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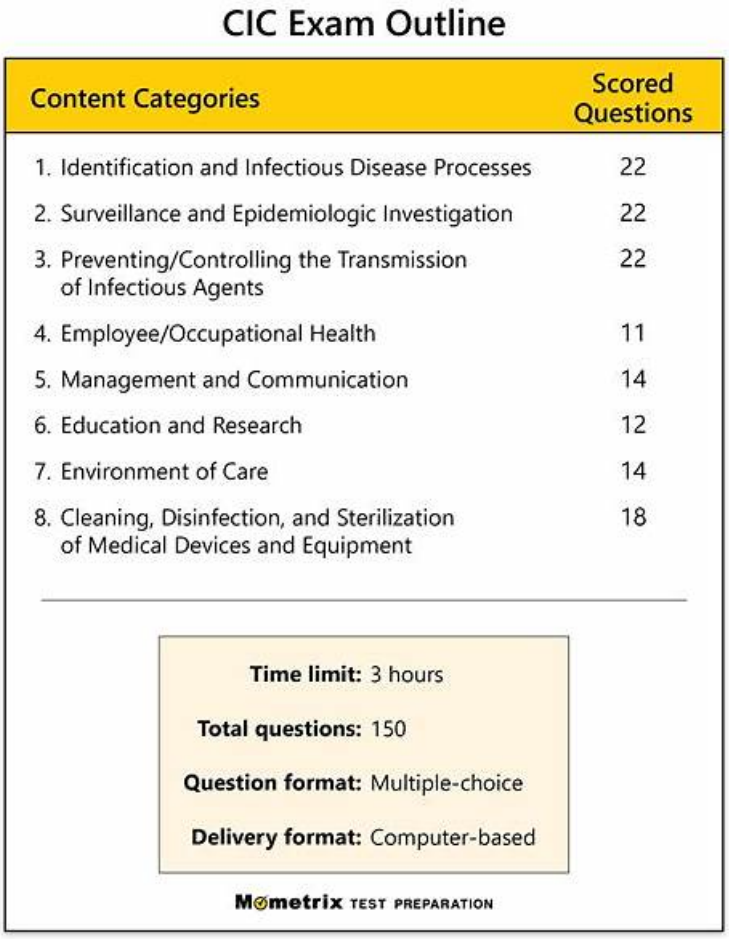

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CBIC Certified Infection Control Exam Sample Questions (Q47-Q52):

NEW QUESTION # 47
What inflammatory reaction may occur in the eye after cataract surgery due to a breach in disinfection and sterilization of intraocular surgical instruments?

- A. Bacterial conjunctivitis
- B. Toxic Anterior Segment Syndrome
- C. Endophthalmitis
- D. Toxic Posterior Segment Syndrome

Answer: B

Explanation:
The correct answer is C, "Toxic Anterior Segment Syndrome," as this is the inflammatory reaction that may occur in the eye after cataract surgery due to a breach in disinfection and sterilization of intraocular surgical instruments. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, Toxic Anterior Segment Syndrome (TASS) is a sterile, acute inflammatory reaction that can result from contaminants introduced during intraocular surgery, such as endotoxins, residues from improper cleaning, or chemical agents left on surgical instruments due to inadequate disinfection or sterilization processes (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). TASS typically presents within 12-48 hours post-surgery with symptoms like pain, redness, and anterior chamber inflammation, and it is distinct from infectious causes because it is not microbial in origin. A breach in reprocessing protocols, such as failure to remove detergents or improper sterilization, is a known risk factor, making it highly relevant to infection prevention efforts in surgical settings.
Option A (endophthalmitis) is an infectious inflammation of the internal eye structures, often caused by bacterial or fungal contamination, which can also result from poor sterilization but is distinguished from TASS by its infectious nature and longer onset (days to weeks). Option B (bacterial conjunctivitis) affects the conjunctiva and is typically a surface infection unrelated to intraocular surgery or sterilization breaches of surgical instruments. Option D (toxic posterior segment syndrome) is not a recognized clinical entity in the context of cataract surgery; inflammation in the posterior segment is more commonly associated with infectious endophthalmitis or other conditions, not specifically linked to reprocessing failures.
The focus on TASS aligns with CBIC's emphasis on ensuring safe reprocessing to prevent adverse outcomes in surgical patients, highlighting the need for rigorous infection control measures (CBIC Practice Analysis,
2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This is supported by CDC and American Academy of Ophthalmology guidelines, which identify TASS as a preventable complication linked to reprocessing errors (CDC Guidelines for Disinfection and Sterilization, 2019; AAO TASS Task Force Report, 2017).
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.3 - Ensure safe reprocessing of medical equipment, 3.5 - Evaluate the environment for infection risks. CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2019. AAO TASS Task Force Report,
2017.

NEW QUESTION # 48
A new hospital disinfectant with a 3-minute contact time has been purchased by Environmental Services. The disinfectant will be rolled out across the patient care 3-minute contact time has been purchased by Environmental Services. The disinfectant will be rolled out across the patient care areas. They are concerned about the high cost of the disinfectant. What advice can the infection preventionist provide?

- A. Use detergents on smooth horizontal surfaces.
- B. Use the new disinfectant for patient washrooms only.
- C. Use new disinfectant for all surfaces in the patient room.
- D. Use detergents on the floors in patient rooms.

Answer: A

Explanation:
The scenario involves the introduction of a new hospital disinfectant with a 3-minute contact time, intended for use across patient care areas, but with concerns raised by Environmental Services about its high cost. The infection preventionist's advice must balance infection control efficacy with cost management, adhering to principles outlined by the Certification Board of Infection Control and Epidemiology (CBIC) and evidence- based practices. The goal is to optimize the disinfectant's use while ensuring a safe environment. Let's evaluate each option:
* A. Use the new disinfectant for patient washrooms only: Limiting the disinfectant to patient washrooms focuses its use on high-touch, high-risk areas where pathogens (e.g., Clostridioides difficile, norovirus) may be prevalent. However, this approach restricts the disinfectant's application to a specific area, potentially leaving other patient care surfaces (e.g., bed rails, tables) vulnerable to

contamination. While cost-saving, it does not address the broad infection control needs across all patient care areas, making it an incomplete strategy.
* B. Use detergents on the floors in patient rooms: Detergents are cleaning agents that remove dirt and organic material but lack the antimicrobial properties of disinfectants. Floors in patient rooms can harbor pathogens, but they are generally considered lower-risk surfaces compared to high-touch areas (e.
g., bed rails, doorknobs). Using detergents instead of the new disinfectant on floors could reduce costs but compromises infection control, as floors may still contribute to environmental transmission (e.g., via shoes or equipment). This option is not optimal given the availability of an effective disinfectant.
* C. Use detergents on smooth horizontal surfaces: Smooth horizontal surfaces (e.g., tables, counters, overbed tables) are common sites for pathogen accumulation and transmission in patient rooms. Using detergents to clean these surfaces removes organic material, which is acritical first step before disinfection. If the 3-minute contact time disinfectant is reserved for high-touch or high-risk surfaces (e.
g., bed rails, call buttons) where disinfection is most critical, this approach maximizes the disinfectant's efficacy while reducing its overall use and cost. This strategy aligns with CBIC guidelines, which emphasize a two-step process (cleaning followed by disinfection) and targeted use of resources, making it a practical and cost-effective recommendation.
* D. Use new disinfectant for all surfaces in the patient room: Using the disinfectant on all surfaces ensures comprehensive pathogen reduction but increases consumption and cost, which is a concern for Environmental Services. While the 3-minute contact time suggests efficiency, overusing the disinfectant on low-risk surfaces (e.g., floors, walls) may not provide proportional infection control benefits and could strain the budget. This approach does not address the cost concern and is less strategic than targeting high-risk areas.
The best advice is C, using detergents on smooth horizontal surfaces to handle routine cleaning, while reserving the new disinfectant for high-touch or high-risk areas where its antimicrobial action is most needed.
This optimizes infection prevention, aligns with CBIC's emphasis on evidence-based environmental cleaning, and addresses the cost concern by reducing unnecessary disinfectant use. The infection preventionist should also recommend a risk assessment to identify priority surfaces for disinfectant application.
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CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV: Environment of Care, which advocates for targeted cleaning and disinfection based on risk.
CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes cost-effective use of disinfectants.
CDC Guidelines for Environmental Infection Control in Healthcare Facilities (2022), which recommend cleaning with detergents followed by targeted disinfection.

NEW QUESTION # 49
A 36-year-old female presents to the Emergency Department with a petechial rash, meningitis, and cardiac arrest. During the resuscitation, a phlebotomist sustained a needlestick injury. The next day, blood cultures reveal Neisseria meningitidis. The exposure management for the phlebotomist is:

- A. Prophylactic rifampin plus isoniazid.
- B. A review of the phlebotomist's hepatitis B vaccine status.
- C. A tuberculin skin test now and in ten weeks.
- D. Work furlough from day ten to day 21 after exposure.

Answer: D

Explanation:
The scenario involves a needlestick injury sustained by a phlebotomist during the resuscitation of a patient diagnosed with Neisseria meningitidis infection, characterized by a petechial rash, meningitis, and cardiac arrest. Neisseria meningitidis is a gram-negative diplococcus that can cause meningococcal disease, including meningitis and septicemia, and is transmitted through direct contact with respiratory secretions or, in rare cases, blood exposure. The exposure management for the phlebotomist must align with infection control guidelines, such as those from the Certification Board of Infection Control and Epidemiology (CBIC) and the CDC, to prevent potential infection. Let's evaluate each option:
* A. Prophylactic rifampin plus isoniazid: Prophylactic antibiotics are recommended for close contacts of individuals with meningococcal disease to prevent secondary cases. Rifampin is a standard prophylactic agent for Neisseria meningitidis exposure, typically administered as a 2-day course (e.g., 600 mg every
12 hours for adults). Isoniazid, however, is used for tuberculosis (TB) prophylaxis and is not indicated for meningococcal disease. Combining rifampin with isoniazid is incorrect, as it reflects a confusion with TB management rather than meningococcal exposure. This option is not appropriate.
* B. A tuberculin skin test now and in ten weeks: A tuberculin skin test (TST) or interferon-gamma release assay (IGRA) is used to screen for latent tuberculosis infection, with a follow-up test at 8-10 weeks to detect conversion after potential TB exposure.

Neisseria meningitidis is not related to TB, and a needlestick injury from a meningococcal patient does not warrant TB testing. This option is irrelevant to the scenario and not the correct exposure management.
* C. Work furlough from day ten to day 21 after exposure: Neisseria meningitidis has an incubation period of 2-10 days, with a maximum of about 14 days in rare cases. The CDC and WHO recommend that healthcare workers exposed to meningococcal disease via needlestick or mucosal exposure be monitored for signs of infection (e.g., fever, rash) and, if symptomatic, isolated and treated.
Additionally, a work restriction or furlough from day 10 to day 21 after exposure is advised to cover the potential incubation period, especially if prophylaxis is declined or contraindicated. This allows time to observe for symptoms and prevents transmission to vulnerable patients. This is a standard infection control measure and the most appropriate initial management step pending prophylaxis decision.
* D. A review of the phlebotomist's hepatitis B vaccine status: Reviewing hepatitis B vaccine status is a critical step following a needlestick injury, as hepatitis B can be transmitted through blood exposure.
However, this applies to bloodborne pathogens (e.g., HBV, HCV, HIV) and is not specific to Neisseria meningitidis, which is primarily a respiratory or mucosal pathogen. While hepatitis B management (e.
g., post-exposure prophylaxis with hepatitis B immunoglobulin or vaccine booster) should be addressed as part of a comprehensive needlestick protocol, it is not the first or most relevant priority for meningococcal exposure.
The best answer is C, as the work furlough from day 10 to day 21 after exposure addresses the specific risk of meningococcal disease following a needlestick injury. This aligns with CBIC's focus on timely intervention and work restriction to prevent transmission in healthcare settings. Prophylactic antibiotics (e.g., rifampin) should also be considered, but the question asks for the exposure management, and furlough is a primary control measure. Hepatitis B and TBconsiderations are secondary and managed separately.
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CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III:
Prevention and Control of Infectious Diseases, which includes protocols for managing exposure to communicable diseases like meningococcal infection.
CBIC Examination Content Outline, Domain IV: Environment of Care, which addresses work restrictions and exposure management.
CDC Guidelines for Meningococcal Disease Prevention and Control (2023), which recommend work furlough and monitoring for exposed healthcare workers.

NEW QUESTION # 50
A task force formed to focus on Clostridioides difficile infections (CDIs). The topic of the meeting discussed selecting the correct germicidal wipe. What important factor does the infection preventionist review?

- A. Correct disposal of the wipe
- B. Cost of a case of wipes
- C. Time the surface remains wet
- D. Size of individual wipes

Answer: C

Explanation:
The correct answer is C, "Time the surface remains wet," as this is the most important factor the infection preventionist (IP) should review when selecting a germicidal wipe for controlling Clostridioides difficile infections (CDIs). According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, effective environmental cleaning is a critical component of infection prevention, particularly for pathogens like C. difficile, which forms hardy spores that are resistant to many disinfectants. The efficacy of a germicidal wipe depends on the contact time-the duration the surface must remain wet with the disinfectant to ensure the killing of C. difficile spores. This is specified by the manufacturer and supported by guidelines from the Centers for Disease Control and Prevention (CDC) and the Environmental Protection Agency (EPA), which emphasize that the disinfectant must remain wet on the surface for the full recommended contact time (typically 1-10 minutes for sporicidal agents) to achieve the desired level of disinfection (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols).
Option A (cost of a case of wipes) is a practical consideration for budgeting but is secondary to efficacy in infection control, especially for a high-priority pathogen like C. difficile. Option B (size of individual wipes) may affect coverage and convenience but does not directly impact the wipe's ability to eliminate the pathogen. Option D (correct disposal of the wipe) is important for preventing cross-contamination and ensuring compliance with waste management protocols, but it is a procedural step after use and not the primary factor in selecting the wipe.
The IP's review of contact time aligns with CBIC's focus on evidence-based practices to prevent healthcare- associated infections (HAIs). For C. difficile, which is a leading cause of HAIs, selecting a wipe with an appropriate sporicidal agent and ensuring adequate wet contact time is essential to disrupt transmission, particularly in outbreak settings (CDC Guidelines for Environmental

Infection Control in Healthcare Facilities, 2019). This factor directly influences the wipe's effectiveness, making it the critical review point for the task force.
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols. CDC Guidelines for Environmental Infection Control in Healthcare Facilities, 2019.

NEW QUESTION # 51
Which of the following statements characterizes the proper use of chemical disinfectants?

- A. A chemical indicator must be used with items undergoing high-level disinfection.
- B. All items to be processed must be cleaned prior to being submerged in solution.
- C. The label on the solution being used must indicate that it kills all viable micro-organisms.
- D. The solution should be adaptable for use as an antiseptic.

Answer: B

Explanation:
The proper use of chemical disinfectants is a critical aspect of infection control, as outlined by the Certification Board of Infection Control and Epidemiology (CBIC). Chemical disinfectants are used to eliminate or reduce pathogenic microorganisms on inanimate objects, and their effective application requires adherence to specific protocols to ensure safety and efficacy. Let's evaluate each option based on infection control standards:
* A. All items to be processed must be cleaned prior to being submerged in solution.: This statement is a fundamental principle of disinfectant use. Cleaning (e.g., removing organic material such as blood, tissue, or dirt) is a prerequisite before disinfection because organic matter can inactivate or reduce the effectiveness of chemical disinfectants. The CBIC emphasizes that proper cleaning is the first step in the disinfection process to ensure that disinfectants can reach and kill microorganisms. This step is universally required for all levels of disinfection (low, intermediate, and high), making it a characterizing feature of proper use.
* B. The label on the solution being used must indicate that it kills all viable micro-organisms.: This statement is misleading. No disinfectant can be guaranteed to kill 100% ofall viable microorganisms under all conditions, as efficacy depends on factors like contact time, concentration, and the presence of organic material. Disinfectant labels typically indicate the types of microorganisms (e.g., bacteria, viruses, fungi) and the level of disinfection (e.g., high-level, intermediate-level) they are effective against, based on standardized tests (e.g., EPA or FDA guidelines). Claiming that a solution kills all viable microorganisms is unrealistic and not a requirement for proper use; instead, the label must specify the intended use and efficacy, which varies by product.
* C. The solution should be adaptable for use as an antiseptic.: An antiseptic is a chemical agent used on living tissue (e.g., skin) to reduce microbial load, whereas a disinfectant is used on inanimate surfaces.
While some chemicals (e.g., alcohol) can serve both purposes, this is not a requirement for proper disinfectant use. The adaptability of a solution for antiseptic use is irrelevant to its classification or application as a disinfectant, which focuses on environmental or equipment decontamination. This statement does not characterize proper disinfectant use.
* D. A chemical indicator must be used with items undergoing high-level disinfection.: Chemical indicators (e.g., test strips or tapes) are used to verify that the disinfection process has met certain parameters (e.g., concentration or exposure time), particularly in sterilization or high-level disinfection (HLD). While this is a recommended practice for quality assurance in HLD (e.g., with glutaraldehyde or hydrogen peroxide), it is not a universal requirement for all chemical disinfectant use. HLD applies specifically to semi-critical items (e.g., endoscopes), and the need for indicators depends on the protocol and facility standards. This statement is too narrow and specific to characterize the proper use of chemical disinfectants broadly.
The correct answer is A, as cleaning prior to disinfection is a foundational and universally applicable step in the proper use of chemical disinfectants. This aligns with CBIC guidelines, which stress the importance of a clean surface to maximize disinfectant efficacy and prevent infection transmission in healthcare settings.
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CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV: Environment of Care, which mandates cleaning as a prerequisite for effective disinfection.
CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes protocols for the proper use of disinfectants, emphasizing pre-cleaning.
CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities (2021), which reinforce that cleaning must precede disinfection to ensure efficacy.

NEW QUESTION # 52
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