a. | Pre-Analytical | | | | |
| | b. | Analytical | | | | |
| | c. | Post-Analytical | | | | |
| | d. | Root Cause | | | | |
| 3. | Errors of omission are medical errors involving inaction such as | | | | | |
| | a. | Omitting a reagent in | n a test | | | |
| | b. | Failing to communication | ate a critical test result | | | |
| | c. | Forgetting to collect | a test sample at a specific tir | ne | | |
| | d. | All the above | | | | |
| 4. | What can be done at the Organizational level to prevent medical errors? | | | | | |
| | a. | Design systems that | minimize the chance of an e | rror | | |
| | b. | Create a culture of di | iscussing near misses | | | |
| | c. | Implement process n | nanagement improvement | | | |
| | d. | All of the above | | | | |
| 5. | The following term means to be "caused by doctors". | | | | | |
| | a. | latrogenic | | | | |
| | b. | Error | | | | |
| | C. | Adverse Event | | | | |
| 6. | We all play a role in reducing and preventing Medical Errors. | | | | | |
| | a. | True | | | | |
| | b. | False | | | | |
| 7. | Identifying possible problems to be analyzed is part of: | | | | | |
| | a. | Pre-Analytical | | | | |
| | b. | Analytical | | | | |
| | c. | Post-Analytical | | | | |
| | d. | Root Cause | | | | |

| 8. Th | | medical errors occur during the time the laboratory is directly involved in the testing of specimens. |
|--------|---------|--|
| | | Pre-Analytical |
| | | Analytical |
| | | Post-Analytical |
| | d. | Root Cause |
| 9. Sc | ome a | dverse events are preventable and some are not preventable |
| | a. | True |
| | b. | False |
| | | can be prevented by designing systems that make it hard for people to do the wrong thing and easy for to do the right thing. |
| | a. | True |
| | b. | False |
| 11. Al | ll adve | erse events are considered medical errors |
| | a. | True |
| | b. | False |
| 12. M | ledica | ll Errors were first published in 1999 by which organization |
| | a. | AHCA |
| | b. | CLIA |
| | c. | CAP |
| | d. | IOM |
| 13. Th | nese a | are examples of medical errors (check all that apply) |
| | | Wrong Diagnosis |
| | | Wrong Treatment |
| | | Operating on the wrong leg |
| | | Equipment failure |
| 14. Th | ne foll | lowing organizations have requirements that address error prevention (check all that apply) |
| | | AHCA |
| | b. | CLIA |
| | _ | CAP |
| | | JCAHO |
| | u. | Jenio |
| 15. Th | | lowing can be found to contribute to the root cause of an error |
| | a. | Communication problems |

b. Staffing Patterns and workflow

c. Inadequate policiesd. All of the above