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Reliable CIC Test Questions & New CIC Exam Question

All of the traits above are available in this web-based CBIC Certified Infection Control Exam (CIC) practice test of ActualtestPDF. The main distinction is that the CBIC Certified Infection Control Exam (CIC) online practice test works with not only Windows but also Mac, Linux, iOS, and Android. Above all, taking the CBIC Certified Infection Control Exam (CIC) web-based practice test while preparing for the examination does not need any software installation.

CBIC Certified Infection Control Exam Sample Questions (Q273-Q278):

NEW QUESTION # 273
A family, including an infant of 8 months, is going on a vacation to Europe. An infection preventionist would recommend:

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

Answer: C

Explanation:
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.

NEW QUESTION # 274
The annual report for Infection Prevention shows a dramatic decrease in urinary catheter days, a decrease in the catheter utilization ratio, and a slight decrease in the number of catheter-associated urinary tract infections (CAUTIs). The report does not show an increase in the overall rate of CAUTI. How would the infection preventionist explain this to the administration?

- A. The rate is not affected by the number of catheter days.

- B. The rate may be higher if the denominator is very small.
- C. Decreasing catheter days will not have an effect on decreasing CAUTI.
- D. The rate is incorrect and needs to be recalculated.

Answer: B

Explanation:
The correct answer is B, "The rate may be higher if the denominator is very small," as this provides the most plausible explanation for the observed data in the annual report. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the CAUTI rate is calculated as the number of CAUTIs per 1,000 catheter days, where catheter days serve as the denominator. The report indicates a dramatic decrease in urinary catheter days and a slight decrease in the number of CAUTIs, yet the overall CAUTI rate has not increased. This discrepancy can occur if the denominator (catheter days) becomes very small, which can inflate or destabilize the rate, potentially masking an actual increase in the infection risk per catheter day (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.2 - Analyze surveillance data). A smaller denominator amplifies the impact of even a slight change in the number of infections, suggesting that the rate may be higher than expected or less reliable, necessitating further investigation.
Option A (the rate is incorrect and needs to be recalculated) assumes an error in the calculation without evidence, which is less specific than the denominator effect explanation. Option C (the rate is not affected by the number of catheter days) is incorrect because the CAUTI rate is directly influenced by the number of catheter days as the denominator; a decrease in catheter days should typically lower the rate if infections decrease proportionally, but the lack of an increase here suggests a calculation or interpretation issue. Option D (decreasing catheter days will not have an effect on decreasing CAUTI) contradicts evidence-based practice, as reducing catheter days is a proven strategy to lower CAUTI incidence, though the rate's stability here indicates a potential statistical artifact.
The explanation focusing on the denominator aligns with CBIC's emphasis on accurate surveillance and data analysis to guide infection prevention strategies, allowing the infection preventionist to advise administration on the need to review data trends or adjust monitoring methods (CBIC Practice Analysis, 2022, Domain II:
Surveillance and Epidemiologic Investigation, Competency 2.5 - Use data to guide infection prevention and control strategies). This insight can prompt a deeper analysis to ensure the CAUTI rate reflects true infection risk.
References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competencies 2.2 - Analyze surveillance data, 2.5 - Use data to guide infection prevention and control strategies.

NEW QUESTION # 275
Which performance improvement model should the infection preventionist use to aid in the evaluation of the infection control plan?

- A. Six Sigma
- B. Plan, Do, Study, Act
- C. Failure mode and effects analysis
- D. Root Cause Analysis

Answer: B

Explanation:
The Plan, Do, Study, Act (PDSA) model is a widely used performance improvement tool in infection prevention. It focuses on continuous quality improvement through planning, implementing, analyzing data, and making adjustments. This model aligns with infection control program evaluations and The Joint Commission's infection prevention and control standards.
Why the Other Options Are Incorrect?
* A. Six Sigma - A data-driven process improvement method but not as commonly used in infection control as PDSA.
* B. Failure Mode and Effects Analysis (FMEA) - Used to identify risks before implementation, rather than ongoing evaluation.
* D. Root Cause Analysis (RCA) - Used to analyze failures after they occur, rather than guiding continuous improvement.
CBIC Infection Control Reference
The PDSA cycle is a recognized model for evaluating and improving infection control plans.

NEW QUESTION # 276
What question would be appropriate for an infection preventionist to ask when reviewing the discussion section of an original article?

- A. Was the correct sample size and analysis method chosen?
- B. Is the study question important, appropriate, and stated clearly?
- C. Are criteria used to measure the exposure and the outcome explicit?
- D. Could alternative explanations account for the observed results?

Answer: D

Explanation:
When reviewing the discussion section of an original article, an infection preventionist must focus on critically evaluating the interpretation of the study findings, their relevance to infection control, and their implications for practice. The discussion section typically addresses the meaning of the results, compares them to existing literature, and considers limitations or alternative interpretations. The appropriate question should align with the purpose of this section and reflect the infection preventionist's need to assess the validity and applicability of the research. Let's analyze each option:
* A. Was the correct sample size and analysis method chosen?: This question pertains to the methodology section of a research article, where the study design, sample size, and statistical methods are detailed.
While these elements are critical for assessing the study's rigor, they are not the primary focus of the discussion section, which interprets results rather than re-evaluating the study design. An infection preventionist might ask this during a review of the methods section, but it is less relevant here.
* B. Could alternative explanations account for the observed results?: The discussion section often explores whether the findings can be explained by factors other than the hypothesized cause, such as confounding variables, bias, or chance. This question is highly appropriate for an infection preventionist, as it encourages a critical assessment of whether the results truly support infection control interventions or if other factors (e.g., environmental conditions, patient factors) might be responsible.
This aligns with CBIC's emphasis on evidence-based practice, where understanding the robustness of conclusions is key to applying research to infection prevention strategies.
* C. Is the study question important, appropriate, and stated clearly?: This question relates to the introduction or background section of an article, where the research question and its significance are established. While important for overall study evaluation, it is not specific to the discussion section, which focuses on interpreting results rather than revisiting the initial question. An infection preventionist might consider this earlier in the review process, but it does not fit the context of the discussion section.
* D. Are criteria used to measure the exposure and the outcome explicit?: This question is relevant to the methods section, where the definitions and measurement tools for exposures (e.g., a specific intervention) and outcomes (e.g., infection rates) are described. The discussion section may reference these criteria but focuses more on their implications rather than their clarity. This makes it less appropriate for the discussion section specifically.
The discussion section is where authors synthesize their findings, address limitations, and consider alternative explanations, making option B the most fitting. For an infection preventionist, evaluating alternative explanations is crucial to ensure that recommended practices (e.g., hand hygiene protocols or sterilization techniques) are based on solid evidence and not confounded by unaddressed variables. This critical thinking is consistent with CBIC's focus on applying research to improve infection control outcomes.
References:
* CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain I: Identification of Infectious Disease Processes, which emphasizes critical evaluation of research evidence.
* CBIC Examination Content Outline, Domain V: Management and Communication, which includes assessing the validity of research findings for infection control decision-making.

NEW QUESTION # 277
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. A review of the phlebotomist's hepatitis B vaccine status.
- B. Prophylactic rifampin plus isoniazid.
- C. Work furlough from day ten to day 21 after exposure.
- D. A tuberculin skin test now and in ten weeks.

Answer: C

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 TB considerations are secondary and managed separately.
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 # 278
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