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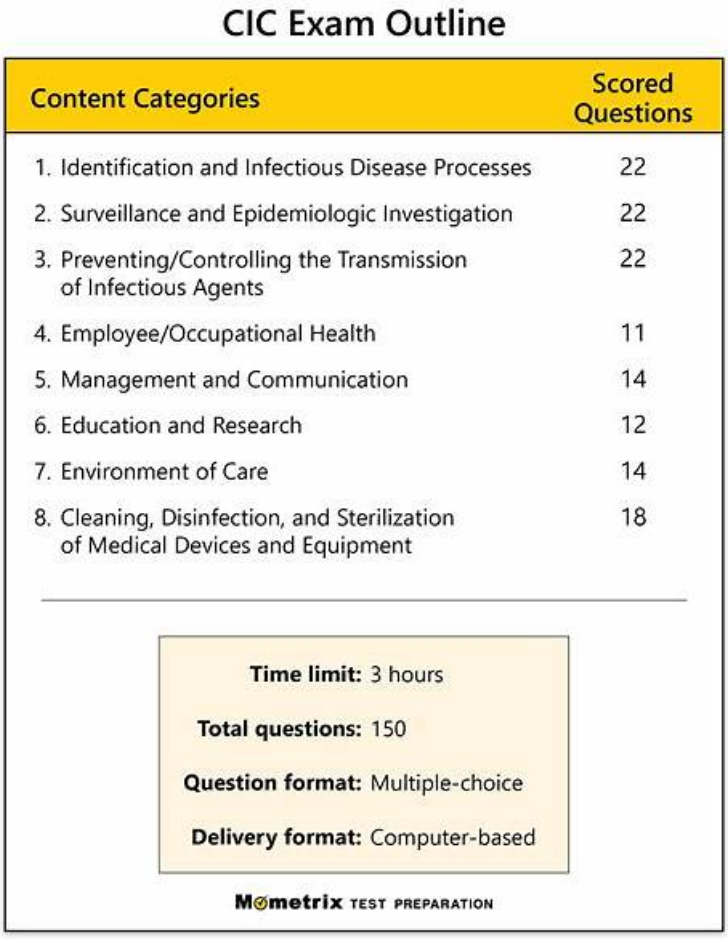

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CBIC Certified Infection Control Exam Sample Questions (Q167-Q172):

NEW QUESTION # 167

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. Verify that employees in high-risk exposure areas of the facility have adequate immunity to measles.
- B. Reassign employees who are pregnant from caring for patients with suspected 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: A

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.
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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 # 168
An employee is presenting to Occupational Health for clearance prior to starting work at a healthcare facility.
They have a history of having received the Bacillus Calmette-Guerin (BCG) vaccination. What is the preferred methodology for pre-work clearance?

- A. Interferon-gamma release assay
- B. Two-step purified protein derivative-based Tuberculin skin test (TST)
- C. Initial chest radiograph
- D. Referral to tuberculosis (TB) clinic

Answer: A

Explanation:
The preferred methodology for pre-work clearance in this scenario is the interferon-gamma release assay (IGRA), making option C the correct choice. This conclusion is supported by the guidelines from the Certification Board of Infection Control and Epidemiology (CBIC), which align with recommendations from the Centers for Disease Control and Prevention (CDC) for tuberculosis (TB) screening in healthcare workers.
The employee's history of receiving the Bacillus Calmette-Guerin (BCG) vaccination, a vaccine commonly used in some countries to prevent severe forms of TB, is significant because it can cause false-positive results in the traditional Tuberculin skin test (TST) due to cross-reactivity with BCG antigens (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology).
The IGRA, such as the QuantiFERON-TB Gold test, measures the release of interferon-gamma from T-cells in response to specific TB antigens (e.g., ESAT-6 and CFP-10) that are not present in BCG or most non- tuberculous mycobacteria. This makes it a more specific and reliable test for detecting latent TB infection (LTBI) in individuals with a history of BCG vaccination, avoiding the false positives associated with the TST.
The CDC recommends IGRA over TST for BCG-vaccinated individuals when screening for TB prior to healthcare employment (CDC Guidelines for Preventing Transmission of Mycobacterium tuberculosis, 2005, updated 2019).
Option A (referral to tuberculosis clinic) is a general action but not a specific methodology for clearance; it may follow testing if results indicate further evaluation is needed. Option B (initial chest radiograph) is used to detect active TB disease rather than latent infection and is not a primary screening method for pre-work clearance, though it may be indicated if IGRA results are positive.
Option D (two-step purified protein derivative-based Tuberculin skin test) is less preferred because the BCG vaccination can lead to persistent cross-reactivity, reducing its specificity and reliability in this context. The two-step TST is typically used to establish a baseline in unvaccinated individuals with potential prior exposure, but it is not ideal for BCG- vaccinated individuals.
The IP's role includes ensuring accurate TB screening to protect both the employee and patients, aligning with CBIC's focus on preventing transmission of infectious diseases in healthcare settings (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents).
References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology; Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents. CDC Guidelines for Preventing Transmission of Mycobacterium tuberculosis, 2005, updated 2019.

NEW QUESTION # 169
On January 31, the nursing staff of a long-term care facility reports that five out of 35 residents have developed high fever, nasal discharge, and a dry cough. The BEST diagnostic tool to determine the causative agent is:

- A. Sputum culture
- B. Legionella serology
- C. Nasopharyngeal swab
- D. Blood culture

Answer: C

Explanation:
The scenario describes a cluster of five out of 35 residents in a long-term care facility developing high fever, nasal discharge, and a dry cough, suggesting a potential respiratory infection outbreak. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the "Identification of Infectious Disease Processes" and "Surveillance and Epidemiologic Investigation" domains, which require selecting the most appropriate diagnostic tool to identify the causative agent promptly. The Centers for Disease Control and Prevention (CDC) provides guidance on diagnostic approaches for respiratory infections, particularly in congregate settings like long-term care facilities.
Option C, "Nasopharyngeal swab," is the best diagnostic tool in this context. The symptoms-high fever, nasal discharge, and a dry cough-are characteristic of upper respiratory infections, such as influenza, respiratory syncytial virus (RSV), or other viral pathogens common in congregate settings. A nasopharyngeal swab is the gold standard for detecting these agents, as it collects samples from the nasopharynx, where many respiratory viruses replicate. The CDC recommends nasopharyngeal swabs for molecular testing (e.g., PCR) to identify viruses like influenza, RSV, or SARS-CoV-2, especially during outbreak investigations in healthcare facilities. The dry cough and nasal discharge align with upper respiratory involvement, making this sample type more targeted than alternatives. Given the potential for rapid spread among vulnerable residents, early identification via nasopharyngeal swab is critical to guide infection control measures.
Option A, "Blood culture," is less appropriate as the best initial tool. Blood cultures are used to detect systemic bacterial infections (e.g., bacteremia or sepsis), but the symptoms described are more suggestive of a primary respiratory infection rather than a bloodstream infection. While secondary bacteremia could occur, blood cultures are not the first-line diagnostic for this presentation and are more relevant if systemic signs (e.
g., hypotension) worsen. Option B, "Sputum culture," is useful for lower respiratory infections, such as pneumonia, where productive cough and sputum production are prominent. However, the dry cough and nasal discharge indicate an upper respiratory focus, and

sputum may be difficult to obtain from elderly residents, reducing its utility here. Option D, "Legionella serology," is specific for diagnosing Legionella pneumophila, which causes Legionnaires' disease, typically presenting with fever, cough, and sometimes gastrointestinal symptoms, often in association with water sources. While possible, the lack of mention of pneumonia or water exposure, combined with the upper respiratory symptoms, makes Legionella serology less likely as the best initial test. Serology also requires time for antibody development, delaying diagnosis compared to direct sampling.
The CBIC Practice Analysis (2022) and CDC guidelines for outbreak management in long-term care facilities (e.g., "Prevention Strategies for Seasonal Influenza in Healthcare Settings," 2018) prioritize rapid respiratory pathogen identification, with nasopharyngeal swabs being the preferred method for viral detection. Given the symptom profile and outbreak context, Option C is the most effective and immediate diagnostic tool to determine the causative agent.
References:
* CBIC Practice Analysis, 2022.
* CDC Prevention Strategies for Seasonal Influenza in Healthcare Settings, 2018.
* CDC Guidelines for the Prevention and Control of Outbreaks in Long-Term Care Facilities, 2015.

NEW QUESTION # 170
A patient with a non-crusted rash has boon diagnosed with Sarcoptes scabiei. The patient is treated with 5% permethrin and precautions are started. The precautions can be stopped

- A. when the bed linen is changed
- B. 24 hours after the second treatment
- C. 24 hours after effective treatment
- D. when the treatment cream is applied

Answer: C

Explanation:
ForSarcoptes scabiei(scabies),Contact Precautionsshould remainin place until 24 hours after effective treatment has been completed. The first-line treatment is5% permethrin cream, which is applied to the entire body and left on for8-14 hoursbefore being washed off.
Why the Other Options Are Incorrect?
* A. When the treatment cream is applied- Themite is still presentand infectiousuntil treatment has fully taken effect.
* B. When the bed linen is changed-While changing linens is necessary, it doesnot indicate that the infestation has cleared.
* D. 24 hours after the second treatment- Mostcases require only one treatmentwith permethrin, though severe cases may need a second dose after a week.
CBIC Infection Control Reference
According toAPIC guidelines,Contact Precautions can be discontinued 24 hours after effective treatment has been administered.

NEW QUESTION # 171
An infection preventionist reviewing patient records in an outpatient hemodialysis center notes an increase in localized infections at catheter access sites. Which of the following strategies reduces the risk of infection in this population?

- A. Creation of an arteriovenous fistula
- B. Placement of a femoral catheter
- C. Use of a non-cuffed percutaneous catheter
- D. Replacement of dialysis catheters monthly

Answer: A

Explanation:
The best strategy to reduce the risk of infection in hemodialysis patients is to use an arteriovenous (AV) fistula as the preferred vascular access method. AV fistulas have the lowest infection rates compared to catheters and grafts because they do not involve foreign material and are less prone to biofilm formation and bloodstream infections.
Why the Other Options Are Incorrect?
* B. Use of a non-cuffed percutaneous catheter - Non-cuffed catheters have a higher risk of bloodstream infections and should be used only for short-term access.
* C. Placement of a femoral catheter - Femoral catheters have higher infection risks and should only be used for bed-bound patients and for the shortest duration possible.
* D. Replacement of dialysis catheters monthly - Routine catheter replacement does not reduce infection risk and should be done only when medically necessary.

CBIC Infection Control Reference
According to APIC guidelines, AV fistulas are the preferred vascular access due to their lower infection rates and improved long-term outcomes.

NEW QUESTION # 172
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