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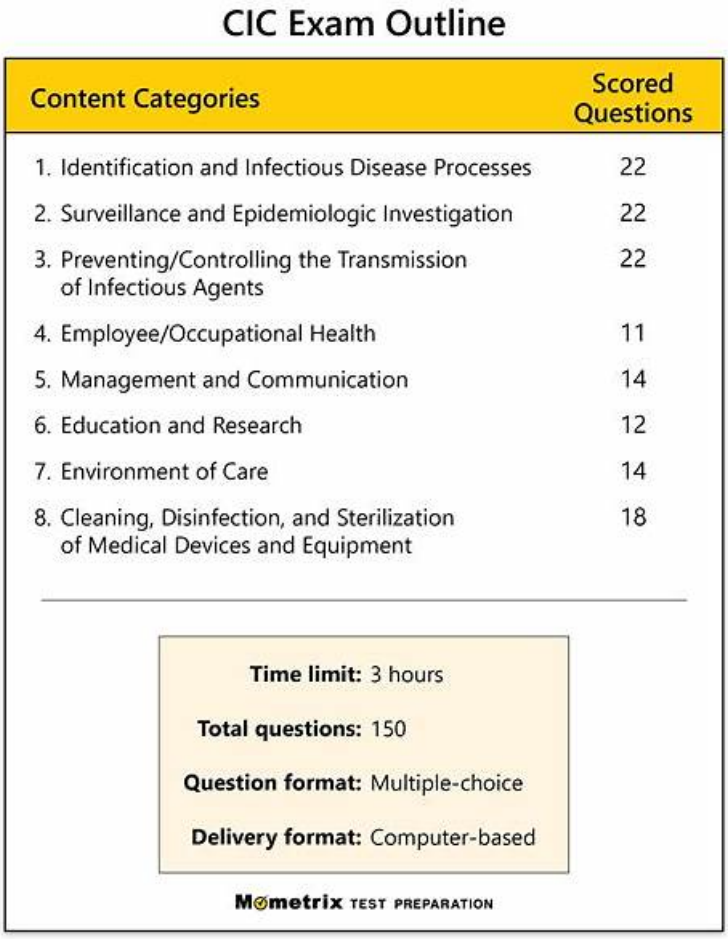

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CBIC Certified Infection Control Exam Sample Questions (Q25-Q30):

NEW QUESTION # 25
What rate is expressed by the number of patients who acquire infections over a specified time period divided by the population at risk of acquiring an infection during that time period?

- A. Period prevalence
- B. Point prevalence
- C. Incidence rate
- D. Disease specific

Answer: C

Explanation:
The incidence rate measures new cases of infection in a population over a defined time period using the formula:
Why the Other Options Are Incorrect?
* B. Disease specific - Refers to infections caused by a particular pathogen, not the general rate of new infections.
* C. Point prevalence - Measures existing cases at a specific point in time, not new cases.
* D. Period prevalence - Includes both old and new cases over a set period, unlike incidence, which only considers new cases.
CBIC Infection Control Reference
APIC defines incidence rate as the number of new infections in a population over a given period.

NEW QUESTION # 26
A patient is Hepatitis B surface antigen (HBsAg) negative, Hepatitis B surface antibody (anti-HBs) positive, and Hepatitis B core antibody (anti-HBc) negative. Which of the following explains these results?

- A. Response to hepatitis B vaccine series
- B. A recent blood transfusion
- C. Previous hepatitis B infection
- D. Low-level hepatitis B infectiousness

Answer: A

Explanation:
The Certification Study Guide (6th edition) explains that interpretation of hepatitis B serologic markers is a fundamental competency for infection preventionists, particularly in occupational health and exposure management. In this scenario, the patient is HBsAg negative, indicating no current hepatitis B infection; anti- HBs positive, indicating immunity; and anti-HBc negative, meaning there has been no prior natural infection with hepatitis B virus.
This specific serologic pattern is diagnostic of immunity due to vaccination. The hepatitis B vaccine contains only purified hepatitis B surface antigen, not core antigen. As a result, vaccinated individuals develop antibodies to the surface antigen (anti-HBs) but do not develop antibodies to the core antigen (anti-HBc). The study guide emphasizes this distinction as the key factor in differentiating vaccine-induced immunity from immunity due to past infection.
The incorrect options reflect different serologic patterns. Previous hepatitis B infection would produce a positive anti-HBc result. A recent blood transfusion does not confer long-term immunity or this marker pattern. Low-level infectivity would require detectable surface antigen or core antibody.
This question reflects a classic CIC exam topic: recognizing the serologic profile of vaccine-induced immunity. Correct interpretation supports appropriate employee health decisions, post-exposure management, and immunization program evaluation.
Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 6: Employee /Occupational Health; Chapter 3: Identification of Infectious Disease Processes.

NEW QUESTION # 27
A patient with suspected active tuberculosis is being transferred from a mental health facility to a medical center by emergency medical services. Which of the following should an infection preventionist recommend to the emergency medical technician (EMT)?

- A. Place a surgical mask on the patient and an N95 respirator on the EMT.
- B. Place a surgical mask on both the patient and the EMT.
- C. Place an N95 respirator on the patient and a surgical mask on the EMT.
- D. Place an N95 respirator on both the patient and the EMT.

Answer: C

Explanation:
Active tuberculosis (TB) is an airborne disease transmitted through the inhalation of droplet nuclei containing Mycobacterium tuberculosis. Effective infection control measures are critical during patient transport to protect healthcare workers, such as emergency medical technicians (EMTs), and to prevent community spread. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the use of appropriate personal protective equipment (PPE) and source control as key strategies in the "Prevention and Control of Infectious Diseases" domain, aligning with guidelines from the Centers for Disease Control and Prevention (CDC).
For a patient with suspected active TB, the primary goal is to contain the infectious particles at the source (the patient) while ensuring the EMT is protected from inhalation exposure. Option C, placing an N95 respirator on the patient and a surgical mask on the EMT, is the most appropriate recommendation. The N95 respirator on the patient serves as source control by filtering the exhaled air, reducing the dispersion of infectious droplets. However, fitting an N95 respirator on the patient may be challenging, especially in an emergency setting or if the patient is uncooperative, so a surgical mask is often used as an alternative source control measure. For the EMT, a surgical mask provides a basic barrier but does not offer the same level of respiratory protection as an N95 respirator. The CDC recommends that healthcare workers, including EMTs, use an N95 respirator (or higher-level respiratory protection) when in close contact with a patient with suspected or confirmed active TB, unless an airborne infection isolation room is available, which is not feasible during transport.
Option A is incorrect because placing a surgical mask on both the patient and the EMT does not provide adequate respiratory protection for the EMT. Surgical masks are not designed to filter small airborne particles like those containing TB bacilli and do not meet the N95 standard required for airborne precautions. Option B is impractical and unnecessary, as placing an N95 respirator on both the patient and the EMT is overly restrictive and logistically challenging, especially for the patient during transport. Option D reverses the PPE roles, placing the surgical mask on the patient (insufficient for source control) and the N95 respirator on the EMT (appropriate for protection but misaligned with the need to control the patient's exhalation). The CBIC and CDC guidelines prioritize source control on the patient and respiratory protection for the healthcare worker, making Option C the best fit.
This recommendation is consistent with the CBIC's emphasis on implementing transmission-based precautions (CDC, 2005, Guideline for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings) and the use of PPE tailored to the mode of transmission, as outlined in the CBIC Practice Analysis (2022).
References:
* CBIC Practice Analysis, 2022.
* CDC Guideline for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings, 2005.

NEW QUESTION # 28
Hand hygiene rates in the facility have been decreasing over time. The Infection Preventionist (IP) surveys staff and finds that hand dryness is the major reason for non-compliance. What step should the IP take?

- A. Allow staff to bring in lotion and carry it in their pockets.
- B. Provide a compatible lotion in a convenient location.
- C. Provide staff lotion in every patient room.
- D. Allow staff to bring in lotion for use at the nurses' station and lounge.

Answer: B

Explanation:
Hand hygiene is a cornerstone of infection prevention, and declining compliance rates pose a significant risk for healthcare-associated infections (HAIs). The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes improving hand hygiene adherence in the "Prevention and Control of Infectious Diseases" domain, aligning with the Centers for Disease Control and Prevention (CDC) "Guideline for Hand Hygiene in Healthcare Settings" (2002). The IP's survey identifies hand dryness as the primary barrier, likely due to the frequent use of alcohol-based hand sanitizers or soap, which can dehydrate skin. The goal is to address this barrier effectively while maintaining infection control standards.
Option B, "Provide a compatible lotion in a convenient location," is the most appropriate step. The CDC and World Health Organization (WHO) recommend using moisturizers to mitigate skin irritation and dryness, which can improve hand hygiene compliance. However, the lotion must be compatible with alcohol-based hand rubs (e.g., free of petroleum-based products that can reduce sanitizer efficacy) and placed in accessible areas (e.g., near sinks or sanitizer dispensers) to encourage use without disrupting workflow. The WHO's
"Guidelines on Hand Hygiene in Health Care" (2009) suggest providing skin care products as part of a multimodal strategy to enhance adherence, making this a proactive, facility-supported solution that addresses the root cause.
Option A, "Provide staff lotion in every patient room," is a good intention but impractical and potentially risky. Placing lotion in patient rooms could lead to inconsistent use, contamination (e.g., from patient contact), or misuse (e.g., staff applying incompatible products), compromising infection control. The CDC advises against uncontrolled lotion distribution in patient care areas. Option C, "Allow staff to bring in lotion and carry it in their pockets," introduces variability in product quality and compatibility. Personal lotions

may contain ingredients (e.g., oils) that inactivate alcohol-based sanitizers, and pocket storage increases the risk of contamination or cross-contamination, which the CDC cautions against. Option D, "Allow staff to bring in lotion for use at the nurses' station and lounge," limits the intervention to non-patient care areas, reducing its impact on hand hygiene during patient interactions. It also shares the compatibility and contamination risks of Option C, making it less effective.
The CBIC Practice Analysis (2022) and CDC guidelines emphasize evidence-based interventions, such as providing approved skin care products in strategic locations to boost compliance. Option B balances accessibility, safety, and compatibility, making it the best step to address hand dryness and improve hand hygiene rates.
References:
* CBIC Practice Analysis, 2022.
* CDC Guideline for Hand Hygiene in Healthcare Settings, 2002.
* WHO Guidelines on Hand Hygiene in Health Care, 2009.

NEW QUESTION # 29
A review of bronchoscopy specimens indicates an unusual number of Mycobacterium fortuitum-positive cultures. Which of the following observations would be the MOST likely cause of this finding?

- A. Rinsing with tap water
- B. Drying with air or alcohol
- C. Bronchoscopes cleaned with sporicidal solution
- D. Inadequate cleaning prior to disinfection

Answer: A

Explanation:
The CBIC Certified Infection Control Exam Study Guide (6th edition) identifies nontuberculous mycobacteria (NTM), including Mycobacterium fortuitum, as organisms commonly associated with water sources, particularly potable water systems. An unusual increase in M. fortuitum-positive bronchoscopy cultures is most often linked to waterborne contamination during endoscope reprocessing, making rinsing with tap water the most likely cause.
Tap water is not sterile and may harbor NTM, which are resistant to standard municipal water treatment and capable of forming biofilms within plumbing systems. If bronchoscopes are rinsed with tap water after high- level disinfection and not followed by appropriate sterile or filtered water rinses and thorough drying, organisms such as M. fortuitum may contaminate internal channels. This can lead to pseudo-outbreaks, where cultures are positive due to contamination rather than true patient infection.
Option B, inadequate cleaning prior to disinfection, can contribute to overall reprocessing failure but is less specifically associated with NTM contamination patterns. Option A is unlikely, as sporicidal solutions are effective disinfectants. Option D, drying with air or alcohol, is a recommended step to reduce microbial growth and would not cause contamination.
For CIC exam preparation, recognizing that tap water exposure during endoscope reprocessing is a classic source of nontuberculous mycobacteria contamination is a key concept in outbreak investigation and device reprocessing surveillance.

NEW QUESTION # 30
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