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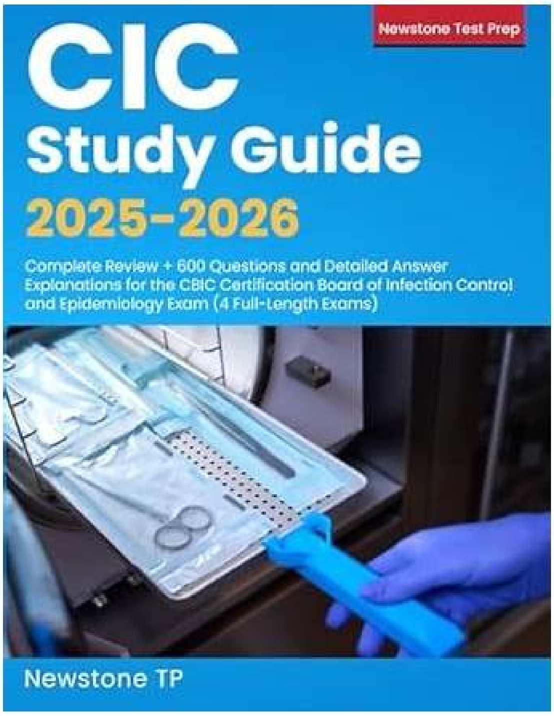

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CBIC Certified Infection Control Exam Sample Questions (Q12-Q17):

NEW QUESTION # 12
In a retrospective case-control study, the initial case group is composed of persons

- A. with the risk factor under investigation
- B. without the disease.
- C. with the disease
- D. without the risk factor under investigation

Answer: C

Explanation:
In a retrospective case-control study, cases and controls are selected based on disease status. The case group is composed of individuals who have the disease (cases), while the control group consists of individuals without the disease. This design allows researchers to look back in time to assess exposure to potential risk factors.
Step-by-Step Justification:
* Selection of Cases and Controls:
* Cases: Individuals who already have the disease.
* Controls: Individuals without the disease but similar in other aspects.
* Direction of Study:
* A retrospective study moves backward from the disease outcome to investigate potential causes or risk factors.
* Data Collection:
* Uses past medical records, interviews, and laboratory results to determine past exposures.
* Common Use:
* Useful for studying rare diseases since cases have already occurred, making it cost-effective compared to cohort studies.
Why Other Options Are Incorrect:
* B. without the disease: (Incorrect) This describes the control group, not the case group.
* C. with the risk factor under investigation: (Incorrect) Risk factors are identified after selecting cases and controls.
* D. without the risk factor under investigation: (Incorrect) The study investigates whether cases had prior exposure, not whether they lacked a risk factor.
CBIC Infection Control References:
* APIC Text, Chapter on Epidemiologic Study Design.

NEW QUESTION # 13
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. The wound is not infected.
- B. Droplet Precautions should be initiated.
- C. The current therapy is not effective.
- D. This is a methicillin-sensitive S. aureus (MSSA) strain.

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 # 14

Which of the following individuals should be excluded from receiving live attenuated influenza virus?

- A. Healthy persons aged 2 to 49
- B. Pregnant persons
- C. Persons with allergies to chicken feathers
- D. Persons simultaneously receiving an inactivated vaccine

Answer: B

Explanation:

The correct answer is A, "Pregnant persons," as they should be excluded from receiving the live attenuated influenza virus (LAIV) vaccine. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, which align with recommendations from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP), the LAIV, commonly known as the nasal spray flu vaccine, contains a live attenuated form of the influenza virus. This vaccine is contraindicated in pregnant individuals due to the theoretical risk of the attenuated virus replicating and potentially harming the fetus, despite limited evidence of adverse outcomes (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents).

Pregnant persons are instead recommended to receive the inactivated influenza vaccine (IIV), which is considered safe during pregnancy.

Option B (healthy persons aged 2 to 49) is incorrect because this group is generally eligible to receive LAIV, provided they have no other contraindications, as the vaccine is approved for healthy, non-pregnant individuals in this age range (CDC Immunization Schedules, 2024). Option C (persons with allergies to chicken feathers) is not a contraindication for LAIV; the vaccine is produced in eggs, and while egg allergy was historically a concern, current guidelines indicate that LAIV can be administered to persons with egg allergies if they can tolerate egg in their diet, with precautions managed by healthcare providers. Option D (persons simultaneously receiving an inactivated vaccine) is also incorrect, as LAIV can be co-administered with inactivated vaccines without issue, according to ACIP recommendations, as there is no significant interference between the two vaccine types.

The exclusion of pregnant persons reflects CBIC's emphasis on tailoring infection prevention strategies, including vaccination programs, to protect vulnerable populations while minimizing risks (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). This decision is based on precautionary principles outlined in CDC and ACIP guidelines to ensure maternal and fetal safety (CDC Prevention and Control of Seasonal Influenza with Vaccines, 2023).

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.1 - Collaborate with organizational leaders, 3.2 - Implement measures to prevent transmission of infectious agents. CDC Prevention and Control of Seasonal Influenza with Vaccines, 2023. CDC Immunization Schedules, 2024.

NEW QUESTION # 15

An infection preventionist (IP) is informed of a measles outbreak in a nearby community. What is the IP's FIRST priority when working with Occupational Health?

- A. Reassign employees who are pregnant from caring for patients with suspected measles.
- B. Verify that employees in high-risk exposure areas of the facility have adequate immunity to measles.
- C. Isolate employees who have recently traveled to areas with measles outbreaks.
- D. Set up a mandatory vaccination clinic in collaboration with Occupational Health and local public health partners.

Answer: B

Explanation:
When an infection preventionist (IP) is informed of a measles outbreak in a nearby community, the immediate priority is to protect healthcare workers and patients from potential exposure, particularly in a healthcare setting where vulnerable populations are present. Working with Occupational Health, the IP must follow a structured approach to mitigate the risk of transmission, guided by principles from the Certification Board of Infection Control and Epidemiology (CBIC) and public health guidelines. Let's evaluate each option to determine the first priority:
* A. Isolate employees who have recently traveled to areas with measles outbreaks: Isolating employees who may have been exposed to measles during travel is an important infection control measure to prevent transmission within the facility. However, this action assumes that exposure has already occurred and requires identification of affected employees first. Without knowing the immunity status of the workforce, this step is reactive rather than preventive and cannot be the first priority.
* B. Reassign employees who are pregnant from caring for patients with suspected measles: Reassigning pregnant employees is a protective measure due to the severe risks measles poses to fetuses (e.g., congenital rubella syndrome risks, though measles itself is more about maternal complications). This action is specific to a subset of employees and depends on identifying patients with suspected measles, which may not yet be confirmed. It is a secondary step that follows assessing overall immunity and exposure risks, making it inappropriate as the first priority.
* C. Verify that employees in high-risk exposure areas of the facility have adequate immunity to measles:
Verifying immunity is the foundational step in preventing measles transmission in a healthcare setting.
Measles is highly contagious, and healthcare workers in high-risk areas (e.g., emergency departments, pediatric wards) are at increased risk of exposure. The CBIC and CDC recommend ensuring that all healthcare personnel have documented evidence of measles immunity (e.g., two doses of MMR vaccine, laboratory evidence of immunity, or prior infection) as a primary infection control strategy during outbreaks. This step allows the IP to identify vulnerable employees, implement targeted interventions, and comply with occupational health regulations. It is the most proactive and immediate priority when an outbreak is reported in the community.
* D. Set up a mandatory vaccination clinic in collaboration with Occupational Health and local public health partners: Establishing a vaccination clinic is a critical long-term strategy to increase immunity and control the outbreak. However, this requires planning, resource allocation, and coordination, which take time. It is a subsequent step that follows verifying immunity status to identify those who need vaccination. While important, it cannot be the first priority due to its logistical demands.
The first priority is C, as verifying immunity among employees in high-risk areas establishes a baseline to prevent transmission before reactive measures (e.g., isolation, reassignment) or broader interventions (e.g., vaccination clinics) are implemented. This aligns with CBIC's focus on proactive risk assessment and occupational health safety during infectious disease outbreaks, ensuring a rapid response to protect the healthcare workforce and patients.
References:
* CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III:
Prevention and Control of Infectious Diseases, which prioritizes immunity verification during outbreaks.
* CBIC Examination Content Outline, Domain IV: Environment of Care, which includes ensuring employee immunity as part of outbreak preparedness.
* CDC Guidelines for Measles Prevention (2023), which recommend verifying healthcare worker immunity as the initial step during a measles outbreak.

NEW QUESTION # 16

A 21-ycnr-old college student was admitted with a high fever. The Emergency Department physician be gan immediate treatment with intravenous vancomycin and ceftriaxone while awaiting blood, urine, and cerebrospinal fluid cultures. The following day. the cultures of both the blood and the cerebrospinal fluid were reported to be growing meningococci. The patient was placed on precautions on admission. Which of the following is correct?

- A. Airborne precautions may be discontinued after 24 hours of therapy.
- B. Droplet precautions must continue
- C. Droplet precautions may be discontinued after 24 hours of therapy.
- D. Airborne precautions must continue.

Answer: C

Explanation:
Meningococcal infections, such as Neisseria meningitidis, are transmitted via respiratory droplets.
According to APIC and CDC guidelines, patients with meningococcal disease should be placed on Droplet Precautions upon admission. These precautions can be discontinued after 24 hours of effective antibiotic therapy.
Why the Other Options Are Incorrect?
* B. Droplet precautions must continue - Droplet Precautions are not needed beyond 24 hours of appropriate therapy because treatment rapidly reduces infectiousness.
* C. Airborne precautions may be discontinued after 24 hours of therapy - Meningococcal infection is not airborne, so Airborne Precautions are never required.
* D. Airborne precautions must continue - Incorrect because meningococci do not transmit via airborne particles.
CBIC Infection Control Reference
According to APIC guidelines, Droplet Precautions should be maintained for at least 24 hours after effective antibiotic therapy initiation.

NEW QUESTION # 17
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