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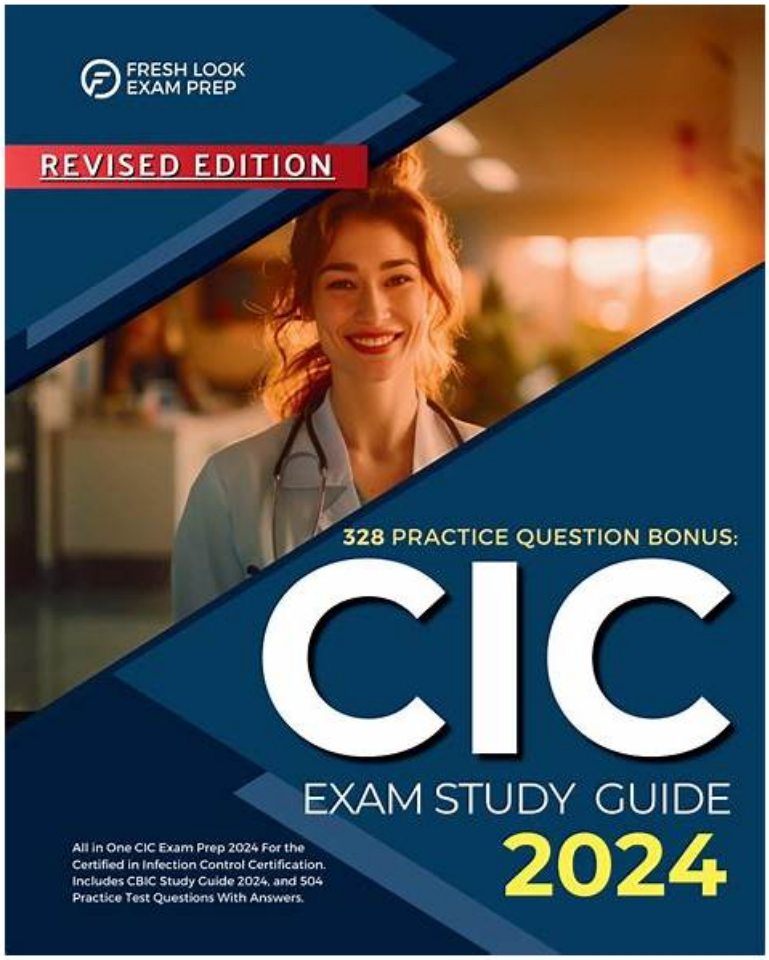

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CBIC Certified Infection Control Exam Sample Questions (Q74-Q79):

NEW QUESTION # 74
During an outbreak of ventilator-associated pneumonia (VAP), the infection preventionist should FIRST:

- A. Isolate all ventilated patients in negative pressure rooms.
- B. Perform bacterial cultures from ventilator circuits.
- C. Implement preemptive antibiotic therapy in all ventilated patients.
- D. Review adherence to ventilator bundle elements.

Answer: D

Explanation:
* Reviewing compliance with VAP prevention bundles (e.g., head-of-bed elevation, oral care, sedation breaks) is the first step in outbreak control.
* Preemptive antibiotics (B) are not recommended due to antibiotic resistance risks.
* Negative pressure rooms (C) are not required for VAP.
* Ventilator circuit cultures (D) do not guide patient management.
CBIC Infection Control References:
* APIC Text, "VAP Prevention Measures," Chapter 11.

NEW QUESTION # 75
An 84-year-old male with a gangrenous foot is admitted to the hospital from an extended-care facility (ECF).
The ECF is notified that the wound grew Enterococcus faecium with the following antibiotic sensitivity results:
ampicillin - R
vancomycin - R
penicillin - R
linezolid - S
This is the fourth Enterococcus species cultured from residents within the same ECF wing in the past month.
The other cultures were from two urine specimens and a draining wound. The Infection Preventionist (IP) should immediately:

- A. Conduct surveillance cultures for this organism in all residents.
- B. Notify the nursing administrator to close the wing to new admissions.
- C. Compare the four culture reports and sensitivity patterns.
- D. Notify the medical director of the outbreak.

Answer: D

Explanation:
The scenario describes a potential outbreak of multidrug-resistant Enterococcus faecium in an extended-care facility (ECF) wing, indicated by four positive cultures (including the current case and three prior cases from urine and a draining wound) within a month. The organism exhibits resistance to ampicillin, vancomycin, and penicillin, but sensitivity to linezolid, suggesting a possible vancomycin-resistant Enterococcus (VRE) strain, which is a significant concern in healthcare settings. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the importance of rapid outbreak detection and response in the "Surveillance and Epidemiologic Investigation" domain, aligning with Centers for Disease Control and Prevention (CDC) guidelines for managing multidrug-resistant organisms (MDROs).
Option A, "Notify the medical director of the outbreak," is the most immediate and critical action. Identifying an outbreak-defined by the CDC as two or more cases of a similar illness linked by time and place-requires prompt notification to the facility's leadership (e.g., medical director) to initiate a coordinated response. The presence of four Enterococcus cases, including a multidrug-resistant strain, within a single ECF wing over a month suggests a potential cluster, necessitating urgent action to assess the scope, implement control measures, and allocate resources. The CDC's "Management of Multidrug-Resistant Organisms in Healthcare Settings" (2006) recommends immediate reporting to facility leadership as the first step to activate an outbreak investigation team, making this the priority.
Option B, "Compare the four culture reports and sensitivity patterns," is an important subsequent step in outbreak investigation. Analyzing the antibiotic susceptibility profiles and culture sources can confirm whether the cases are epidemiologically linked (e.g., clonal spread of VRE) and guide treatment and control strategies. However, this is a detailed analysis that follows initial notification

and should not delay alerting the medical director. Option C, "Conduct surveillance cultures for this organism in all residents," is a proactive measure to determine the prevalence of Enterococcus faecium, especially VRE, within the wing. The CDC recommends targeted surveillance during outbreaks, but this requires prior authorization and planning by the outbreak team, making it a secondary action after notification. Option D, "Notify the nursing administrator to close the wing to new admissions," may be a control measure to prevent further spread, as suggested by the CDC for MDRO outbreaks. However, closing a unit is a significant decision that should be guided by the medical director and infection control team after assessing the situation, not an immediate independent action by the IP.
The CBIC Practice Analysis (2022) and CDC guidelines prioritize rapid communication with leadership to initiate a structured outbreak response, including resource allocation and policy adjustments. Given the multidrug-resistant nature and cluster pattern, notifying the medical director (Option A) is the most immediate and appropriate action to ensure a comprehensive response.
References:
* CBIC Practice Analysis, 2022.
* CDC Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006.

NEW QUESTION # 76
A patient with suspected active tuberculosis is being transferred from a mental health facility to a medical center by emergency medical services. Which of the following should an infection preventionist recommend to the emergency medical technician (EMT)?

- A. Place a surgical mask on both the patient and the EMT.
- B. Place a surgical mask on the patient and an N95 respirator on the EMT.
- C. Place an N95 respirator on the patient and a surgical mask on the EMT.
- D. Place an N95 respirator on both the patient and the EMT.

Answer: C

Explanation:
Active tuberculosis (TB) is an airborne disease transmitted through the inhalation of droplet nuclei containing Mycobacterium tuberculosis. Effective infection control measures are critical during patient transport to protect healthcare workers, such as emergency medical technicians (EMTs), and to prevent community spread. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the use of appropriate personal protective equipment (PPE) and source control as key strategies in the "Prevention and Control of Infectious Diseases" domain, aligning with guidelines from the Centers for Disease Control and Prevention (CDC).
For a patient with suspected active TB, the primary goal is to contain the infectious particles at the source (the patient) while ensuring the EMT is protected from inhalation exposure. Option C, placing an N95 respirator on the patient and a surgical mask on the EMT, is the most appropriate recommendation. The N95 respirator on the patient serves as source control by filtering the exhaled air, reducing the dispersion of infectious droplets. However, fitting an N95 respirator on the patient may be challenging, especially in an emergency setting or if the patient is uncooperative, so a surgical mask is often used as an alternative source control measure. For the EMT, a surgical mask provides a basic barrier but does not offer the same level of respiratory protection as an N95 respirator. The CDC recommends that healthcare workers, including EMTs, use an N95 respirator (or higher-level respiratory protection) when in close contact with a patient with suspected or confirmed active TB, unless an airborne infection isolation room is available, which is not feasible during transport.
Option A is incorrect because placing a surgical mask on both the patient and the EMT does not provide adequate respiratory protection for the EMT. Surgical masks are not designed to filter small airborne particles like those containing TB bacilli and do not meet the N95 standard required for airborne precautions. Option B is impractical and unnecessary, as placing an N95 respirator on both the patient and the EMT is overly restrictive and logistically challenging, especially for the patient during transport. Option D reverses the PPE roles, placing the surgical mask on the patient (insufficient for source control) and the N95 respirator on the EMT (appropriate for protection but misaligned with the need to control the patient's exhalation). The CBIC and CDC guidelines prioritize source control on the patient and respiratory protection for the healthcare worker, making Option C the best fit.
This recommendation is consistent with the CBIC's emphasis on implementing transmission-based precautions (CDC, 2005, Guideline for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings) and the use of PPE tailored to the mode of transmission, as outlined in the CBIC Practice Analysis (2022).
References:
* CBIC Practice Analysis, 2022.
* CDC Guideline for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings, 2005.

NEW QUESTION # 77
Which water type is suitable for drinking yet may still be a risk for disease transmission?

- A. Potable water
- B. Distilled water
- C. Grey water
- D. Purified water

Answer: A

Explanation:
To determine which water type is suitable for drinking yet may still pose a risk for disease transmission, we need to evaluate each option based on its definition, treatment process, and potential for contamination, aligning with infection control principles as outlined by the Certification Board of Infection Control and Epidemiology (CBIC).
* A. Purified water: Purified water undergoes a rigorous treatment process (e.g., reverse osmosis, distillation, or deionization) to remove impurities, contaminants, and microorganisms. This results in water that is generally safe for drinking and has a very low risk of disease transmission when properly handled and stored. However, if the purification process is compromised or if contamination occurs post-purification (e.g., due to improper storage or distribution), there could be a theoretical risk.
Nonetheless, purified water is not typically considered a primary source of disease transmission under standard conditions.
* B. Grey water: Grey water refers to wastewater generated from domestic activities such as washing dishes, laundry, or bathing, which may contain soap, food particles, and small amounts of organic matter. It is not suitable for drinking due to its potential contamination with pathogens (e.g., bacteria, viruses) and chemicals. Grey water is explicitly excluded from potable water standards and poses a significant risk for disease transmission, making it an unsuitable choice for this question.
* C. Potable water: Potable water is water that meets regulatory standards for human consumption, as defined by organizations like the World Health Organization (WHO) or the U.S. Environmental Protection Agency (EPA). It is treated to remove harmful pathogens and contaminants, making it safe for drinking under normal circumstances. However, despite treatment, potable water can still pose a risk for disease transmission if the distribution system is contaminated (e.g., through biofilms, cross- connections, or inadequate maintenance of pipes). Outbreaks of waterborne diseases like Legionnaires' disease or gastrointestinal infections have been linked to potable water systems, especially in healthcare settings. This makes potable water the best answer, as it is suitable for drinking yet can still carry a risk under certain conditions.
* D. Distilled water: Distilled water is produced by boiling water and condensing the steam, which removes most impurities, minerals, and microorganisms. It is highly pure and safe for drinking, often used in medical and laboratory settings. Similar to purified water, the risk of disease transmission is extremely low unless contamination occurs after distillation due to improper handling or storage. Like purified water, it is not typically associated with disease transmission risks in standard use.
The key to this question lies in identifying a water type that is both suitable for drinking and has a documented potential for disease transmission. Potable water fits this criterion because, while it is intended for consumption and meets safety standards, it can still be a vector for disease if the water supply or distribution system is compromised. This is particularly relevant in infection control, where maintaining water safety in healthcare facilities is a critical concern addressed by CBIC guidelines.
References:
* CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III:
Prevention and Control of Infectious Diseases, which highlights the importance of water safety and the risks of contamination in potable water systems.
* CBIC Examination Content Outline, Domain IV: Environment of Care, which includes managing waterborne pathogens (e.g., Legionella) in potable water supplies.

NEW QUESTION # 78
Which of the following strategies is MOST effective in reducing surgical site infections (SSI) in orthopedic procedures?

- A. Use of sterile adhesive wound dressings for 10 days postoperatively.
- B. Administration of prophylactic antibiotics postoperatively for 48 hours.
- C. Routine intraoperative wound irrigation with povidone-iodine.
- D. Perioperative normothermia maintenance.

Answer: D

Explanation:
* Perioperative normothermia maintenance reduces SSI rates by improving immune function and tissue perfusion.
* Routine wound irrigation (B) has no strong evidence supporting SSI prevention.
* Prolonged antibiotic use (C) increases antibiotic resistance without added benefit.
* Extended use of wound dressings (D) does not reduce SSI rates.
CBIC Infection Control References:
* APIC Text, "SSI Prevention in Surgery," Chapter 12.

NEW QUESTION # 79
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