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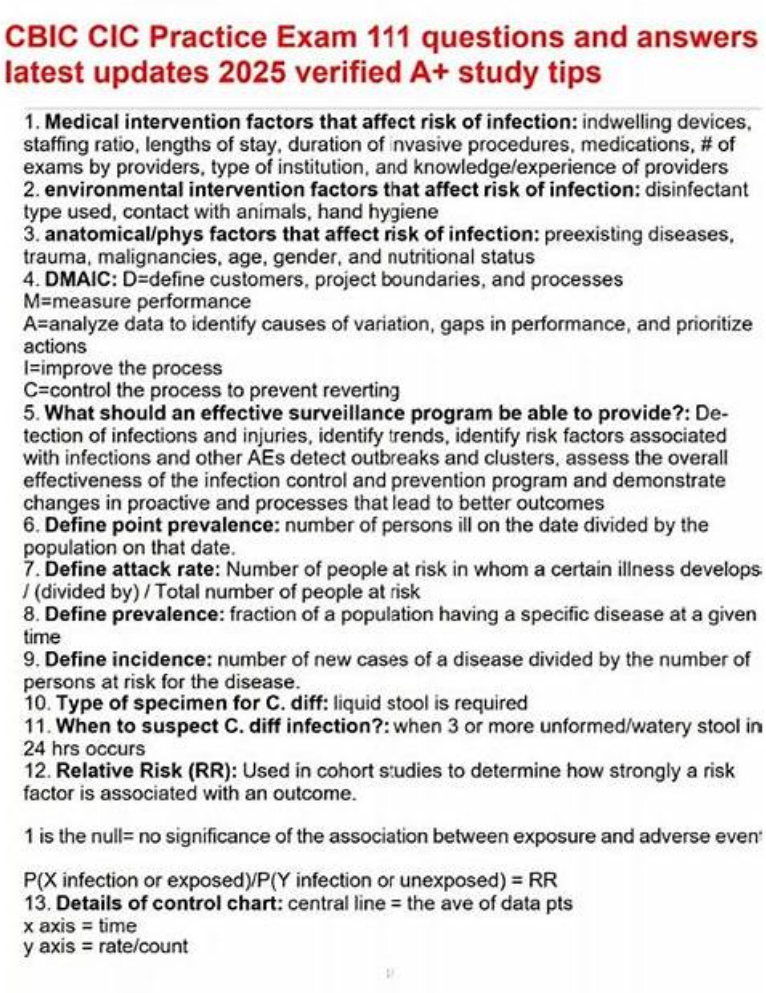

CBIC CIC Practice Exam 111 questions and answers latest updates 2025 verified A+ study tips

1. **Medical intervention factors that affect risk of infection:** indwelling devices, staffing ratio, lengths of stay, duration of invasive procedures, medications, # of exams by providers, type of institution, and knowledge/experience of providers
2. **environmental intervention factors that affect risk of infection:** disinfectant type used, contact with animals, hand hygiene
3. **anatomical/phys factors that affect risk of infection:** preexisting diseases, trauma, malignancies, age, gender, and nutritional status
4. **DMAIC:** D=define customers, project boundaries, and processes
M=measure performance
A=analyze data to identify causes of variation, gaps in performance, and prioritize actions
I=improve the process
C=control the process to prevent reverting
5. **What should an effective surveillance program be able to provide?:** Detection of infections and injuries, identify trends, identify risk factors associated with infections and other AEs detect outbreaks and clusters, assess the overall effectiveness of the infection control and prevention program and demonstrate changes in proactive and processes that lead to better outcomes
6. **Define point prevalence:** number of persons ill on the date divided by the population on that date.
7. **Define attack rate:** Number of people at risk in whom a certain illness develops / (divided by) / Total number of people at risk
8. **Define prevalence:** fraction of a population having a specific disease at a given time
9. **Define incidence:** number of new cases of a disease divided by the number of persons at risk for the disease.
10. **Type of specimen for C. diff:** liquid stool is required
11. **When to suspect C. diff infection?:** when 3 or more unformed/watery stool in 24 hrs occurs
12. **Relative Risk (RR):** Used in cohort studies to determine how strongly a risk factor is associated with an outcome.

1 is the null= no significance of the association between exposure and adverse even

P(X infection or exposed)/P(Y infection or unexposed) = RR
13. **Details of control chart:** central line = the ave of data pts
x axis = time
y axis = rate/count

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CBIC Certified Infection Control Exam Sample Questions (Q58-Q63):

NEW QUESTION # 58
The infection preventionist (IP) collaborates with the Intravenous Therapy team to select the best antiseptic for use during the insertion of an intravascular device for adults. For a patient with no contraindications, what antiseptic should the IP suggest?

- A. Povidone-iodine
- B. Chlorhexidine
- C. Alcohol
- D. Antibiotic ointment

Answer: B

Explanation:
The selection of an appropriate antiseptic for the insertion of an intravascular device (e.g., peripheral or central venous catheters) is a critical infection prevention measure to reduce the risk of catheter-related bloodstream infections (CRBSIs). The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes evidence-based practices in the "Prevention and Control of Infectious Diseases" domain, which includes adhering to guidelines for aseptic technique during invasive procedures. The Centers for Disease Control and Prevention (CDC) provides specific recommendations for skin antisepsis, as outlined in the "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017).
Option A, chlorhexidine, is the preferred antiseptic for skin preparation prior to intravascular device insertion in adults with no contraindications. Chlorhexidine, particularly in a 2% chlorhexidine gluconate (CHG) with 70% isopropyl alcohol solution, is recommended by the CDC due to its broad-spectrum antimicrobial activity, residual effect (which continues to kill bacteria after application), and superior efficacy compared to other agents in reducing CRBSI rates. Studies cited in the CDC guidelines demonstrate that chlorhexidine-based preparations significantly lower infection rates compared to povidone-iodine or alcohol alone, making it the gold standard for this procedure when tolerated by the patient.
Option B, povidone-iodine, is an alternative antiseptic that can be used for skin preparation. It is effective against a wide range of microorganisms and is often used when chlorhexidine is contraindicated (e.g., in patients with chlorhexidine allergy). However, its efficacy is less persistent than chlorhexidine, and it requires longer drying time, which can be a limitation in busy clinical settings. The CDC considers povidone-iodine a second-line option unless chlorhexidine is unavailable or unsuitable. Option C, alcohol (e.g., 70% isopropyl or ethyl alcohol), has rapid bactericidal activity but lacks a residual effect, making it less effective for prolonged protection during catheter dwell time. It is often used as a component of chlorhexidine-alcohol combinations but is not recommended as a standalone antiseptic for intravascular device insertion. Option D, antibiotic ointment, is not appropriate for skin preparation during insertion. Antibiotic ointments (e.g., bacitracin or mupirocin) are sometimes applied to catheter sites post-insertion to prevent infection, but their use is discouraged by the CDC due to the risk of promoting antibiotic resistance and fungal infections, and they are not classified as antiseptics for initial skin antisepsis.
The CBIC Practice Analysis (2022) supports the adoption of CDC-recommended practices, and the 2017 CDC guidelines explicitly state that chlorhexidine-based preparations with alcohol should be used for skin antisepsis unless contraindicated. For a patient with no contraindications, the infection preventionist should suggest chlorhexidine to optimize patient safety and align with best practices.
References:
* CBIC Practice Analysis, 2022.
* CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.

NEW QUESTION # 59
An infection preventionist is reviewing employee health immunization policies. What is the recommendation for tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) for a 55-year-old nurse who received all childhood vaccinations?

- A. Two doses of Tdap vaccine at least 14 days apart
- B. No additional vaccination is recommended
- C. Two doses of Tdap vaccine at least 28 days apart
- D. One dose of Tdap vaccine

Answer: D

Explanation:
The correct answer is A, "One dose of Tdap vaccine," as this is the recommended immunization for a 55-year- old nurse who

received all childhood vaccinations. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, which align with recommendations from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP), adults who have completed a primary series of childhood vaccinations (typically 5 doses of DTaP or DTP) should receive a single booster dose of Tdap if they have not previously received it. This is especially critical for healthcare personnel, such as a 55-year-old nurse, due to their increased risk of exposure to pertussis and the need to protect vulnerable patients (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents). The Tdap vaccine, which protects against tetanus, diphtheria, and pertussis, is recommended once between ages 11-64, with a preference for administration in early adulthood (e.g., 19-26 years) or as soon as feasible for older adults, including this 55-year-old nurse, to ensure immunity against pertussis, which wanes over time. For individuals aged 65 and older, Tdap is still recommended if not previously received, though Tdap is preferred over Td (tetanus and diphtheria only) for healthcare workers to address pertussis risk.
Option B (two doses of Tdap vaccine at least 14 days apart) and Option C (two doses of Tdap vaccine at least 28 days apart) are not standard recommendations for adults with a complete childhood vaccination history.
Multiple doses are typically reserved for individuals with incomplete primary series or specific high-risk conditions, not for this scenario. Option D (no additional vaccination is recommended) is incorrect because, even with a complete childhood series, a Tdap booster is advised for healthcare workers to maintain protection, especially given the nurse's occupational exposure risks (CDC Immunization Schedules, 2024).
After receiving the Tdap booster, a Td booster every 10 years is recommended to maintain tetanus and diphtheria immunity, but the initial Tdap dose is the priority for this nurse.
The recommendation for one Tdap dose aligns with CBIC's emphasis on evidence-based immunization policies to prevent transmission of vaccine-preventable diseases in healthcare settings (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). This ensures the nurse is protected and contributes to herd immunity, reducing the risk of pertussis outbreaks in the healthcare environment.
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.1 - Collaborate with organizational leaders, 3.2 - Implement measures to prevent transmission of infectious agents. CDC Immunization Schedules, 2024. ACIP Recommendations for Tdap, 2011 (updated 2023).

NEW QUESTION # 60
Which of the following represents a class II surgical wound?

- A. Incisions involving the biliary tract, appendix, vagina, and oropharynx.
- B. Incisional wounds following nonpenetrating (blunt) trauma.
- C. Old traumatic wounds with retained devitalized tissue.
- D. Incisions in which acute, nonpurulent inflammation are seen.

Answer: D

Explanation:
Surgical wounds are classified by the Centers for Disease Control and Prevention (CDC) into four classes based on the degree of contamination and the likelihood of postoperative infection. This classification system, detailed in the CDC's Guidelines for Prevention of Surgical Site Infections (1999), is a cornerstone of infection prevention and control, aligning with the Certification Board of Infection Control and Epidemiology (CBIC) standards in the "Prevention and Control of Infectious Diseases" domain. The classes are as follows:
* Class I (Clean): Uninfected operative wounds with no inflammation, typically closed primarily, and not involving the respiratory, alimentary, genital, or urinary tracts.
* Class II (Clean-Contaminated): Operative wounds with controlled entry into a sterile or minimally contaminated tract (e.g., biliary or gastrointestinal), with no significant spillage or infection present.
* Class III (Contaminated): Open, fresh wounds with significant spillage (e.g., from a perforated viscus) or major breaks in sterile technique.
* Class IV (Dirty-Infected): Old traumatic wounds with retained devitalized tissue or existing clinical infection.
Option A, "Incisions in which acute, nonpurulent inflammation are seen," aligns with a Class II surgical wound. The presence of acute, nonpurulent inflammation suggests a controlled inflammatory response without overt infection, which can occur in clean-contaminated cases where a sterile tract (e.g., during elective gastrointestinal surgery) is entered under controlled conditions. The CDC defines Class II wounds as those involving minor contamination without significant spillage or infection, and nonpurulent inflammation fits this category, often seen in early postoperative monitoring.
Option B, "Incisional wounds following nonpenetrating (blunt) trauma," does not fit the Class II definition.
These wounds are typically classified based on the trauma context and are more likely to be considered contaminated (Class III) or dirty (Class IV) if there is tissue damage or delayed treatment, rather than clean- contaminated. Option C, "Incisions involving the biliary tract, appendix, vagina, and oropharynx," describes anatomical sites that, when surgically accessed, often fall into Class II if the procedure is elective and controlled (e.g., cholecystectomy), but the phrasing suggests a general category rather than a specific

wound state with inflammation, making it less precise for Class II. Option D, "Old traumatic wounds with retained devitalized tissue," clearly corresponds to Class IV (dirty-infected) due to the presence of necrotic tissue and potential existing infection, which is inconsistent with Class II.
The CBIC Practice Analysis (2022) emphasizes the importance of accurate wound classification for implementing appropriate infection prevention measures, such as antibiotic prophylaxis or sterile technique adjustments. The CDC guidelines further specify that Class II wounds may require tailored interventions based on the observed inflammatory response, supporting Option A as the correct answer. Note that the phrasing in Option A contains a minor grammatical error ("inflammation are seen" should be "inflammation is seen"), but this does not alter the clinical intent or classification.
References:
* CBIC Practice Analysis, 2022.
* CDC Guidelines for Prevention of Surgical Site Infections, 1999.

NEW QUESTION # 61
The cleaning and disinfection process that is appropriate for a particular surgical instrument depends on

- A. the policies of the sterile processing department.
- B. instruments contaminated with blood must be bleach cleaned first.
- C. the device manufacturer's written instructions for use.
- D. all surgical instruments are cleaned and sterilized in the same manner.

Answer: C

Explanation:
The correct answer is C, "the device manufacturer's written instructions for use," as this is the factor that determines the appropriate cleaning and disinfection process for a particular surgical instrument. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the reprocessing of surgical instruments must follow the specific instructions provided by the device manufacturer to ensure safety and efficacy. These instructions account for the instrument's material, design, and intended use, specifying the appropriate cleaning agents, disinfection methods, sterilization techniques, and contact times to prevent damage and ensure the elimination of pathogens (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This is also mandated by regulatory standards, such as those from the Food and Drug Administration (FDA) and the Association for the Advancement of Medical Instrumentation (AAMI), which require adherence to manufacturer guidelines to maintain device integrity and patient safety.
Option A (all surgical instruments are cleaned and sterilized in the same manner) is incorrect because different instruments have unique characteristics (e.g., materials like stainless steel vs. delicate optics), necessitating tailored reprocessing methods rather than a one-size-fits-all approach. Option B (instruments contaminated with blood must be bleach cleaned first) is a misconception; while blood contamination requires thorough cleaning, bleach is not universally appropriate and may damage certain instruments unless specified by the manufacturer. Option D (the policies of the sterile processing department) may guide internal procedures but must be based on and subordinate to the manufacturer's instructions to ensure compliance and effectiveness.
The emphasis on manufacturer instructions aligns with CBIC's focus on evidence-based reprocessing practices to prevent healthcare-associated infections (HAIs) and protect patients (CBIC Practice Analysis,
2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). Deviating from these guidelines can lead to inadequate sterilization or instrument damage, increasing infection risks.
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.3 - Ensure safe reprocessing of medical equipment, 3.5 - Evaluate the environment for infection risks. AAMI ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities.

NEW QUESTION # 62
An infection preventionist in the role of educator is teaching risk reduction activities to patients and families.
For which of the following groups is the pneumococcal vaccine MOST appropriate?

- A. International travelers
- B. Immunocompromised newborns
- C. Patients in behavioral health settings
- D. Asplenic patients

Answer: D

Explanation:
The pneumococcal vaccine is designed to protect against infections caused by Streptococcus pneumoniae, a bacterium responsible

for diseases such as pneumonia, meningitis, and bacteremia. The appropriateness of this vaccine depends on the population's risk profile, particularly their susceptibility to invasive pneumococcal disease (IPD). The Certification Board of Infection Control and Epidemiology (CBIC) highlights the role of infection preventionists as educators in promoting vaccination as a key risk reduction strategy, aligning with the "Education and Training" domain (CBIC Practice Analysis, 2022). The Centers for Disease Control and Prevention (CDC) provides specific guidelines on pneumococcal vaccination, recommending it for individuals at higher risk due to underlying medical conditions or immunologic status.
Option A, asplenic patients, refers to individuals who have had their spleen removed (e.g., due to trauma or disease) or have a nonfunctional spleen (e.g., in sickle cell disease). The spleen plays a critical role in clearing encapsulated bacteria like Streptococcus pneumoniae from the bloodstream. Without a functioning spleen, these patients are at significantly increased risk of overwhelming post-splenectomy infection (OPSI), with pneumococcal disease being a leading cause. The CDC and Advisory Committee on Immunization Practices (ACIP) strongly recommend pneumococcal vaccination, including both PCV15/PCV20 and PPSV23, for asplenic patients, making this group the most appropriate for the vaccine in this context. The infection preventionist should prioritize educating these patients and their families about the vaccine's importance and timing.
Option B, international travelers, may benefit from various vaccines depending on their destination (e.g., yellow fever or typhoid), but pneumococcal vaccination is not routinely recommended unless they have specific risk factors (e.g., asplenia or chronic illness) or are traveling to areas with high pneumococcal disease prevalence. This group is not inherently a priority for pneumococcal vaccination. Option C, immunocompromised newborns, includes infants with congenital immunodeficiencies or other conditions, who may indeed require pneumococcal vaccination as part of their routine immunization schedule (e.g., PCV15 or PCV20 starting at 2 months). However, newborns are generally covered under universal childhood vaccination programs, and the question's focus on "MOST appropriate" suggests a group with a more specific, elevated risk, which asplenic patients fulfill. Option D, patients in behavioral health settings, may have varied health statuses, but this group is not specifically targeted for pneumococcal vaccination unless they have additional risk factors (e.g., chronic diseases), making it less appropriate than asplenic patients.
The CBIC emphasizes tailoring education to high-risk populations, and the CDC's Adult and Pediatric Immunization Schedules (2023) identify asplenic individuals as a top priority for pneumococcal vaccination due to their extreme vulnerability. Thus, the infection preventionist should focus on asplenic patients as the group for whom the pneumococcal vaccine is most appropriate.
References:
* CBIC Practice Analysis, 2022.
* CDC Adult Immunization Schedule, 2023.
* CDC Pediatric Immunization Schedule, 2023.
* ACIP Recommendations for Pneumococcal Vaccination, 2022.

NEW QUESTION # 63
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