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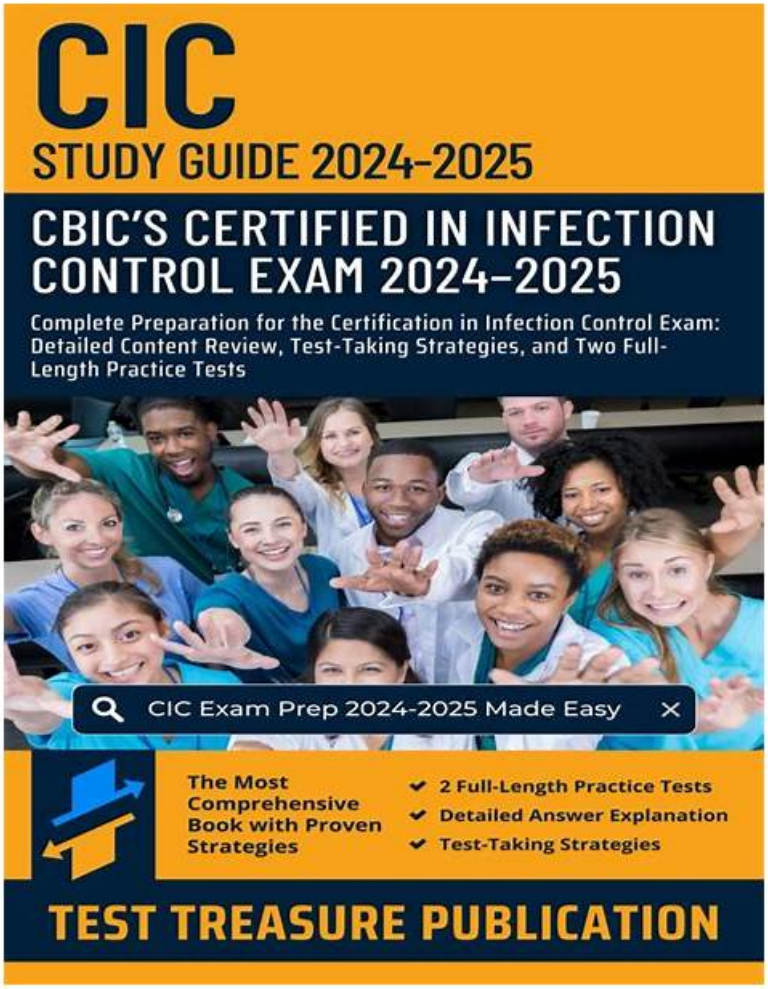

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CBIC Certified Infection Control Exam Sample Questions (Q83-Q88):

NEW QUESTION # 83
Assume the mean age of onset for patients with tuberculosis (TB) is 62 years, with one standard deviation of
5 years, and the age of onset follows a normal distribution. What is the percentage of patients expected to have the age of onset ranging from 57 to 67 years?

- A. 68%
- B. 99%
- C. 34%
- D. 95%

Answer: A

Explanation:
To determine the percentage of patients with an age of onset ranging from 57 to 67 years, we need to apply the properties of a normal distribution. In a normal distribution, the mean represents the central point, and the standard deviation defines the spread of the data. Here, the mean age of onset is 62 years, and the standard deviation is 5 years. The range of 57 to 67 years corresponds to one standard deviation below the mean (62 - 5
= 57) to one standard deviation above the mean (62 + 5 = 67).
In a normal distribution, approximately 68% of the data falls within one standard deviation of the mean (i.e., between # - # and # + #, where # is the mean and # is the standard deviation). This is a well-established statistical principle, often referred to as the 68-95-99.7 rule (or empirical rule) in statistics. Specifically, 34% of the data lies between the mean and one standard deviation above the mean, and another 34% lies between the mean and one standard deviation below the mean, totaling 68% for the range spanning one standard deviation on both sides of the mean.
Let's verify this:
* The lower bound (57 years) is exactly one standard deviation below the mean (62 - 5 = 57).
* The upper bound (67 years) is exactly one standard deviation above the mean (62 + 5 = 67).
* Thus, the range from 57 to 67 years encompasses the middle 68% of the distribution.
Option A (34%) represents the percentage of patients within one standard deviation on only one side of the mean (e.g., 62 to 67 or 57 to 62), not the full range. Option C (95%) corresponds to approximately two standard deviations from the mean (62 ± 10 years, or 52 to 72 years), which is wider than the given range.
Option D (99%) aligns with approximately three standard deviations (62 ± 15 years, or 47 to 77 years), which is even broader.
Since the question specifies a range of one standard deviation on either side of the mean, the correct answer is 68%, corresponding to Option B.
In infection control, understanding the distribution of disease onset ages can help infection preventionists identify at-risk populations and allocate resources effectively, aligning with the CBIC's focus on surveillance and data analysis (CBIC Practice Analysis, 2022). While the CBIC does not directly address statistical calculations in its core documents, the application of normal distribution principles is a standard epidemiological tool endorsed in public health guidelines, which inform CBIC practices.
References:
* CBIC Practice Analysis, 2022.
* Public Health Epidemiology Guidelines, Normal Distribution and Empirical Rule (commonly accepted statistical standards).

NEW QUESTION # 84
A 36-year-old female presents to the Emergency Department with a petechial rash, meningitis, and cardiac arrest. During the resuscitation, a phlebotomist sustained a needlestick injury. The next day, blood cultures reveal Neisseria meningitidis. The exposure management for the phlebotomist is:

- A. A review of the phlebotomist's hepatitis B vaccine status.
- B. Work furlough from day ten to day 21 after exposure.
- C. Prophylactic rifampin plus isoniazid.
- D. A tuberculin skin test now and in ten weeks.

Answer: B

Explanation:
The scenario involves a needlestick injury sustained by a phlebotomist during the resuscitation of a patient diagnosed with Neisseria meningitidis infection, characterized by a petechial rash, meningitis, and cardiac arrest. Neisseria meningitidis is a gram-negative diplococcus that can cause meningococcal disease, including meningitis and septicemia, and is transmitted through direct contact with respiratory secretions or, in rare cases, blood exposure. The exposure management for the phlebotomist must align with infection

control guidelines, such as those from the Certification Board of Infection Control and Epidemiology (CBIC) and the CDC, to prevent potential infection. Let's evaluate each option:
* A. Prophylactic rifampin plus isoniazid: Prophylactic antibiotics are recommended for close contacts of individuals with meningococcal disease to prevent secondary cases. Rifampin is a standard prophylactic agent for Neisseria meningitidis exposure, typically administered as a 2-day course (e.g., 600 mg every
12 hours for adults). Isoniazid, however, is used for tuberculosis (TB) prophylaxis and is not indicated for meningococcal disease. Combining rifampin with isoniazid is incorrect, as it reflects a confusion with TB management rather than meningococcal exposure. This option is not appropriate.
* B. A tuberculin skin test now and in ten weeks: A tuberculin skin test (TST) or interferon-gamma release assay (IGRA) is used to screen for latent tuberculosis infection, with a follow-up test at 8-10 weeks to detect conversion after potential TB exposure. Neisseria meningitidis is not related to TB, and a needlestick injury from a meningococcal patient does not warrant TB testing. This option is irrelevant to the scenario and not the correct exposure management.
* C. Work furlough from day ten to day 21 after exposure: Neisseria meningitidis has an incubation period of 2-10 days, with a maximum of about 14 days in rare cases. The CDC and WHO recommend that healthcare workers exposed to meningococcal disease via needlestick or mucosal exposure be monitored for signs of infection (e.g., fever, rash) and, if symptomatic, isolated and treated.
Additionally, a work restriction or furlough from day 10 to day 21 after exposure is advised to cover the potential incubation period, especially if prophylaxis is declined or contraindicated. This allows time to observe for symptoms and prevents transmission to vulnerable patients. This is a standard infection control measure and the most appropriate initial management step pending prophylaxis decision.
* D. A review of the phlebotomist's hepatitis B vaccine status: Reviewing hepatitis B vaccine status is a critical step following a needlestick injury, as hepatitis B can be transmitted through blood exposure.
However, this applies to bloodborne pathogens (e.g., HBV, HCV, HIV) and is not specific to Neisseria meningitidis, which is primarily a respiratory or mucosal pathogen. While hepatitis B management (e.
g., post-exposure prophylaxis with hepatitis B immunoglobulin or vaccine booster) should be addressed as part of a comprehensive needlestick protocol, it is not the first or most relevant priority for meningococcal exposure.
The best answer is C, as the work furlough from day 10 to day 21 after exposure addresses the specific risk of meningococcal disease following a needlestick injury. This aligns with CBIC's focus on timely intervention and work restriction to prevent transmission in healthcare settings. Prophylactic antibiotics (e.g., rifampin) should also be considered, but the question asks for the exposure management, and furlough is a primary control measure. Hepatitis B and TB considerations are secondary and managed separately.
References:
* CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III:
Prevention and Control of Infectious Diseases, which includes protocols for managing exposure to communicable diseases like meningococcal infection.
* CBIC Examination Content Outline, Domain IV: Environment of Care, which addresses work restrictions and exposure management.
* CDC Guidelines for Meningococcal Disease Prevention and Control (2023), which recommend work furlough and monitoring for exposed healthcare workers.

NEW QUESTION # 85
An infection preventionist (IP) encounters a surgeon at the nurse's station who loudly disagrees with the IP's surgical site infection findings. The IP's BEST response is to:

- A. Ask the surgeon to speak in a more private setting to review their concerns.
- B. Calmly explain that the findings are credible.
- C. Report the surgeon to the chief of staff.
- D. Ask the surgeon to change their tone and leave the nurses' station if they refuse.

Answer: A

Explanation:
The scenario involves a conflict between an infection preventionist (IP) and a surgeon regarding surgical site infection (SSI) findings, occurring in a public setting (the nurse's station). The IP's response must align with professional communication standards, infection control priorities, and the principles of collaboration and conflict resolution as emphasized by the Certification Board of Infection Control and Epidemiology (CBIC).
The "best" response should de-escalate the situation, maintain professionalism, and facilitate a constructive dialogue. Let's evaluate each option:
* A. Report the surgeon to the chief of staff: Reporting the surgeon to the chief of staff might be considered if the behavior escalates or violates policy (e.g., harassment or disruption), but it is an escalation that should be a last resort. This action does not address the

immediate disagreement about the SSI findings or attempt to resolve the issue collaboratively. It could also strain professional relationships and is not the best initial response, as it bypasses direct communication.
* B. Calmly explain that the findings are credible: Explaining the credibility of the findings is important and demonstrates the IP's confidence in their work, which is based on evidence-based infection control practices. However, doing so in a public setting like the nurse's station, especially with a loud disagreement, may not be effective. The surgeon may feel challenged or defensive, potentially worsening the situation. While this response has merit, it lacks consideration of the setting and the need for privacy to discuss sensitive data.
* C. Ask the surgeon to speak in a more private setting to review their concerns: This response is the most appropriate as it addresses the immediate need to de-escalate the public confrontation and move the discussion to a private setting. It shows respect for the surgeon's concerns, maintains professionalism, and allows the IP to review the SSI findings (e.g., data collection methods, definitions, or surveillance techniques) in a controlled environment. This aligns with CBIC's emphasis on effective communication and collaboration with healthcare teams, as well as the need to protect patient confidentiality and maintain a professional atmosphere. It also provides an opportunity to educate the surgeon on the evidence behind the findings, which is a key IP role.
* D. Ask the surgeon to change their tone and leave the nurses' station if they refuse: Requesting a change in tone is reasonable given the loud disagreement, but demanding the surgeon leave if they refuse is confrontational and risks escalating the conflict. This approach could damage the working relationship and does not address the underlying disagreement about the SSI findings. While maintaining a respectful environment is important, this response prioritizes control over collaboration and is less constructive than seeking a private discussion.
The best response is C, as it promotes a professional, collaborative approach by moving the conversation to a private setting. This allows the IP to address the surgeon's concerns, explain the SSI surveillance methodology (e.g., NHSN definitions or CBIC guidelines), and maintain a positive working relationship, which is critical for effective infection prevention programs. This strategy reflects CBIC's focus on leadership, communication, and teamwork in healthcare settings.
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CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain V: Management and Communication, which stresses effective interpersonal communication and conflict resolution.
CBIC Examination Content Outline, Domain V: Leadership and Program Management, which includes collaborating with healthcare personnel and addressing disagreements professionally.
CDC Guidelines for SSI Surveillance (2023), which emphasize the importance of clear communication of findings to healthcare teams.

NEW QUESTION # 86
An infection preventionist (IP) is asked to evaluate a series of published sources about CAUTI prevention strategies. Which source shows the strongest evidence for the IP to implement change?

- A. A randomized controlled trial from another hospital
- B. Data from a case study from a well-designed case-control or cohort study
- C. Evidence from reports written by authorities who are on expert committees
- D. A systematic review of relevant controlled studies and evidence-based practices

Answer: D

Explanation:
When an IP is selecting evidence to support practice change, the "strength" of evidence is typically judged using an evidence hierarchy. In most evidence pyramids, systematic reviews (often with meta-analysis) of well-designed studies sit at or near the top because they use explicit methods to search for, appraise, and synthesize findings across multiple studies-reducing the influence of chance results and individual-study bias.
Option D is therefore strongest: a systematic review of relevant controlled studies and evidence-based practices provides the most robust overall summary for decision-making compared with any single study.
Randomized controlled trials (option A) are strong primary studies, but they represent one setting/population and can be affected by local factors; a high-quality systematic review places RCTs in context and evaluates consistency across multiple trials.
Observational designs (option C, cohort/case-control) are generally lower in the hierarchy for intervention effectiveness due to confounding risk, and expert committee reports (option B) are typically considered lower- level evidence unless they are explicitly based on systematic evidence review methods. For implementing CAUTI prevention changes, relying first on systematic syntheses best supports standardized, evidence-based practice.

NEW QUESTION # 87
Though basic principles of emergency management remain the same for all types of disasters, which of the following interventions varies to address the specific needs of the situation?

- A. Preparedness
- B. Recovery
- C. Mitigation
- D. Response

Answer: D

Explanation:
The CBIC Certified Infection Control Exam Study Guide (6th edition) explains that emergency management is commonly described using four interrelated phases: mitigation, preparedness, response, and recovery.
While all four phases are essential components of disaster management, the response phase is the intervention that varies the most depending on the specific type of disaster.
Response refers to the immediate actions taken during or directly after an event to protect life, contain hazards, and reduce further harm. These actions are highly situation-dependent. For example, the response to an infectious disease outbreak may involve isolation precautions, surge staffing, and antimicrobial management, whereas the response to a natural disaster may focus on evacuation, trauma care, and infrastructure stabilization. Because hazards differ widely in scope, transmission, severity, and resource needs, response activities must be tailored to the specific emergency.
Mitigation and preparedness are largely proactive and standardized, focusing on risk reduction and planning before an event occurs. Recovery also follows more predictable patterns, emphasizing restoration of services, evaluation, and long-term improvement. In contrast, response is dynamic and must be adapted in real time based on the nature, scale, and impact of the incident.
For the CIC exam, this question tests understanding of emergency management frameworks. The key concept is that response activities are the most variable, making option C the correct answer.

NEW QUESTION # 88
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