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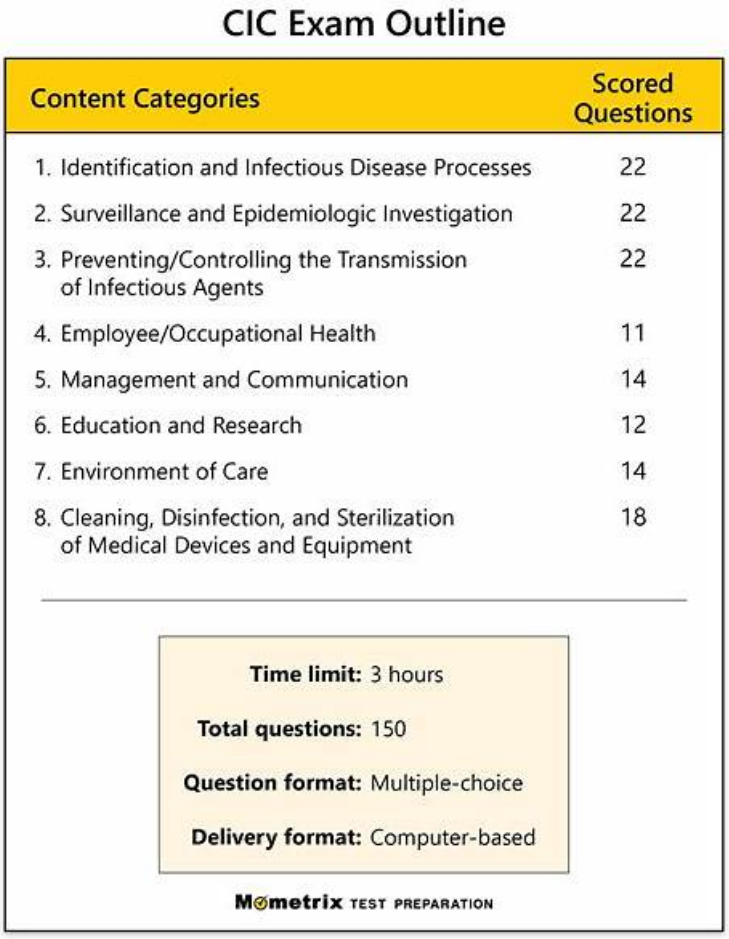

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New developments in the tech sector always bring new job opportunities. These new jobs have to be filled with the CBIC Certified Infection Control Exam (CIC) certification holders. So to fill the space, you need to pass the CBIC Certified Infection Control Exam (CIC) exam. Earning the CBIC Certified Infection Control Exam (CIC) certification helps you clear the obstacles you face while working in the CBIC field. To get prepared for the CBIC Certified Infection Control Exam (CIC) certification exam, applicants face a lot of trouble if the study material is not updated. They are using outdated materials resulting in failure and loss of money and time.

CBIC Certified Infection Control Exam Sample Questions (Q124-Q129):

NEW QUESTION # 124

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 both the patient and the EMT.
- B. Place a surgical mask on the patient and an N95 respirator on 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 # 125
Which of the following pathogens is associated with the highest risk of seroconversion after percutaneous exposure?

- A. Hepatitis A
- B. Syphilis
- C. Hepatitis C
- D. Shigella

Answer: C

Explanation:
Among the listed pathogens,Hepatitis Chas thehighest risk of seroconversion following a percutaneous exposure, though it's important to note thatHepatitis Bactually has the highest overall risk. However, since Hepatitis B is not listed among the options, the correct choice from the available ones isHepatitis C.
* TheAPIC Textconfirms:
"The average risk of seroconversion after a percutaneous injury involving blood infected with hepatitis C virus is approximately 1.8 percent".
* The other options are not bloodborne pathogens typically associated with high seroconversion risks after needlestick or percutaneous exposure:

* A. Shigella- transmitted fecal-orally, not percutaneously.
* B. Syphilis- transmitted sexually or via mucous membranes.
* C. Hepatitis A- primarily fecal-oral transmission, low occupational seroconversion risk.
References:
APIC Text, 4th Edition, Chapter 103 - Occupational Exposure to Bloodborne Pathogens

NEW QUESTION # 126
A healthcare worker experiences a percutaneous exposure to a patient with untreated HIV. The next step is to:

- A. Retest for HIV after 6 months before deciding on PEP.
- B. Offer post-exposure prophylaxis only if symptoms develop.
- C. Wait for HIV test results before starting treatment.
- D. Initiate HIV post-exposure prophylaxis (PEP) within 2 hours.

Answer: D

Explanation:
* HIV post-exposure prophylaxis (PEP) should be initiated within 2 hours to be most effective.
* Waiting for results (B) delays critical treatment.
* PEP should always be offered after high-risk exposure, not only if symptoms develop (C).
* Retesting after 6 months (D) is recommended but should not delay PEP initiation.
CBIC Infection Control References:
* APIC Text, "Bloodborne Pathogens and PEP," Chapter 11.

NEW QUESTION # 127
Following an outbreak of Hepatitis A, the water supply is sampled. A high count of which of the following isolates would indicate that the water was a potential source?

- A. Pseudomonads
- B. Coliforms
- C. Acinetobacter
- D. Legionella

Answer: B

Explanation:
Coliform bacteria are indicators of fecal contamination in water, making them a critical measure of water safety. Hepatitis A is a virus primarily transmitted via the fecal-oral route, often through contaminated food or water.
Step-by-Step Justification:
* Fecal Contamination and Hepatitis A:
* Hepatitis A virus (HAV) spreads through ingestion of water contaminated with fecal matter. High coliform counts indicate fecal contamination and increase the risk of HAV outbreaks.
* Use of Coliforms as Indicators:
* Public health agencies use total coliforms and Escherichia coli (E. coli) as primary indicators of water safety because they signal fecal pollution.
* Waterborne Transmission of Hepatitis A:
* Hepatitis A outbreaks have been traced to contaminated drinking water, ice, and improperly treated wastewater. Coliform detection signals a need for immediate action.
Why Other Options Are Incorrect:
* B. Pseudomonads:
* Pseudomonads (e.g., Pseudomonas aeruginosa) are environmental bacteria but are not indicators of fecal contamination.
* C. Legionella:
* Legionella species cause Legionnaires' disease through inhalation of contaminated aerosols, not through fecal-oral transmission.
* D. Acinetobacter:
* Acinetobacter species are opportunistic pathogens in healthcare settings but are not indicators of waterborne fecal contamination.
CBIC Infection Control References:
* APIC Text, "Water Systems and Infection Control Measures".
* APIC Text, "Hepatitis A Transmission and Waterborne Outbreaks".

NEW QUESTION # 128
An 84-year-old male with a gangrenous foot is admitted to the hospital from an extended-care facility (ECF).
The ECF is notified that the wound grew Enterococcus faecium with the following antibiotic sensitivity results:
ampicillin - R
vancomycin - R
penicillin - R
linezolid - S
This is the fourth Enterococcus species cultured from residents within the same ECF wing in the past month.
The other cultures were from two urine specimens and a draining wound. The Infection Preventionist (IP) should immediately:

- A. Compare the four culture reports and sensitivity patterns.
- B. Conduct surveillance cultures for this organism in all residents.
- C. Notify the nursing administrator to close the wing to new admissions.
- D. Notify the medical director of the outbreak.

Answer: D

Explanation:
The scenario describes a potential outbreak of multidrug-resistant Enterococcus faecium in an extended-care facility (ECF) wing, indicated by four positive cultures (including the current case and three prior cases from urine and a draining wound) within a month. The organism exhibits resistance to ampicillin, vancomycin, and penicillin, but sensitivity to linezolid, suggesting a possible vancomycin-resistant Enterococcus (VRE) strain, which is a significant concern in healthcare settings. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the importance of rapid outbreak detection and response in the "Surveillance and Epidemiologic Investigation" domain, aligning with Centers for Disease Control and Prevention (CDC) guidelines for managing multidrug-resistant organisms (MDROs).
Option A, "Notify the medical director of the outbreak," is the most immediate and critical action. Identifying an outbreak-defined by the CDC as two or more cases of a similar illness linked by time and place-requires prompt notification to the facility's leadership (e.g., medical director) to initiate a coordinated response. The presence of four Enterococcus cases, including a multidrug-resistant strain, within a single ECF wing over a month suggests a potential cluster, necessitating urgent action to assess the scope, implement control measures, and allocate resources. The CDC's "Management of Multidrug-Resistant Organisms in Healthcare Settings" (2006) recommends immediate reporting to facility leadership as the first step to activate an outbreak investigation team, making this the priority.
Option B, "Compare the four culture reports and sensitivity patterns," is an important subsequent step in outbreak investigation. Analyzing the antibiotic susceptibility profiles and culture sources can confirm whether the cases are epidemiologically linked (e.g., clonal spread of VRE) and guide treatment and control strategies. However, this is a detailed analysis that follows initial notification and should not delay alerting the medical director. Option C, "Conduct surveillance cultures for this organism in all residents," is a proactive measure to determine the prevalence of Enterococcus faecium, especially VRE, within the wing. The CDC recommends targeted surveillance during outbreaks, but this requires prior authorization and planning by the outbreak team, making it a secondary action after notification. Option D, "Notify the nursing administrator to close the wing to new admissions," may be a control measure to prevent further spread, as suggested by the CDC for MDRO outbreaks. However, closing a unit is a significant decision that should be guided by the medical director and infection control team after assessing the situation, not an immediate independent action by the IP.
The CBIC Practice Analysis (2022) and CDC guidelines prioritize rapid communication with leadership to initiate a structured outbreak response, including resource allocation and policy adjustments. Given the multidrug-resistant nature and cluster pattern, notifying the medical director (Option A) is the most immediate and appropriate action to ensure a comprehensive response.
References:
* CBIC Practice Analysis, 2022.
* CDC Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006.

NEW QUESTION # 129
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