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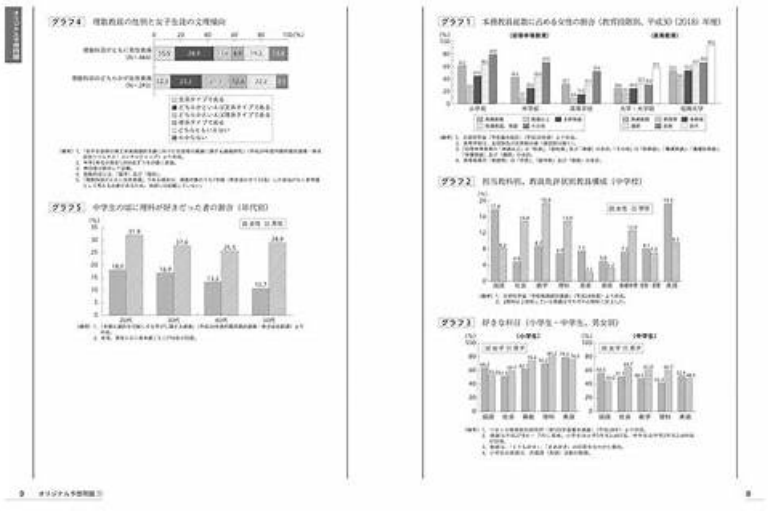

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>> CIC復習テキスト <<

最高のCIC復習テキスト & 合格スムーズCIC試験勉強書 | 素敵なCIC日本語版と英語版 CBIC Certified Infection Control Exam

Pass4TestのCBICのCIC問題集を選んだら、成功を選ぶのに等しいです。もしうちの学習教材を購入するなら、Pass4Testは一年間で無料更新サービスを提供することができます。Pass4TestのCBICのCIC認定試験の合格率は１００パーセントになっています。不合格になる場合或いはCBICのCIC問題集がどんな問題があれば、私たちは全額返金することを保証いたします。

CBIC Certified Infection Control Exam 認定 CIC 試験問題 (Q138-Q143):

質問 # 138
A patient with shortness of breath and a history of a tuberculin skin test (TST) of 15 mm induration was admitted to a semi-private room. The infection preventionist's FIRST action should be to

- A. contact the roommate's physician to initiate TST.
- B. transfer the patient to an airborne infection isolation room and initiate appropriate isolation for tuberculosis (TB).
- C. report the findings to the Employee Health Department to initiate exposure follow-up of hospital staff.
- D. review the patient's medical record to determine the likelihood of pulmonary tuberculosis (TB).

正解：D

解説：

Before initiating airborne precautions, theinfection preventionist must first confirm the clinical suspicion of active TB.
Step-by-Step Justification:
* Confirming Active TB:
* Apositive tuberculin skin test (TST) alone does not indicate active disease.
* A review ofchest X-ray, symptoms, and risk factorsis needed.
* Medical Record Review:
* Past TB history, imaging, and sputum testingare key to diagnosis.
* Not all TST-positive patients require isolation.
Why Other Options Are Incorrect:
* A. Contact the roommate's physician to initiate TST:Premature, asno confirmation of active TB existsyet.
* C. Report findings to Employee Health for staff follow-up:Should occuronly after TB confirmation
.
* D. Transfer to airborne isolation immediately:Airborne isolation is necessaryonly if active TB is suspected based on clinical findings.
CBIC Infection Control References:

質問 # 139
An infection preventionist is notified of a patient with Gram negative diplococci from a cerebral spinal fluid specimen. The patient was intubated during ambulance transport and intravenous lines are placed after arrival to the Emergency Department (ED). The patient was immediately placed in Droplet Precautions upon admission to the ED. Which of the following statements is true regarding the need for evaluating exposure to communicable illness?

- A. ED personnel should be evaluated for possible exposure.
- B. Ambulance personnel should be evaluated for possible exposure.
- C. Follow-up evaluation is not necessary as the appropriate precautions were promptly instituted.
- D. Follow-up evaluation is not required for this laboratory finding.

正解：B

解説：
The correct answer is C, "Ambulance personnel should be evaluated for possible exposure," as this statement is true regarding the need for evaluating exposure to communicable illness. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the presence of Gram negative diplococci in a cerebral spinal fluid (CSF) specimen is suggestive of a serious bacterial infection, most likely Neisseria meningitidis, which causes meningococcal disease. This condition is highly contagious and can be transmitted through respiratory droplets or direct contact with respiratory secretions, particularly during procedures like intubation (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.1 - Identify infectious disease processes). The patient was intubated during ambulance transport, creating a potential aerosol-generating procedure (AGP) that could have exposed ambulance personnel to infectious droplets before Droplet Precautions were instituted upon arrival at the Emergency Department (ED). Therefore, evaluating ambulance personnel for possible exposure is necessary to assess their risk and determine if post-exposure prophylaxis (e.g., antibiotics) or monitoring is required.
Option A (follow-up evaluation is not required for this laboratory finding) is incorrect because the identification of Gram negative diplococci in CSF is a critical finding that warrants investigation due to the potential for meningococcal disease, a reportable and transmissible condition. Option B (ED personnel should be evaluated for possible exposure) is less applicable since the patient was immediately placed in Droplet Precautions upon ED admission, minimizing exposure risk to ED staff after that point, though it could be considered if exposure occurred before precautions were fully implemented. Option D (follow-up evaluation is not necessary as the appropriate precautions were promptly instituted) is inaccurate because the prompt institution of Droplet Precautions in the ED does not retroactively address the exposure risk during ambulance transport, where precautions were not in place.
The focus on evaluating ambulance personnel aligns with CBIC's emphasis on identifying and mitigating transmission risks associated with communicable diseases, particularly in high-risk settings like ambulance transport (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents). This step is supported by CDC guidelines, which recommend exposure evaluation and prophylaxis for close contacts of meningococcal disease cases (CDC Meningococcal Disease Management, 2021).
References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.1 - Identify infectious disease processes; Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents. CDC Meningococcal Disease Management, 2021.

質問 # 140
There are four cases of ventilator-associated pneumonia in a surgical intensive care unit with a total of 200 ventilator days and a

census of 12 patients. Which of the following BEST expresses how this should be reported?

- A. Postoperative pneumonia rate of 6% in SICU patients
- B. Ventilator-associated pneumonia rate of 2%
- C. 20 ventilator-associated pneumonia cases/1000 ventilator days
- D. More information is needed regarding ventilator days per patient

正解：C

解説：
The standard way to reportventilator-associated pneumonia (VAP) ratesis:
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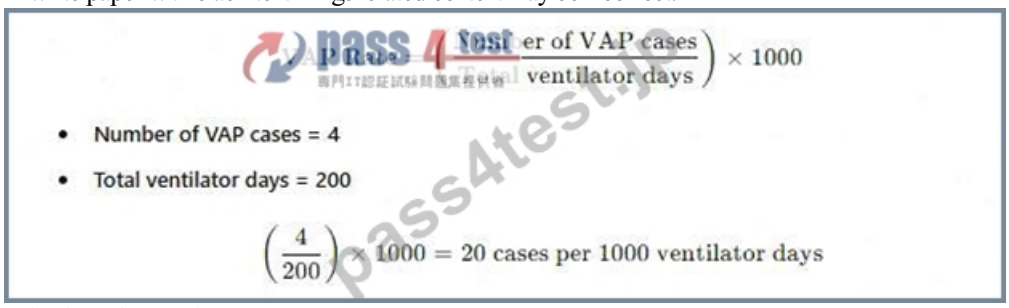

Why the Other Options Are Incorrect?
* A. Ventilator-associated pneumonia rate of 2%- This does not use thecorrect denominator (ventilator days).
* C. Postoperative pneumonia rate of 6% in SICU patients-Not relevant, as the data focuses onVAP, not postoperative pneumonia.
* D. More information is needed regarding ventilator days per patient-The total ventilator days are already provided, so no additional data is required.
CBIC Infection Control Reference
APIC and NHSN recommend reporting VAP rates as cases per 1,000 ventilator days.

質問 # 141
The infection preventionist (IP) collaborates with the Intravenous Therapy team to select the best antiseptic for use during the insertion of an intravascular device for adults. For a patient with no contraindications, what antiseptic should the IP suggest?

- A. Alcohol
- B. Povidone-iodine
- C. Chlorhexidine
- D. Antibiotic ointment

正解：C

解説：
The selection of an appropriate antiseptic for the insertion of an intravascular device (e.g., peripheral or central venous catheters) is a critical infection prevention measure to reduce the risk of catheter-related bloodstream infections (CRBSIs). The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes evidence-based practices in the "Prevention and Control of Infectious Diseases" domain, which includes adhering to guidelines for aseptic technique during invasive procedures. The Centers for Disease Control and Prevention (CDC) provides specific recommendations for skin antisepsis, as outlined in the "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017).
Option A, chlorhexidine, is the preferred antiseptic for skin preparation prior to intravascular device insertion in adults with no contraindications. Chlorhexidine, particularly in a 2% chlorhexidine gluconate (CHG) with 70% isopropyl alcohol solution, is recommended by the CDC due to its broad-spectrum antimicrobial activity, residual effect (which continues to kill bacteria after application), and superior efficacy compared to other agents in reducing CRBSI rates. Studies cited in the CDC guidelines demonstrate that chlorhexidine-based preparations significantly lower infection rates compared to povidone-iodine or alcohol alone, making it the gold standard for this procedure when tolerated by the patient.
Option B, povidone-iodine, is an alternative antiseptic that can be used for skin preparation. It is effective against a wide range of microorganisms and is often used when chlorhexidine is contraindicated (e.g., in patients with chlorhexidine allergy). However, its efficacy is less persistent than chlorhexidine, and it requires longer drying time, which can be a limitation in busy clinical settings. The CDC considers povidone-iodine a second-line option unless chlorhexidine is unavailable or unsuitable. Option C, alcohol (e.g., 70% isopropyl or ethyl alcohol), has rapid bactericidal activity but lacks a residual effect, making it less effective for prolonged protection during catheter dwell time. It is often used as a component of chlorhexidine-alcohol combinations but is not recommended as a standalone antiseptic for intravascular device insertion. Option D, antibiotic ointment, is not appropriate for skin preparation during

insertion. Antibiotic ointments (e.g., bacitracin or mupirocin) are sometimes applied to catheter sites post-insertion to prevent infection, but their use is discouraged by the CDC due to the risk of promoting antibiotic resistance and fungal infections, and they are not classified as antiseptics for initial skin antisepsis.
The CBIC Practice Analysis (2022) supports the adoption of CDC-recommended practices, and the 2017 CDC guidelines explicitly state that chlorhexidine-based preparations with alcohol should be used for skin antisepsis unless contraindicated. For a patient with no contraindications, the infection preventionist should suggest chlorhexidine to optimize patient safety and align with best practices.
References:
* CBIC Practice Analysis, 2022.
* CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.

質問 # 142
A Quality Improvement Committee is trying to decrease catheter-associated urinary tract infections (CAUTIs) in the hospital. Which of the following would be an outcome measure that would help to show a reduction in CAUTIs?

- A. Percentage of patients with indwelling urinary catheters
- B. Percentage of staff trained to insert indwelling urinary catheters
- C. Rate of patients receiving daily indwelling urinary catheter care
- D. Rate of CAUTI per 1000 indwelling urinary catheter days

正解：D

解説：
Anoutcome measuretracks the end result of healthcare processes. TheCAUTI rate per 1,000 catheter days directly measures the frequency of infections, making it an ideal outcome metric.
* From theAPIC Text:
"An incidence rate (i.e., the number of new cases during a time period, such as the rate of patients with urinary catheters who get a CAUTI) is a frequently used outcome performance measure."
* Other choices like care compliance or training areprocess measures, not outcomes.
References:
APIC Text, 4th Edition, Chapter 17 - Performance Measures

質問 # 143
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