認定するCIC関連試験試験-試験の準備方法-正確的なCIC日本語試験対策

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今日では、ShikenPASS柔軟な学習方法が電子製品の開発でますます一般的になっています。 CBICこの分野で最も主導的な立場にあるため、CICの実際の試験にも最新のテクノロジーが適用されています。 CIC学習教材を使用すると、まったく新しい快適な学習体験を得ることができます。 さらに、CIC練習資料には3つのバージョンがあるため、さまざまな選択肢があります。 同時に、あなたはCIC試験に合格し、CBIC Certified Infection Control Exam学習教材の有効性と正確性について希望する認定を取得する必要があります。

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>> CIC関連試験 <<

CIC日本語試験対策 & CICテスト難易度

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CBIC Certified Infection Control Exam 認定 CIC 試験問題 (Q284-Q289):

質問 # 284
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. Notify the medical director of the outbreak.
- B. Notify the nursing administrator to close the wing to new admissions.
- C. Conduct surveillance cultures for this organism in all residents.
- D. Compare the four culture reports and sensitivity patterns.

正解：A

解説：
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.

質問 # 285
A family, including an infant of 8 months, is going on a vacation to Europe. An infection preventionist would recommend:

- A. Family immunization records should be reviewed by their provider.
- B. Exposure to rabies should be avoided.
- C. The infant should not travel until at least 12 months of age.
- D. Family members should be vaccinated for yellow fever.

正解：A

解説：
When advising a family, including an 8-month-old infant, planning a vacation to Europe, an infection preventionist (IP) must consider travel-related health risks and vaccination recommendations tailored to the destination and age-specific guidelines. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the "Education and Training" domain, which includes providing evidence-based advice to prevent infections, aligning with the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) travel health recommendations.
Option D, "Family immunization records should be reviewed by their provider," is the most appropriate recommendation. Europe, as a region, includes countries with varying health risks, but it is generally considered a low-risk area for many vaccine-preventable diseases compared to tropical regions. The CDC's
"Travelers' Health" guidelines (2023) recommend that all travelers, including infants, have their immunization status reviewed by a healthcare provider prior to travel to ensure compliance with routine vaccinations (e.g., measles, mumps, rubella [MMR], diphtheria, tetanus, pertussis [DTaP], and polio) and to assess any destination-specific needs. For an 8-month-old, the review would confirm that the infant has received age-appropriate vaccines (e.g., the first doses of DTaP, Hib, PCV, and IPV, typically starting at 2 months) and is on schedule for the 6- and 12-month doses. This step ensures the family's overall protection and identifies any gaps, making it a proactive and universally applicable recommendation.
Option A, "Exposure to rabies should be avoided," is a general travel safety tip applicable to any destination where rabies is endemic

(e.g., parts of Eastern Europe or rural areas with wildlife). However, rabies risk in most European countries is low, and pre-exposure vaccination is not routinely recommended for travelers unless specific high-risk activities (e.g., handling bats) are planned. The CDC advises avoiding animal bites rather than vaccinating unless indicated, making this less specific and urgent than a records review. Option B,

"Family members should be vaccinated for yellow fever," is incorrect. Yellow fever is not endemic in Europe, and vaccination is not required or recommended for travel to any European country. The WHO International Health Regulations (2005) and CDC list yellow fever vaccination as mandatory only for travelers from or to certain African and South American regions, rendering this irrelevant. Option C, "The infant should not travel until at least 12 months of age," lacks a clear evidence base. While some vaccines (e.g., MMR) are typically given at 12 months, the 8-month-old can travel safely if up-to-date on age-appropriate immunizations. The CDC allows travel for infants as young as 6 weeks with medical clearance, and delaying travel to 12 months is not a standard recommendation unless specific risks (e.g., disease outbreaks) are present, which are not indicated here.

The CBIC Practice Analysis (2022) and CDC Travelers' Health resources prioritize pre-travel health assessments, including immunization reviews, as the foundation for safe travel. Option D ensures a comprehensive approach tailored to the family's needs, making it the best recommendation for a trip to Europe.

References:

* CBIC Practice Analysis, 2022.

* CDC Travelers' Health, 2023.

* WHO International Health Regulations, 2005.

The correct answer is B, "Blood pressure cuff," as this item is appropriately cleaned with a disinfectant that is an approved hospital disinfectant with no tuberculocidal claim. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the selection of disinfectants for medical equipment depends on the item's classification and intended use. The Environmental Protection Agency (EPA) categorizes hospital disinfectants based on their efficacy against specific pathogens, with tuberculocidal claims indicating effectiveness against Mycobacterium tuberculosis, a highly resistant organism. A disinfectant without a tuberculocidal claim is suitable for non-critical items-those that contact intact skin but not mucous membranes or sterile tissues-such as blood pressure cuffs, which require only low-level disinfection to reduce bacterial and viral loads (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols).

This aligns with CDC guidelines, which designate low-level disinfectants as adequate for non-critical surfaces.

Option A (laryngoscope blades) is incorrect because laryngoscope blades are semi-critical items that contact mucous membranes (e.g., the oropharynx) and require high-level disinfection or sterilization, which necessitates a disinfectant with tuberculocidal activity to ensure efficacy against a broader spectrum of pathogens, including mycobacteria. Option C (respiratory therapy equipment) is also incorrect, as this equipment (e.g., ventilators or nebulizers) is semi-critical or critical depending on its use, requiring at least intermediate- to high-level disinfection, which exceeds the capability of a non-tuberculocidal disinfectant.

Option D (ultrasound probe) is inappropriate if used on intact skin (non-critical, allowing low-level disinfection), but many ultrasound probes contact mucous membranes or sterile sites, necessitating high-level disinfection with a tuberculocidal agent, making this option unreliable without context.

The selection of a blood pressure cuff aligns with CBIC's emphasis on using appropriate disinfectants based on the Spaulding classification to prevent healthcare-associated infections (HAIs) (CBIC Practice Analysis,

2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This is supported by EPA and CDC guidelines, which guide disinfectant use based on item risk levels (EPA Disinfectant Product List, 2023; CDC Disinfection Guidelines, 2019).

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.4 - Implement environmental cleaning and disinfection protocols, 3.5 - Evaluate the environment for infection risks. EPA Disinfectant Product List, 2023. CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2019.

質問 # 286

An infection preventionist is preparing a report about an outbreak of scabies in a long-term care facility. How would this information be displayed in an epidemic curve?

- A. Prepare a bar graph with no patient identifiers showing the number of cases over a specific period of time.
- B. List case names, room numbers, and date the infestation was identified using a logarithmic scale.
- C. Prepare a scatter plot by patient location showing case prevalence over a specific period of time.
- D. List case medical record numbers and the number of days in the facility to date of onset, showing data in a scatter plot.

正解： A

解説：

An epidemic curve, commonly used in infection prevention and control to visualize the progression of an outbreak, is a graphical representation of the number of cases over time. According to the principles outlined by the Certification Board of Infection Control and Epidemiology (CBIC), an epidemic curve is most effectively displayed using a bar graph or histogram that tracks the number of

new cases by date or time interval (e.g., daily, weekly) without revealing patient identifiers, ensuring compliance with privacy regulations such as HIPAA. Option C aligns with this standard practice, as it specifies preparing a bar graph with no patient identifiers, focusing solely on the number of cases over a specific period. This allows infection preventionists to identify patterns, such as the peak of the outbreak or potential sources of transmission, while maintaining confidentiality.
Option A is incorrect because listing case names and room numbers with a logarithmic scale violates patient privacy and is not a standard method for constructing an epidemic curve. Logarithmic scales are typically used for data with a wide range of values, but they are not the preferred format for epidemic curves, which prioritize clarity over time. Option B is also incorrect, as using medical record numbers and scatter plots to show days in the facility to onset does not align with the definition of an epidemic curve, which focuses on case counts over time rather than individual patient timelines or scatter plot formats. Option D is inappropriate because a scatter plot by patient location emphasizes spatial distribution rather than the temporal progression central to an epidemic curve. While location data can be useful in outbreak investigations, it is typically analyzed separately from the epidemic curve.
The CBIC emphasizes the importance of epidemic curves in the "Identification of Infectious Disease Processes" domain, where infection preventionists use such tools to monitor and control outbreaks (CBIC Practice Analysis, 2022). Specifically, the use of anonymized data in graphical formats is a best practice to protect patient information while providing actionable insights, as detailed in the CBIC Infection Prevention and Control (IPC) guidelines.
References:
* CBIC Practice Analysis, 2022.
* CBIC Infection Prevention and Control Guidelines (IPC), Section on Outbreak Investigation and Epidemic Curve Construction.

質問 # 287

A patient who is pregnant has multidrug-resistant tuberculosis. She presents to the hospital for delivery. She continues to have a productive cough and has sputum smears positive for acid-fast bacilli (AFB), despite treatment. An infection preventionist should recommend which of the following?

- A. The infant may go from Airborne Precautions in the nursery to the mother's room, as long as the mother wears a mask when the infant is in the room.
- B. No isolation is required for the infant; however, the mother should be placed in Airborne Precautions.
- C. Immediately separate the infant from the mother at delivery and place the infant in Airborne Precautions until discharge.
- D. The infant should "room in" with the mother and the mother should wear a mask at all times.

正解： A

解説：

The CBIC Certified Infection Control Exam Study Guide (6th edition) addresses management of tuberculosis (TB) in the peripartum setting, emphasizing protection of the neonate while supporting maternal-infant bonding when safely possible. In this scenario, the mother has active, infectious multidrug-resistant TB, as evidenced by persistent productive cough and positive AFB smears, and therefore requires Airborne Precautions.
Newborns are at high risk for TB infection due to immature immune systems; however, complete and prolonged separation is not always required. The recommended approach is to initially place the infant in Airborne Precautions in the nursery and allow limited, controlled contact with the mother once appropriate safeguards are in place. When the infant is brought to the mother's room, the mother must wear a surgical mask to reduce droplet nuclei exposure, and exposure time should be minimized.
Option A is overly restrictive and not required unless safe controls cannot be maintained. Option B is incorrect because unrestricted rooming-in places the infant at unacceptable risk. Option D is incorrect because the infant does require protection when the mother is infectious.
For the CIC exam, it is critical to recognize that TB management balances infection prevention with family- centered care. Controlled infant exposure with maternal masking is the recommended practice when mothers remain infectious at delivery.

質問 # 288

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

正解： C

解説：

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.

質問 # 289

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