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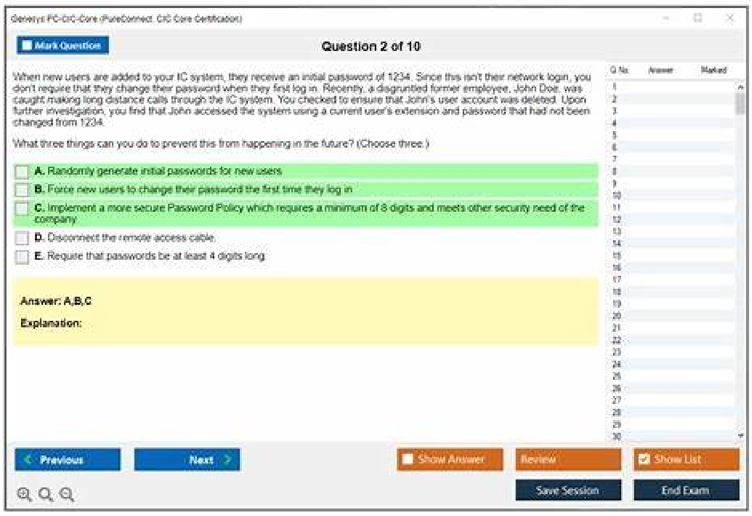

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CBIC Certified Infection Control Exam Sample Questions (Q168-Q173):

NEW QUESTION # 168
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. 99%
- B. 34%
- C. 68%
- D. 95%

Answer: C

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 # 169
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. Calmly explain that the findings are credible.
- B. Ask the surgeon to speak in a more private setting to review their concerns.
- 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: B

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 # 170
At a facility with 10.000 employees. 5,000 are at risk for bloodborne pathogen exposure. Over the past five years, 100 of the 250 needlestick injuries involved exposure to bloodborne pathogens, and 2% of exposed employees seroconverted. How many employees became infected?

- A. 0
- B. 1
- C. 2
- D. 3

Answer: C

Explanation:
To determine the number of employees whoseroconverted(became infected) after aneedlestick exposure, we use the given data:
* Total Needlestick Injuries:250
* Needlestick Injuries Involving Bloodborne Pathogens:100
* Seroconversion Rate:2%
Calculation:
A black text with black numbers AI-generated content may be incorrect.
Why Other Options Are Incorrect:
* A. 1:Incorrect calculation;2% of 100 is 2, not 1.
* C. 5:Overestimates the actual number of infections.
* D. 10:Exceeds the calculated value based on given data.
CBIC Infection Control References:
* APIC Text, "Occupational Exposure and Seroconversion Risks".
* APIC Text, "Bloodborne Pathogens and Needlestick Injury Prevention"

NEW QUESTION # 171
A healthcare facility has installed a decorative water fountain in their lobby for the enjoyment of patients and visitors. What is an important issue for the infection preventionist to consider?

- A. Aerosolization of Legionella pneumophila
- B. Children getting Salmonella enteritidis
- C. Cryptosporidium growth in the fountain
- D. Growth of Acinetobacter baumannii

Answer: A

Explanation:
The installation of a decorative water fountain in a healthcare facility lobby introduces a potential environmental hazard that an

infection preventionist must evaluate, guided by the Certification Board of Infection Control and Epidemiology (CBIC) principles and infection control best practices. Water features can serve as reservoirs for microbial growth and dissemination, particularly in settings with vulnerable populations such as patients. The key is to identify the most significant infection risk associated with such a water source. Let's analyze each option:
* A. Children getting Salmonella enteritidis: Salmonella enteritidis is a foodborne pathogen typically associated with contaminated food or water sources like poultry, eggs, or untreated drinking water.
While children playing near a fountain might theoretically ingest water, Salmonella is not a primary concern for decorative fountains unless they are specifically contaminated with fecal matter, which is uncommon in a controlled healthcare environment. This risk is less relevant compared to other waterborne pathogens.
* B. Cryptosporidium growth in the fountain: Cryptosporidium is a parasitic protozoan that causes gastrointestinal illness, often transmitted through contaminated drinking water or recreational water (e.
g., swimming pools). While decorative fountains could theoretically harbor Cryptosporidium if contaminated, this organism requires specific conditions (e.g., fecal contamination) and is more associated with untreated or poorly maintained water systems. In a healthcare setting with regular maintenance, this is a lower priority risk compared to bacterial pathogens spread via aerosols.
* C. Aerosolization of Legionella pneumophila: Legionella pneumophila is a gram-negative bacterium that thrives in warm, stagnant water environments, such as cooling towers, hot water systems, and decorative fountains. It causes Legionnaires' disease, a severe form of pneumonia, and Pontiac fever, both transmitted through inhalation of contaminated aerosols. In healthcare facilities, where immunocompromised patients are present, aerosolization from a water fountain poses a significant risk, especially if the fountain is not regularly cleaned, disinfected, or monitored. The CBIC and CDC highlight Legionella as a critical concern in water management programs, making this the most important issue for an infection preventionist to consider.
* D. Growth of Acinetobacter baumannii: Acinetobacter baumannii is an opportunistic pathogen commonly associated with healthcare-associated infections (e.g., ventilator-associated pneumonia, wound infections), often found on medical equipment or skin. While it can survive in moist environments, its growth in a decorative fountain is less likely compared to Legionella, which is specifically adapted to water systems. The risk ofAcinetobacter transmission via a fountain is minimal unless it becomes a direct contamination source, which is not a primary concern for this scenario.
The most important issue is C, aerosolization of Legionella pneumophila, due to its potential to cause severe respiratory infections, its association with water features, and the heightened vulnerability of healthcare facility populations. The infection preventionist should ensure the fountain is included in the facility's water management plan, with regular testing, maintenance, and disinfection to prevent Legionella growth and aerosol spread, as recommended by CBIC and CDC guidelines.
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CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV:
Environment of Care, which addresses waterborne pathogens like Legionella in healthcare settings.
CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes managing environmental risks such as water fountains.
CDC Toolkit for Controlling Legionella in Common Sources of Exposure (2021), which identifies decorative fountains as a potential source of Legionella aerosolization.

NEW QUESTION # 172
A nurse claims to have acquired hepatitis A virus infection as the result of occupational exposure. The source patient had an admitting diagnosis of viral hepatitis. Further investigation of this incident reveals a 5-day interval between exposure and onset of symptoms in the nurse. The patient has immunoglobulin G antibodies to hepatitis A. From the evidence, the infection preventionist may correctly conclude which of the following?

- A. The evidence at this time fails to support the nurse's claim.
- B. The patient has serologic evidence of recent hepatitis A viral infection.
- C. The 5-day incubation period is consistent with hepatitis A virus transmission.
- D. The nurse should be given hepatitis A virus immunoglobulin.

Answer: A

Explanation:
The infection preventionist's (IP) best conclusion, based on the provided evidence, is that the evidence at this time fails to support the nurse's claim of acquiring hepatitis A virus (HAV) infection through occupational exposure. This conclusion is grounded in the clinical and epidemiological understanding of HAV, as aligned with the Certification Board of Infection Control and Epidemiology (CBIC) guidelines. Hepatitis A typically has an incubation period ranging from 15 to 50 days, with an average of approximately 28-30 days, following exposure to the virus (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology). The reported 5-day interval between exposure and symptom onset in the nurse is significantly shorter than the expected incubation period, making it inconsistent with HAV transmission. Additionally, the presence of immunoglobulin G (IgG) antibodies in the source patient indicates past exposure or immunity to HAV, rather than an active or recent infection, which would typically be associated with immunoglobulin M (IgM) antibodies during the acute phase.

Option A (the nurse should be given hepatitis A virus immunoglobulin) is not supported because post- exposure prophylaxis with HAV immunoglobulin is recommended only within 14 days of exposure to a confirmed case with active infection, and the evidence here does not confirm a recent exposure or active case.
Option C (the patient has serologic evidence of recent hepatitis A viral infection) is incorrect because IgG antibodies signify past infection or immunity, not a recent infection, which would require IgM antibodies.
Option D (the 5-day incubation period is consistent with hepatitis A virus transmission) is inaccurate due to the mismatch with the known incubation period of HAV.
The IP's role includes critically evaluating epidemiological data to determine the likelihood of transmission events. The discrepancy in the incubation period and the serologic status of the patient suggest that the nurse's claim may not be substantiated by the current evidence, necessitating further investigation rather than immediate intervention or acceptance of the claim. This aligns with CBIC's emphasis on accurate identification and investigation of infectious disease processes (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.2 - Investigate suspected outbreaks or exposures).
References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competencies 1.2 - Investigate suspected outbreaks or exposures, 1.3 - Apply principles of epidemiology.

NEW QUESTION # 173
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