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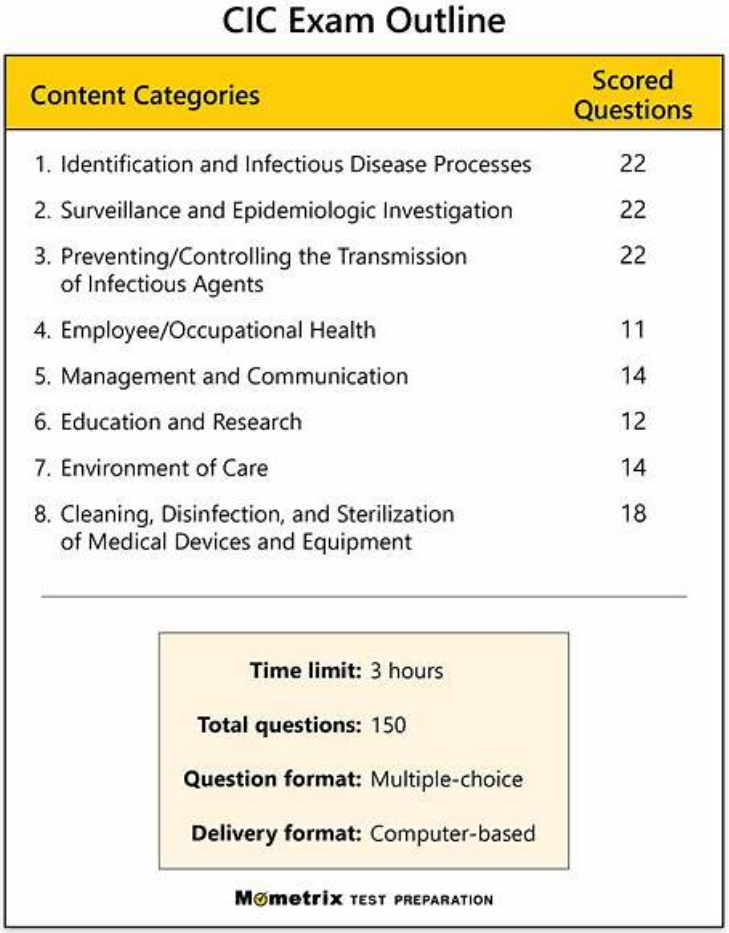


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## CBIC Certified Infection Control Exam Sample Questions (Q141-Q146):

**NEW QUESTION # 141**
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. Ask the surgeon to change their tone and leave the nurses' station if they refuse.
- D. Report the surgeon to the chief of staff.

**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.
References:
* 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 # 142**
Given the formula for calculating incidence rates, the Y represents which of the following?


- A. Population at risk
- B. Number of events
- C. Population served
- D. Number of infected patients

**Answer: A**

Explanation:
Incidence rate is a fundamental epidemiological measure used to quantify the frequency of new cases of a disease within a specified population over a defined time period. The Certification Board of Infection Control and Epidemiology (CBIC) supports the use of such metrics in the "Surveillance and Epidemiologic Investigation" domain, aligning with the Centers for Disease Control and Prevention (CDC) "Principles of Epidemiology in Public Health Practice" (3rd Edition, 2012). The formula provided, XY×K=Rate\frac{X}{Y} \times K = RateYX×K=Rate, represents the standard incidence rate calculation, where KKK is a constant (e.g., 1,000 or 100,000) to express the rate per unit population, and the question asks what YYY represents among the given options.
In the incidence rate formula, XXX typically represents the number of new cases (or events) of the disease occurring during a specific period, and YYY represents the population at risk during that same period. The ratio XY\frac{X}{Y}YX yields the rate per unit of population, which is then multiplied by KKK to standardize the rate (e.g., cases per 1,000 persons). The CDC defines the denominator (YYY) as the population at risk, which includes individuals susceptible to the disease over the observation period. Option B ("Number of infected patients") might suggest XXX if it specified new cases, but as the denominator YYY, it is incorrect because incidence focuses on new cases relative to the at-risk population, not the total number of infected individuals (which could include prevalent cases). Option C ("Population at risk") correctly aligns with YYY, representing the base population over which the rate is calculated.
Option A, "Population served," is a broader term that might include the total population under care (e.g., in a healthcare facility), but it is not specific to those at risk for new infections, making it less precise. Option D,
"Number of events," could align with XXX (new cases or events), but as the denominator YYY, it does not fit the formula's structure. The CBIC Practice Analysis (2022) and CDC guidelines reinforce that the denominator in incidence rates is the population at risk, ensuring accurate measurement of new disease occurrence.
References:
* CBIC Practice Analysis, 2022.
* CDC Principles of Epidemiology in Public Health Practice, 3rd Edition, 2012.

**NEW QUESTION # 143**
In a retrospective case-control study, the initial case group is composed of persons

- A. without the disease.
- B. with the disease
- C. without the risk factor under investigation
- D. with the risk factor under investigation

**Answer: B**

Explanation:
In a retrospective case-control study, cases and controls are selected based on disease status. The case group is composed of individuals who have the disease (cases), while the control group consists of individuals without the disease. This design allows researchers to look back in time to assess exposure to potential risk factors.
Step-by-Step Justification:
* Selection of Cases and Controls:
* Cases: Individuals who already have the disease.
* Controls: Individuals without the disease but similar in other aspects.
* Direction of Study:
* A retrospective study moves backward from the disease outcome to investigate potential causes or risk factors.
* Data Collection:
* Uses past medical records, interviews, and laboratory results to determine past exposures.
* Common Use:
* Useful for studying rare diseases since cases have already occurred, making it cost-effective compared to cohort studies.

Why Other Options Are Incorrect:
* B. without the disease: (Incorrect) This describes the control group, not the case group.
* C. with the risk factor under investigation: (Incorrect) Risk factors are identified after selecting cases and controls.
* D. without the risk factor under investigation: (Incorrect) The study investigates whether cases had prior exposure, not whether they lacked a risk factor.
CBIC Infection Control References:
* APIC Text, Chapter on Epidemiologic Study Design.

**NEW QUESTION # 144**
There are four cases of ventilator-associated pneumonia in a surgical intensive care unit with a total of 200 ventilator days and a census of 12 patients. Which of the following BEST expresses how this should be reported?

- A. Postoperative pneumonia rate of 6% in SICU patients
- B. 20 ventilator-associated pneumonia cases/1000 ventilator days
- C. More information is needed regarding ventilator days per patient
- D. Ventilator-associated pneumonia rate of 2%

**Answer: B**

Explanation:
The standard way to report ventilator-associated pneumonia (VAP) rates is:
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$$\text{VAP Rate} = \left(\frac{\text{Number of VAP cases}}{\text{Total ventilator days}}\right) \times 1000$$

- Number of VAP cases = 4
- Total ventilator days = 200

$$\left(\frac{4}{200}\right) \times 1000 = 20 \text{ cases per } 1000 \text{ ventilator days}$$

Why the Other Options Are Incorrect?
* A. Ventilator-associated pneumonia rate of 2% - This does not use the correct denominator (ventilator days).
* C. Postoperative pneumonia rate of 6% in SICU patients - Not relevant, as the data focuses on VAP, not postoperative pneumonia.
* D. More information is needed regarding ventilator days per patient - The total ventilator days are already provided, so no additional data is required.
CBIC Infection Control Reference
APIC and NHSN recommend reporting VAP rates as cases per 1,000 ventilator days.

**NEW QUESTION # 145**
An adult with an incomplete vaccination history presents with an uncontrollable, rapid and violent cough, fever, and runny nose. Healthcare personnel should suspect

- A. Rhinovirus.
- B. Pertussis.
- C. Bronchitis.
- D. Adenovirus.

**Answer: B**

Explanation:
The correct answer is A, "Pertussis," as healthcare personnel should suspect this condition based on the presented symptoms and the patient's incomplete vaccination history. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, pertussis, caused by the bacterium Bordetella pertussis, is characterized by an initial phase of mild respiratory symptoms (e.g., runny nose, low-grade fever) followed by a distinctive uncontrollable, rapid, and violent cough, often described as a "whooping" cough.

This presentation is particularly concerning in adults with incomplete vaccination histories, as the pertussis vaccine's immunity (e.g., DTaP or Tdap) wanes over time, increasing susceptibility (CBIC Practice Analysis,
2022, Domain I: Identification of Infectious Disease Processes, Competency 1.1 - Identify infectious disease processes). Pertussis is highly contagious and poses a significant risk in healthcare settings, necessitating prompt suspicion and isolation to prevent transmission.
Option B (rhinovirus) typically causes the common cold with symptoms like runny nose, sore throat, and mild cough, but it lacks the violent, paroxysmal cough characteristic of pertussis. Option C (bronchitis) may involve cough and fever, often due to viral or bacterial infection, but it is not typically associated with the rapid and violent cough pattern or linked to vaccination status in the same way as pertussis. Option D (adenovirus) can cause respiratory symptoms, including cough and fever, but it is more commonly associated with conjunctivitis or pharyngitis and does not feature the hallmark violent cough of pertussis.
The suspicion of pertussis aligns with CBIC's emphasis on recognizing infectious disease patterns to initiate timely infection control measures, such as droplet precautions and prophylaxis for exposed individuals (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents). Early identification is critical, especially in healthcare settings, to protect vulnerable patients and staff, and the incomplete vaccination history supports this differential diagnosis given pertussis's vaccine-preventable nature (CDC Pink Book: Pertussis, 2021).
References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.1 - Identify infectious disease processes; Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents. CDC Pink Book:
Pertussis, 2021.

**NEW QUESTION # 146**
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