

✓ "Review Page Number" references correspond to the numbers in the lower right corner of each page.

1.) The report to 'Err is Human: Building A Safer Health System' was released by IOM in _____. (Review Page 1)

- **A.** 1983
- **B.** 1999
- **C.** 2004

2.) _____ means any untoward medical occurrence or injury that results from a medical intervention rather than an underlying condition. (Review Page 4)

- A. Medical Error
- B. Adverse Event
- **C.** Sentinel Event

3.) The majority of all medical errors can fit into one of _____ error types. (Review Page 5)

- A. two
- B. four
- C. six

4.) A specimen stored at the wrong temperature prior to testing would be considered

a ______ error. (Review Page 7)

- A. Pre-Analytical
- B. Analytical
- **C.** Post-Analytical

5.) The Joint Commission (TJC) adopted a formal Sentinel Event policy in _____. (Review Page 9)

- **A.** 1984
- **B.** 1996
- **C.** 2007

6.) Organizations are required to report sentinel events to The Joint Commission. (Review Page 11)

- A. True
- B. False

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7.) Organizations should submit a comprehensive systematic analysis and corrective action plan within _____ business days of the event or of becoming aware of the event. (Review Page 12)

- **A.** 21
- **B.** 45
- **C.** 70

8.) When preparing reports for TJC, they must be acceptable to move forward with the process, which includes being _____. (Review Page 14)

- A. detailed, timely, and fact filled
- B. brief, credible, and acceptable
- C. thorough, credible, and acceptable

9.) A root cause analysis focuses primarily on the organization's systems and processes, as opposed to the individual's performance. (Review Page 16)

- A. True
- B. False

10.) The National Patient Safety Goals focus on problems in healthcare safety and how to solve them. (Review Page 20)

- A. True
- B. False

-- END OF QUIZ --