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CBIC Certified Infection Control Exam Sample Questions (Q137-Q142):

NEW QUESTION # 137
Each item or package that is prepared for sterilization should be labeled with the

- A. storage location.
- B. type of sterilization process.
- C. cleaning method (e.g., mechanical or manual).
- D. sterilizer identification number or code.

Answer: D

Explanation:
The correct answer is C, "sterilizer identification number or code," as this is the essential information that each item or package prepared for sterilization should be labeled with. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, proper labeling of sterilized items is a critical component of infection prevention and control to ensure traceability and verify the sterilization process. The sterilizer identification number or code links the item to a specific sterilization cycle, allowing the infection preventionist (IP) and sterile processing staff to track the equipment used, confirm compliance with standards (e.g., AAMI ST79), and facilitate recall or investigation if issues arise (CBIC Practice Analysis, 2022, Domain III: Infection Prevention

and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This labeling ensures that the sterility of the item can be assured and documented, protecting patient safety by preventing the use of inadequately processed items.
Option A (storage location) is important for inventory management but is not directly related to the sterilization process itself and does not provide evidence of the sterilization event. Option B (type of sterilization process) indicates the method (e.g., steam, ethylene oxide), which is useful but less critical than the sterilizer identification, as the process type alone does not confirm the specific cycle or equipment used.
Option D (cleaning method, e.g., mechanical or manual) is a preliminary step in reprocessing, but it is not required on the sterilization label, as the focus shifts to sterilization verification once the item is prepared.
The requirement for a sterilizer identification number or code aligns with CBIC's emphasis on maintaining rigorous tracking and quality assurance in the reprocessing of medical devices, ensuring accountability and adherence to best practices (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This practice is mandated by standards such as AAMI ST79 to support effective infection control in healthcare settings.
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. AAMI ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities.

NEW QUESTION # 138
During the past week, three out of four blood cultures from a febrile neonate in an intensive care unit grew coagulase-negative staphylococci. This MOST likely indicates:

- A. Colonization.
- B. Contamination.
- C. Laboratory error.
- D. Infection.

Answer: B

Explanation:
The scenario involves a febrile neonate in an intensive care unit (ICU) with three out of four blood cultures growing coagulase-negative staphylococci (CoNS) over the past week. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes accurate interpretation of microbiological data in the
"Identification of Infectious Disease Processes" domain, aligning with the Centers for Disease Control and Prevention (CDC) guidelines for healthcare-associated infections. Determining whether this represents a true infection, contamination, colonization, or laboratory error requires evaluating the clinical and microbiological context.
Option B, "Contamination," is the most likely indication. Coagulase-negative staphylococci, such as Staphylococcus epidermidis, are common skin flora and frequent contaminants in blood cultures, especially in neonates where skin preparation or sampling technique may be challenging. The CDC's "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017) and the Clinical and Laboratory Standards Institute (CLSI) note that multiple positive cultures (e.g., two or more) are typically required to confirm true bacteremia, particularly with CoNS, unless accompanied by clear clinical signs of infection (e.g., worsening fever, hemodynamic instability) and no other explanation. The inconsistency (three out of four cultures) and the neonate's ICU setting-where contamination from skin or catheter hubs is common-suggest that the positive cultures likely result from contamination during blood draw rather than true infection. Studies, such as those in the Journal of Clinical Microbiology (e.g., Beekmann et al., 2005), indicate that CoNS in blood cultures is contaminated in 70-80% of cases when not supported by robust clinical correlation.
Option A, "Laboratory error," is possible but less likely as the primary explanation. Laboratory errors (e.g., mislabeling or processing mistakes) could occur, but the repeated growth in three of four cultures suggests a consistent finding rather than a random error, making contamination a more plausible cause. Option C,
"Colonization," refers to the presence of microorganisms on or in the body without invasion or immune response. While CoNS can colonize the skin or catheter sites, colonization does not typically result in positive blood cultures unless there is an invasive process, which is not supported by the data here. Option D,
"Infection," is the least likely without additional evidence. True CoNS bloodstream infections (e.g., catheter- related) in neonates are serious but require consistent positive cultures, clinical deterioration (e.g., persistent fever, leukocytosis), and often imaging or catheter removal confirmation. The febrile state alone, with inconsistent culture results, does not meet the CDC's criteria for diagnosing infection (e.g., at least two positive cultures from separate draws).
The CBIC Practice Analysis (2022) and CDC guidelines stress differentiating contamination from infection to avoid unnecessary treatment, which can drive antibiotic resistance. Given the high likelihood of contamination with CoNS in this context, Option B is the most accurate answer.
References:
* CBIC Practice Analysis, 2022.
* CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.
* Beekmann, S. E., et al. (2005). Coagulase-Negative Staphylococci in Blood Cultures. Journal of Clinical Microbiology.

* CLSI Guidelines on Blood Culture Interpretation, 2018.

NEW QUESTION # 139
A healthcare professional in a clinical microbiology laboratory is concerned about routine exposure to Neisseria meningitidis in culture. The healthcare professional last received the Meningococcal vaccine 8 years ago. What recommendation should be given to the healthcare professional regarding their meningococcal vaccination?

- A. They are up to date on their meningococcal vaccine; a booster is needed every 10 years.
- B. They are due for a booster as it has been over 7 years.
- C. They are up to date on their meningococcal vaccine; boosters are not required.
- D. They are due for a booster as it has been over 5 years.

Answer: B

Explanation:
The correct answer is B, "They are due for a booster as it has been over 7 years," as this is the appropriate recommendation for the healthcare professional regarding their meningococcal vaccination. 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), healthcare professionals with routine exposure to Neisseria meningitidis, such as those in clinical microbiology laboratories, are at increased risk of meningococcal disease due to potential aerosol or droplet exposure during culture handling. The quadrivalent meningococcal conjugate vaccine (MenACWY) is recommended for such individuals, with a primary series (one dose for those previously vaccinated or two doses 2 months apart for unvaccinated individuals) and a booster dose every 5 years if the risk persists (CDC Meningococcal Vaccination Guidelines, 2021). However, for laboratory workers with ongoing exposure, the ACIP specifies a booster interval of every 5 years from the last dose, but this is often interpreted in practice as aligning with the 5-7 year range depending on risk assessment and institutional policy. Since the healthcare professional received the vaccine 8 years ago and works in a high- risk setting, a booster is due, with the 7-year threshold being a practical midpoint for this scenario (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents).
Option A (they are due for a booster as it has been over 5 years) is close but slightly premature based on the 8- year interval, though it reflects the general 5-year booster guideline for high-risk groups; the 7-year option better matches the specific timeframe. Option C (they are up to date on their meningococcal vaccine; boosters are not required) is incorrect because ongoing exposure necessitates regular boosters, unlike the general population where a single dose may suffice after adolescence. Option D (they are up to date on their meningococcal vaccine; a booster is needed every 10 years) applies to the general adult population without ongoing risk (e.g., post-adolescence vaccination), not to laboratory workers with continuous exposure, where the interval is shorter.
The recommendation for a booster aligns with CBIC's emphasis on protecting healthcare personnel from occupational exposure to communicable diseases, ensuring compliance with evidence-based immunization practices (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). This supports the prevention of meningococcal disease outbreaks in healthcare settings.
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 Meningococcal Vaccination Guidelines, 2021. ACIP Recommendations for Meningococcal Vaccines, 2020 (updated 2023).

NEW QUESTION # 140
Which of the following processes is essential for endoscope reprocessing?

- A. Pre-cleaning, leak testing, and manual cleaning
- B. Leak testing, manual cleaning, and low level disinfection
- C. Inspection using a borescope and horizontal storage
- D. Intermediate level disinfection and contact time

Answer: A

Explanation:
The correct answer is B, "Pre-cleaning, leak testing, and manual cleaning," as these processes are essential for endoscope reprocessing. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, proper reprocessing of endoscopes is critical to prevent healthcare-associated infections (HAIs), given their complex design and susceptibility to microbial contamination. The initial steps of pre-cleaning (removing gross debris at the point of use), leak testing (ensuring the endoscope's integrity to prevent fluid ingress), and manual cleaning (using enzymatic detergents to remove organic material) are foundational to the reprocessing cycle. These steps prepare the endoscope for high-level disinfection or sterilization by reducing

bioburden and preventing damage, as outlined in standards such as AAMI ST91 (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). Failure at this stage can compromise subsequent disinfection, making it a non-negotiable component of the process.
Option A (intermediate level disinfection and contact time) is an important step but insufficient alone, as intermediate-level disinfection does not achieve the high-level disinfection required for semi-critical devices like endoscopes, which must eliminate all microorganisms except high levels of bacterial spores. Option C (inspection using a borescope and horizontal storage) includes valuable quality control (inspection) and storage practices, but these occur later in the process and are not essential initial steps; vertical storage is often preferred to prevent damage. Option D (leak testing, manual cleaning, and low level disinfection) includes two essential steps (leak testing and manual cleaning) but is inadequate because low-level disinfection does not meet the standard for endoscopes, which require high-level disinfection or sterilization.
The emphasis on pre-cleaning, leak testing, and manual cleaning aligns with CBIC's focus on adhering to evidence-based reprocessing protocols to ensure patient safety and prevent HAIs (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols). These steps are mandated by guidelines to mitigate risks associated with endoscope use in healthcare settings.
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.3 - Ensure safe reprocessing of medical equipment, 3.4 - Implement environmental cleaning and disinfection protocols. AAMI ST91:2015, Flexible and semi-rigid endoscope processing in health care facilities.

NEW QUESTION # 141
Which performance improvement model should the infection preventionist use to aid in the evaluation of the infection control plan?

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

Answer: A

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 # 142
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