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CBIC Certified Infection Control Exam Sample Questions (Q283-Q288):

NEW QUESTION # 283

Based on the compiled results of learner needs assessments, the staff has an interest in hepatitis B, wound care, and continuing education credits. What should be the infection preventionist's next step?

- A. Conduct personal interviews with the staff
- B. Offer a lecture on hepatitis B and wound care
- C. Write program goals and objectives
- D. Directly observe behavioral changes

Answer: C

Explanation:

The infection preventionist's (IP) next step, based on the compiled results of learner needs assessments indicating staff interest in hepatitis B, wound care, and continuing education credits, should be to write program goals and objectives. This step is critical in the educational planning process, as outlined by the Certification Board of Infection Control and Epidemiology (CBIC) guidelines.

According to CBIC, effective infection prevention education programs begin with a structured approach that includes defining clear goals and objectives tailored to the identified needs of the learners (CBIC Practice Analysis, 2022, Domain IV:

Education and Research, Competency 4.1 - Develop and implement educational programs). Writing program goals and objectives ensures that the educational content aligns with the staff's interests and professional development needs, such as understanding hepatitis B prevention, wound care techniques, and earning continuing education credits. This step provides a foundation for designing relevant and measurable outcomes, which can later guide the development of lectures, training materials, or other interventions.

Option A (conduct personal interviews with the staff) is less appropriate as the next step because the needs assessment has already been completed, providing sufficient data on staff interests. Additional interviews might be useful for refining details but are not the immediate priority. Option B (offer a lecture on hepatitis B and wound care) is a subsequent action that follows the establishment of goals and objectives, as delivering content without a structured plan may lack focus or fail to meet educational standards. Option D (directly observe behavioral changes) is an evaluation step that occurs after the education program has been implemented and is not the initial action required.

By starting with program goals and objectives, the IP ensures a systematic approach that adheres to CBIC's emphasis on evidence-based education and continuous improvement in infection prevention practices. This process also facilitates collaboration with stakeholders to meet accreditation or certification requirements, such as those for continuing education credits.

References: CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs.

NEW QUESTION # 284

Peripherally inserted central catheter (PICC)-associated bloodstream infections (BSIs) have been increasing over the past four months. Which of the following interventions is MOST likely to have contributed to the increase?

- A. Use of chlorhexidine skin antiseptics during insertion of the PICC
- B. Replacement of the intravenous administration sets every 72 hours
- C. Use of a positive pressure device on the PICC
- D. Daily bathing adult intensive care unit patients with chlorhexidine

Answer: B

Explanation:

Peripherally inserted central catheter (PICC)-associated bloodstream infections (BSIs) are a significant concern in healthcare settings, and identifying factors contributing to their increase is critical for infection prevention. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the

"Surveillance and Epidemiologic Investigation" and "Prevention and Control of Infectious Diseases" domains, which align with the Centers for Disease Control and Prevention (CDC) guidelines for preventing intravascular catheter-related infections. The question

asks for the intervention most likely to have contributed to the rise in PICC-associated BSIs over four months, requiring an evaluation of each option based on evidence-based practices.

Option C, "Replacement of the intravenous administration sets every 72 hours," is the most likely contributor to the increase. The CDC's "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017) recommend that intravenous administration sets (e.g., tubing for fluids or medications) be replaced no more frequently than every 72-96 hours unless clinically indicated (e.g., contamination or specific therapy requirements). Frequent replacement, such as every 72 hours as a routine practice, can introduce opportunities for contamination during the change process, especially if aseptic technique is not strictly followed. Studies cited in the CDC guidelines, including those by O'Grady et al. (2011), indicate that unnecessary manipulation of catheter systems increases the risk of introducing pathogens, potentially leading to BSIs. A change to a 72-hour replacement schedule, if not previously standard, could explain the observed increase over the past four months.

Option A, "Use of chlorhexidine skin antiseptics during insertion of the PICC," is a recommended practice to reduce BSIs. Chlorhexidine, particularly in a 2% chlorhexidine gluconate with 70% alcohol solution, is the preferred skin antiseptic for catheter insertion due to its broad-spectrum activity and residual effect, as supported by the CDC (2017). This intervention should decrease, not increase, infection rates, making it an unlikely contributor. Option B, "Daily bathing adult intensive care unit patients with chlorhexidine," is another evidence-based strategy to reduce healthcare-associated infections, including BSIs, by decolonizing the skin of pathogens like *Staphylococcus aureus*. The CDC and SHEA (Society for Healthcare Epidemiology of America) guidelines (2014) endorse chlorhexidine bathing in intensive care units, suggesting it should lower, not raise, BSI rates. Option D, "Use of a positive pressure device on the PICC," aims to prevent catheter occlusion and reduce the need for frequent flushing, which could theoretically decrease infection risk by minimizing manipulation. However, there is no strong evidence linking positive pressure devices to increased BSIs; if improperly used or maintained, they might contribute marginally, but this is less likely than the impact of frequent tubing changes.

The CBIC Practice Analysis (2022) and CDC guidelines highlight that deviations from optimal catheter maintenance practices, such as overly frequent administration set replacements, can increase infection risk.

Given the four-month timeframe and the focus on an intervention's potential negative impact, Option C stands out as the most plausible contributor due to the increased manipulation and contamination risk associated with routine 72-hour replacements.

References:

CBIC Practice Analysis, 2022.

CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.

O'Grady, N. P., et al. (2011). Guidelines for the Prevention of Intravascular Catheter-Related Infections. Clinical Infectious Diseases.

SHEA Compendium, Strategies to Prevent Central Line-Associated Bloodstream Infections, 2014.

NEW QUESTION # 285

Following recent renovations on an oncology unit, three patients were identified with *Aspergillus* infections.

The infections were thought to be facility-acquired. Appropriate environmental microbiological monitoring would be to culture the:

- A. Ice
- B. Carpet
- C. Air
- D. Aerators

Answer: C

Explanation:

The scenario describes an outbreak of *Aspergillus* infections among three patients on an oncology unit following recent renovations, with the infections suspected to be facility-acquired. *Aspergillus* is a mold commonly associated with environmental sources, particularly airborne spores, and its presence in immunocompromised patients (e.g., oncology patients) poses a significant risk. The infection preventionist must identify the appropriate environmental microbiological monitoring strategy, guided by the Certification Board of Infection Control and Epidemiology (CBIC) and CDC recommendations. Let's evaluate each option:

* A. Air: *Aspergillus* species are ubiquitous molds that thrive in soil, decaying vegetation, and construction dust, and they are primarily transmitted via airborne spores. Renovations can disturb these spores, leading to aerosolization and inhalation by vulnerable patients. Culturing the air using methods such as settle plates, air samplers, or high-efficiency particulate air (HEPA) filtration monitoring is a standard practice to detect *Aspergillus* during construction or post-renovation in healthcare settings, especially oncology units where patients are at high risk for invasive aspergillosis. This aligns with CBIC's emphasis on environmental monitoring for airborne pathogens, making it the most appropriate choice.

* B. Ice: Ice can be a source of contamination with bacteria (e.g., *Pseudomonas*, *Legionella*) or other pathogens if improperly handled or stored, but it is not a typical reservoir for *Aspergillus*, which is a mold requiring organic material and moisture for growth. While ice safety is important in infection control, culturing ice is irrelevant to an *Aspergillus* outbreak linked to renovations and is not a priority in this context.

* C. Carpet: Carpets can harbor dust, mold, and other microorganisms, especially in high-traffic or poorly maintained areas.

Aspergillus spores could theoretically settle in carpet during renovations, but carpets are not a primary source of airborne transmission unless disturbed (e.g., vacuuming). Culturing carpet might be a secondary step if air sampling indicates widespread contamination, but it is less direct and less commonly recommended as the initial monitoring site compared to air sampling.

* D. Aerators: Aerators (e.g., faucet aerators) can harbor waterborne pathogens like *Pseudomonas* or *Legionella* due to biofilm formation, but *Aspergillus* is not typically associated with water systems unless there is significant organic contamination or aerosolization from water sources (e.g., cooling towers). Culturing aerators is relevant for waterborne outbreaks, not for an *Aspergillus* outbreak linked to renovations, making this option inappropriate.

The best answer is A, culturing the air, as *Aspergillus* is an airborne pathogen, and renovations are a known risk factor for spore dispersal in healthcare settings. This monitoring strategy allows the infection preventionist to confirm the source, assess the extent of contamination, and implement control measures (e.g., enhanced filtration, construction barriers) to protect patients. This is consistent with CBIC and CDC guidelines for managing fungal outbreaks in high-risk units.

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CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV:

Environment of Care, which recommends air sampling for *Aspergillus* during construction-related outbreaks.

CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes environmental monitoring for facility-acquired infections.

CDC Guidelines for Environmental Infection Control in Healthcare Facilities (2022), which advocate air culturing to detect *Aspergillus* post-renovation in immunocompromised patient areas.

NEW QUESTION # 286

An infection preventionist is utilizing the Shewhart/Deming cycle in an infection control program performance improvement project. In which of the following steps are the results of the interventions compared with the original goal?

- A. Study
- B. Plan
- C. Act
- D. Do

Answer: A

Explanation:

The correct answer is D, "Study," as this is the step in the Shewhart/Deming cycle (commonly known as the Plan-Do-Study-Act [PDSA] cycle) where the results of the interventions are compared with the original goal.

According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the PDSA cycle is a systematic approach to quality improvement, widely used in infection control programs to test and refine interventions. The cycle consists of four stages: Plan (designing the intervention and setting goals), Do (implementing the intervention on a small scale), Study (analyzing the data and comparing outcomes against the original goal), and Act (standardizing successful changes or adjusting based on findings) (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs). The Study phase is critical for assessing whether the intervention achieved the intended reduction in infection rates or other performance metrics, providing evidence to guide the next steps.

Option A (Do) involves the execution of the planned intervention, focusing on implementation rather than evaluation, so it does not include comparing results. Option B (Act) is the final step where successful interventions are implemented on a broader scale or adjustments are made, but it follows the comparison made in the Study phase. Option C (Plan) is the initial stage of setting objectives and designing the intervention, which occurs before any results are available for comparison.

The emphasis on the Study phase aligns with CBIC's focus on using data to evaluate the effectiveness of infection prevention strategies, ensuring that performance improvement projects are evidence-based and goal-oriented (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.4 - Evaluate the effectiveness of infection prevention and control interventions). This step enables the infection preventionist to determine if the original goal—such as reducing healthcare-associated infections—was met, facilitating continuous improvement.

References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.4 - Evaluate the effectiveness of infection prevention and control interventions; Domain IV:

Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs.

NEW QUESTION # 287

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

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 # 288

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