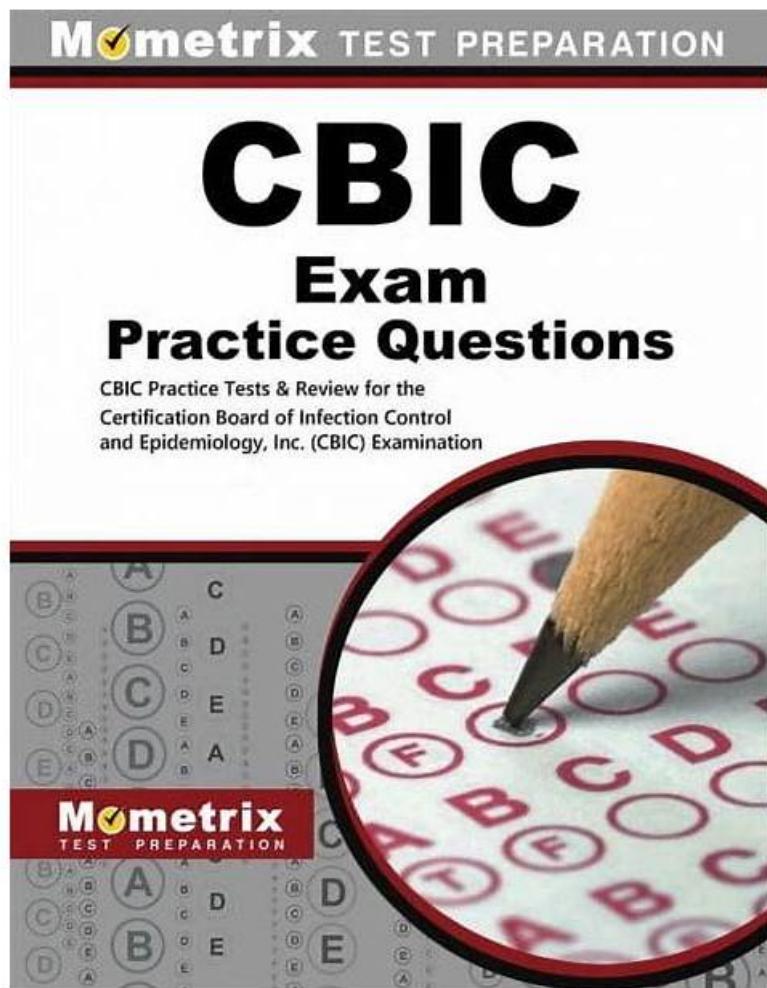


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## CBIC Certified Infection Control Exam Sample Questions (Q100-Q105):

### NEW QUESTION # 100

What is the correct order of steps for reprocessing critical medical equipment?

- A. Disinfect, clean, sterilize
- B. Disinfect, sterilize
- C. Clean, sterilize, disinfect
- D. Clean, sterilize

**Answer: D**

Explanation:

The correct answer is D, "Clean, sterilize," as this represents the correct order of steps for reprocessing critical medical equipment. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, critical medical equipment-items that enter sterile tissues or the vascular system (e.g., surgical instruments, implants)-must undergo a rigorous reprocessing cycle to ensure they are free of all microorganisms, including spores. The process begins with cleaning to remove organic material, debris, and soil, which is essential to allow subsequent sterilization to be effective. Sterilization, the final step, uses methods such as steam, ethylene oxide, or hydrogen peroxide gas to achieve a sterility assurance level (SAL) of 10##, eliminating all microbial life (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). Disinfection, while important for semi-critical devices, is not a step in the reprocessing of critical items, as it does not achieve the sterility required; it is a separate process for non-critical or semi-critical equipment.

Option A (clean, sterilize, disinfect) is incorrect because disinfecting after sterilization is unnecessary and redundant, as sterilization already achieves a higher level of microbial kill. Option B (disinfect, clean, sterilize) reverses the logical sequence; cleaning must precede any disinfection or sterilization to remove bioburden, and disinfection is not appropriate for critical items. Option C (disinfect, sterilize) omits cleaning and incorrectly prioritizes disinfection, which is insufficient for critical equipment requiring full sterility.

The focus on cleaning followed by sterilization aligns with CBIC's emphasis on evidence-based reprocessing protocols to prevent healthcare-associated infections (HAIs), ensuring that critical equipment is safe for patient use (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols). This sequence is supported by standards such as AAMI ST79, which outlines the mandatory cleaning step before sterilization to ensure efficacy and safety.

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 ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities.

### NEW QUESTION # 101

Ongoing education for the Infection Preventionist (IP) is MOST important because

- A. self-directed learning is not a major force for the adult learner.
- B. motivation to change comes from the Management Team.
- C. it is necessary to maintain a competitive edge.
- D. the healthcare environment is fast-paced with frequent changes.

**Answer: D**

Explanation:

Ongoing education for Infection Preventionists (IPs) is essential due to the rapidly evolving healthcare landscape and emergence of new infectious diseases, regulations, and technologies.

\* From the APIC Text:

"Professional development is essential to keeping the infection preventionist up to date with the latest knowledge, skills, and strategies for preventing infections."

\* The APIC/JCR Workbook also notes:

"Because information related to emerging infectious diseases... changes rapidly... IPs should actively review information for updates and guidance." References:

APIC Text, 4th Edition, Chapter 2 - Competency and Certification

APIC/JCR Workbook, 4th Edition, Chapter 3 - Education and Training

## NEW QUESTION # 102

A 36-year-old female presents to the Emergency Department with a petechial rash, meningitis, and cardiac arrest. During the resuscitation, a phlebotomist sustained a needlestick injury. The next day, blood cultures reveal *Neisseria meningitidis*. The exposure management for the phlebotomist is:

- A. Prophylactic rifampin plus isoniazid.
- B. A review of the phlebotomist's hepatitis B vaccine status.
- C. A tuberculin skin test now and in ten weeks.
- D. Work furlough from day ten to day 21 after exposure.

**Answer: D**

Explanation:

The scenario involves a needlestick injury sustained by a phlebotomist during the resuscitation of a patient diagnosed with *Neisseria meningitidis* infection, characterized by a petechial rash, meningitis, and cardiac arrest. *Neisseria meningitidis* is a gram-negative diplococcus that can cause meningococcal disease, including meningitis and septicemia, and is transmitted through direct contact with respiratory secretions or, in rare cases, blood exposure. The exposure management for the phlebotomist must align with infection control guidelines, such as those from the Certification Board of Infection Control and Epidemiology (CBIC) and the CDC, to prevent potential infection. Let's evaluate each option:

- \* A. Prophylactic rifampin plus isoniazid: Prophylactic antibiotics are recommended for close contacts of individuals with meningococcal disease to prevent secondary cases. Rifampin is a standard prophylactic agent for *Neisseria meningitidis* exposure, typically administered as a 2-day course (e.g., 600 mg every 12 hours for adults). Isoniazid, however, is used for tuberculosis (TB) prophylaxis and is not indicated for meningococcal disease. Combining rifampin with isoniazid is incorrect, as it reflects a confusion with TB management rather than meningococcal exposure. This option is not appropriate.
- \* B. A tuberculin skin test now and in ten weeks: A tuberculin skin test (TST) or interferon-gamma release assay (IGRA) is used to screen for latent tuberculosis infection, with a follow-up test at 8-10 weeks to detect conversion after potential TB exposure. *Neisseria meningitidis* is not related to TB, and a needlestick injury from a meningococcal patient does not warrant TB testing. This option is irrelevant to the scenario and not the correct exposure management.
- \* C. Work furlough from day ten to day 21 after exposure: *Neisseria meningitidis* has an incubation period of 2-10 days, with a maximum of about 14 days in rare cases. The CDC and WHO recommend that healthcare workers exposed to meningococcal disease via needlestick or mucosal exposure be monitored for signs of infection (e.g., fever, rash) and, if symptomatic, isolated and treated.

Additionally, a work restriction or furlough from day 10 to day 21 after exposure is advised to cover the potential incubation period, especially if prophylaxis is declined or contraindicated. This allows time to observe for symptoms and prevents transmission to vulnerable patients. This is a standard infection control measure and the most appropriate initial management step pending prophylaxis decision.

- \* D. A review of the phlebotomist's hepatitis B vaccine status: Reviewing hepatitis B vaccine status is a critical step following a needlestick injury, as hepatitis B can be transmitted through blood exposure.

However, this applies to bloodborne pathogens (e.g., HBV, HCV, HIV) and is not specific to *Neisseria meningitidis*, which is primarily a respiratory or mucosal pathogen. While hepatitis B management (e.g., post-exposure prophylaxis with hepatitis B immunoglobulin or vaccine booster) should be addressed as part of a comprehensive needlestick protocol, it is not the first or most relevant priority for meningococcal exposure.

The best answer is C, as the work furlough from day 10 to day 21 after exposure addresses the specific risk of meningococcal disease following a needlestick injury. This aligns with CBIC's focus on timely intervention and work restriction to prevent transmission in healthcare settings. Prophylactic antibiotics (e.g., rifampin) should also be considered, but the question asks for the exposure management, and furlough is a primary control measure. Hepatitis B and TB considerations are secondary and managed separately.

References:

\* CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III: Prevention and Control of Infectious Diseases, which includes protocols for managing exposure to communicable diseases like meningococcal infection.

\* CBIC Examination Content Outline, Domain IV: Environment of Care, which addresses work restrictions and exposure management.

\* CDC Guidelines for Meningococcal Disease Prevention and Control (2023), which recommend work furlough and monitoring for exposed healthcare workers.

## NEW QUESTION # 103

A 17-year-old presents to the Emergency Department with fever, stiff neck, and vomiting. A lumbar puncture is done. The Gram stain shows Gram negative diplococci. Presumptive identification of the organism is

- A. Listeria monocytogenes
- B. Haemophilus influenzae
- C. Streptococcus pneumoniae
- D. **Neisseria meningitidis**

**Answer: D**

Explanation:

The Gram stain showing Gram-negative diplococci in cerebrospinal fluid (CSF) is characteristic of *Neisseria meningitidis*, a leading cause of bacterial meningitis in adolescents and young adults.

Step-by-Step Justification:

\* Gram Stain Interpretation:

\* Gram-negative diplococci in CSF strongly suggest *Neisseria meningitidis*.

\* Classic Symptoms of Meningitis:

\* Fever, stiff neck, and vomiting are hallmark signs of meningococcal meningitis.

\* *Neisseria meningitidis* vs. Other Bacteria:

\* *Haemophilus influenzae* (Option A) # Gram-negative coccobacilli.

\* *Listeria monocytogenes* (Option C) # Gram-positive rods.

\* *Streptococcus pneumoniae* (Option D) # Gram-positive diplococci.

CBIC Infection Control References:

\* APIC Ready Reference for Microbes, 'Neisseria meningitidis and Meningitis'.

#### NEW QUESTION # 104

Which of the following pathogens is associated with the highest risk of seroconversion after percutaneous exposure?

- A. **Hepatitis C**
- B. Syphilis
- C. Hepatitis A
- D. Shigella

**Answer: A**

Explanation:

Among the listed pathogens, Hepatitis C has the highest risk of seroconversion following a percutaneous exposure, though it's important to note that Hepatitis B actually has the highest overall risk. However, since Hepatitis B is not listed among the options, the correct choice from the available ones is Hepatitis C.

\* The APIC Text confirms:

"The average risk of seroconversion after a percutaneous injury involving blood infected with hepatitis C virus is approximately 1.8 percent".

\* The other options are not bloodborne pathogens typically associated with high seroconversion risks after needlestick or percutaneous exposure:

\* A. Shigella- transmitted fecal- orally, not percutaneously.

\* B. Syphilis- transmitted sexually or via mucous membranes.

\* C. Hepatitis A- primarily fecal-oral transmission, low occupational seroconversion risk.

References:

APIC Text, 4th Edition, Chapter 103 - Occupational Exposure to Bloodborne Pathogens

#### NEW QUESTION # 105

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