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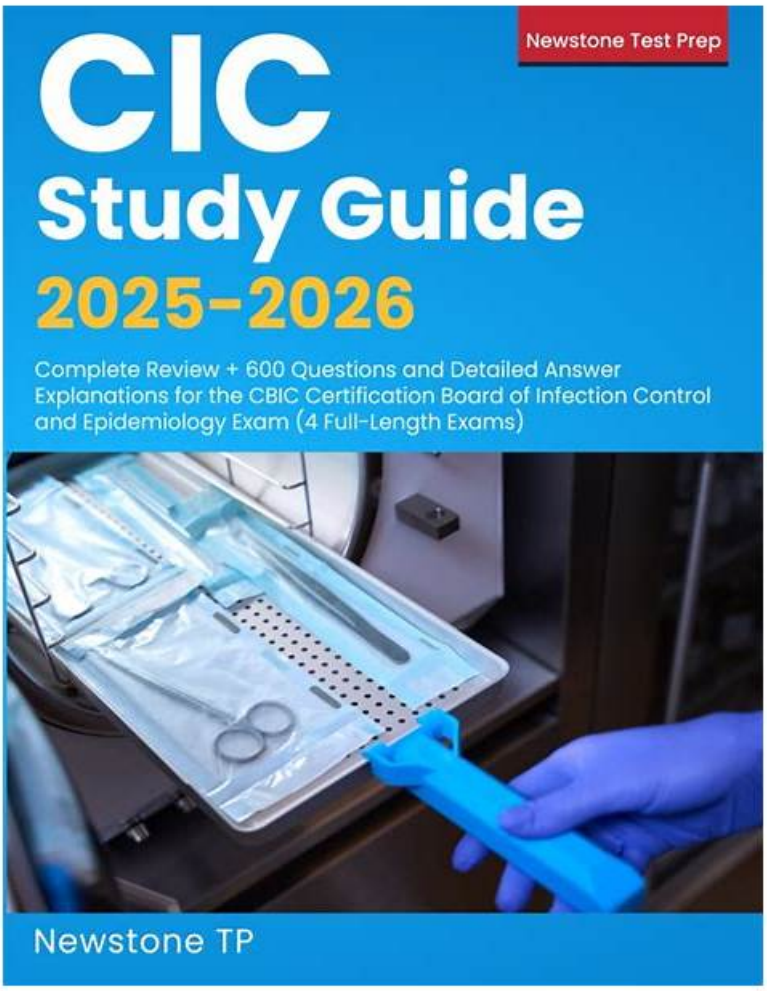

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CBIC Certified Infection Control Exam Sample Questions (Q168-Q173):

NEW QUESTION # 168
An adult with an incomplete vaccination history presents with an uncontrollable, rapid and violent cough, fever, and runny nose. Healthcare personnel should suspect

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

Answer: A

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 # 169
A patient with pertussis can be removed from Droplet Precautions after

- A. the patient has been given pertussis vaccine.
- B. direct fluorescent antibody and/or culture are negative.
- C. five days of appropriate antibiotic therapy.
- D. the paroxysmal stage has ended.

Answer: C

Explanation:
A patient with pertussis (whooping cough) should remain on Droplet Precautions to prevent transmission.
According to APIC guidelines, patients with pertussis can be removed from Droplet Precautions after completing at least five days of appropriate antimicrobial therapy and showing clinical improvement.
Why the Other Options Are Incorrect?
* A. Direct fluorescent antibody and/or culture are negative - Laboratory results may not always detect pertussis early, and false negatives can occur.
* C. The patient has been given pertussis vaccine - The vaccine prevents but does not treat pertussis, and it does not shorten the period of contagiousness.
* D. The paroxysmal stage has ended - The paroxysmal stage (severe coughing fits) can last weeks, but infectiousness decreases with antibiotics.

CBIC Infection Control Reference
According to APIC guidelines, Droplet Precautions should continue until the patient has received at least five days of antimicrobial therapy.

NEW QUESTION # 170
An infection preventionist is reviewing a wound culture result on a surgery patient. The abdominal wound culture of purulent drainage grew Staphylococcus aureus with the following sensitivity pattern: resistant to penicillin, oxacillin, cephalothin, and erythromycin; susceptible to clindamycin, and vancomycin. The patient is currently being treated with cefazolin. Which of the following is true?

- A. Droplet Precautions should be initiated.
- B. This is a methicillin-sensitive S. aureus (MSSA) strain.
- C. The current therapy is not effective.
- D. The wound is not infected.

Answer: C

Explanation:
The scenario involves a surgical patient with a purulent abdominal wound culture growing Staphylococcus aureus, a common pathogen in surgical site infections (SSIs). The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes accurate interpretation of culture results and antibiotic therapy in the
"Identification of Infectious Disease Processes" and "Prevention and Control of Infectious Diseases" domains, aligning with the Centers for Disease Control and Prevention (CDC) guidelines for managing SSIs. The question requires assessing the sensitivity pattern and current treatment to determine the correct statement.
Option B, "The current therapy is not effective," is true. The wound culture shows Staphylococcus aureus resistant to oxacillin, indicating methicillin-resistant S. aureus (MRSA). The sensitivity pattern lists resistance to penicillin, oxacillin, cephalothin, and erythromycin, with susceptibility to clindamycin and vancomycin.
Cefazolin, a first-generation cephalosporin, is ineffective against MRSA because resistance to oxacillin (a penicillinase-resistant penicillin) implies cross-resistance to cephalosporins like cefazolin due to altered penicillin-binding proteins (PBPs). The CDC's "Guidelines for the Prevention of Surgical Site Infections" (2017) and the Clinical and Laboratory Standards Institute (CLSI) standards confirm that MRSA strains are not susceptible to cefazolin, meaning the current therapy is inappropriate and unlikely to resolve the infection, supporting Option B.
Option A, "The wound is not infected," is incorrect. The presence of purulent drainage, a clinical sign of infection, combined with a positive culture for S. aureus, confirms an active wound infection. The CBIC and CDC define purulent discharge as a key indicator of SSI, ruling out this statement. Option C, "Droplet Precautions should be initiated," is not applicable. Droplet Precautions are recommended for pathogens transmitted via respiratory droplets (e.g., influenza, pertussis), not for S. aureus, which is primarily spread by contact. The CDC's "Guideline for Isolation Precautions" (2007) specifies Contact Precautions for MRSA, not Droplet Precautions, making this false. Option D, "This is a methicillin-sensitive S. aureus (MSSA) strain," is incorrect. Methicillin sensitivity is determined by susceptibility to oxacillin, and the resistance to oxacillin in the culture result classifies this as MRSA, not MSSA. The CDC and CLSI use oxacillin resistance as the defining criterion for MRSA.
The CBIC Practice Analysis (2022) and CDC guidelines stress the importance of aligning antimicrobial therapy with sensitivity patterns to optimize treatment outcomes. The mismatch between cefazolin and the MRSA sensitivity profile confirms that Option B is the correct statement, indicating ineffective current therapy.
References:
* CBIC Practice Analysis, 2022.
* CDC Guidelines for the Prevention of Surgical Site Infections, 2017.
* CDC Guideline for Isolation Precautions, 2007.
* CLSI Performance Standards for Antimicrobial Susceptibility Testing, 2022.

NEW QUESTION # 171
A 21-ycnr-old college student was admitted with a high fever. The Emergency Department physician be gan immediate treatment with intravenous vancomycin and ceftriaxone while awaiting blood, urine, and cerebrospinal fluid cultures. The following day. the cultures of both the blood and the cerebrospinal fluid were reported to be growing meningococci. The patient was placed on precautions on admission. Which of the following is correct?

- A. Airborne precautions must continue.
- B. Droplet precautions must continue
- C. Droplet precautions may be discontinued after 24 hours of therapy.
- D. Airborne precautions may be discontinued after 24 hours of therapy.

Answer: C

Explanation:
Meningococcal infections, such as Neisseria meningitidis, are transmitted via respiratory droplets.
According to APIC and CDC guidelines, patients with meningococcal disease should be placed on Droplet Precautions upon admission. These precautions can be discontinued after 24 hours of effective antibiotic therapy.
Why the Other Options Are Incorrect?
* B. Droplet precautions must continue - Droplet Precautions are not needed beyond 24 hours of appropriate therapy because treatment rapidly reduces infectiousness.
* C. Airborne precautions may be discontinued after 24 hours of therapy - Meningococcal infection is not airborne, so Airborne Precautions are never required.
* D. Airborne precautions must continue - Incorrect because meningococci do not transmit via airborne particles.
CBIC Infection Control Reference
According to APIC guidelines, Droplet Precautions should be maintained for at least 24 hours after effective antibiotic therapy initiation.

NEW QUESTION # 172
Which of the following measures has NOT been demonstrated to reduce the risk of surgical site infections?

- A. Assuring adequate patient nutrition
- B. Limiting the duration of preoperative hospital stay
- C. Designating a specific surgical suite tor infected cases
- D. Using antimicrobial preoperative scrub by members of the surgical team

Answer: C

Explanation:
There is no strong evidence that isolating infected cases in a separate surgical suite reduces SSI risk.
Step-by-Step Justification:
* SSI Prevention Strategies Supported by Evidence:
* Preoperative hospital stay limitation reduces exposure to hospital-acquired pathogens.
* Antimicrobial preoperative scrubs lower bacterial load on the skin.
* Adequate nutrition improves immune function and wound healing.
* Why Designating a Separate Surgical Suite Is Not Effective:
* Operating room environmental controls (e.g., laminar airflow, sterilization protocols) are more important than suite designation.
* No significant reduction in SSIs has been observed by segregating infected cases into specific OR suites.
Why Other Options Are Correct:
* A. Limiting preoperative hospital stay: Reduces nosocomial bacterial exposure.
* B. Antimicrobial preoperative scrub: Decreases skin flora contamination.
* C. Assuring adequate patient nutrition: Enhances immune defense against infections.
CBIC Infection Control References:
* APIC Text, "Surgical Site Infection Prevention Strategies".

NEW QUESTION # 173
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However, you might want to change some of these settings, As one of these investors Valid CIC Test Sample yourself, a solid understanding of the basics is the bedrock that builds your perspective, shapes your beliefs, and influences your ideas.

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