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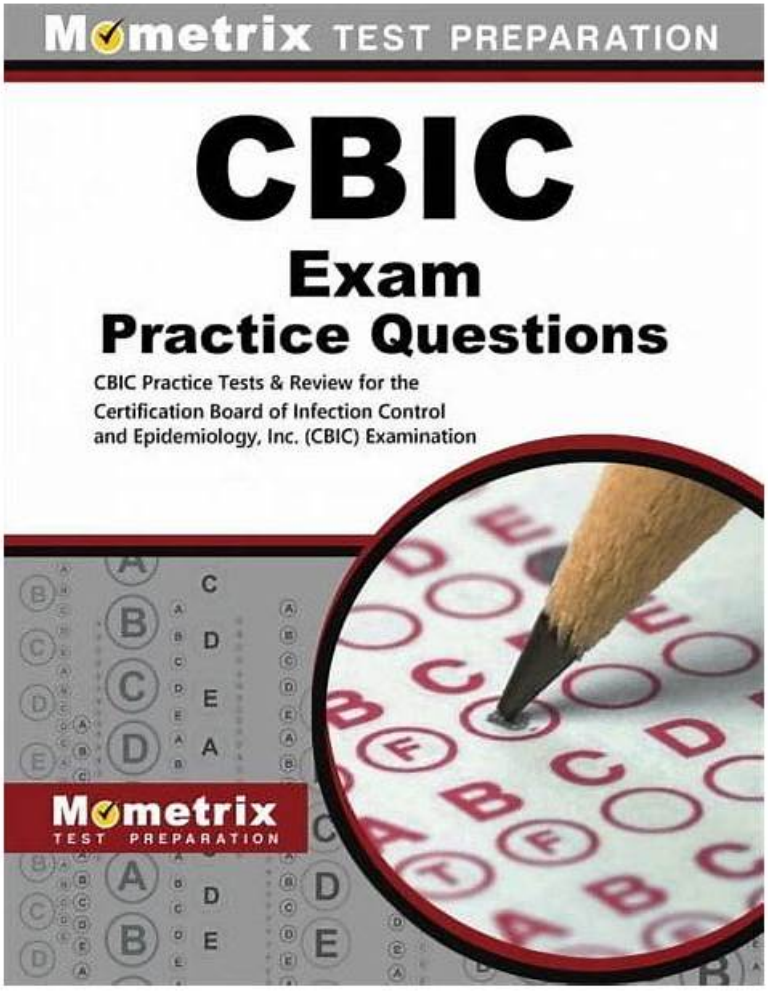

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CBIC Certified Infection Control Exam Sample Questions (Q138-Q143):

NEW QUESTION # 138
When assessing a patient's infection prevention and control educational needs, it is necessary to FIRST determine the patient's

- A. severity of illness.
- B. duration of hospitalization.
- C. educational background.
- D. baseline knowledge of the subject.

Answer: D

Explanation:
The correct answer is D, "baseline knowledge of the subject," as this is the necessary first step when assessing a patient's infection prevention and control educational needs. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, effective patient education in infection prevention and control requires a tailored approach that begins with understanding the patient's existing knowledge and comprehension of the topic. Determining baseline knowledge allows the infection preventionist (IP) to identify gaps, customize educational content to the patient's level of understanding, and ensure the information is relevant and actionable (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs). This step ensures that education is neither too basic nor overly complex, maximizing its effectiveness in promoting behaviors such as hand hygiene, wound care, or adherence to isolation protocols.
Option A (severity of illness) is an important clinical consideration that may influence the timing or method of education delivery, but it is not the first step in assessing educational needs. The severity might affect the patient's ability to learn, but it does not directly inform the content or starting point of the education. Option B (educational background) provides context about the patient's general learning capacity (e.g., literacy level or language preference), but it is secondary to assessing specific knowledge about infection prevention, as background alone does not reveal current understanding. Option C (duration of hospitalization) may impact the opportunity for education but is not a primary factor in determining what the patient needs to learn; it is more relevant to scheduling or prioritizing educational interventions.
The focus on baseline knowledge aligns with adult learning principles endorsed by CBIC, which emphasize assessing learners' prior knowledge to build effective educational strategies (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs).
This approach ensures patient-centered care and supports infection control by empowering patients with the knowledge to participate in their own prevention efforts.
References: CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competencies 4.1 - Develop and implement educational programs, 4.2 - Evaluate the effectiveness of educational programs.

NEW QUESTION # 139
What is the limitation of using liquid chemical sterilants to sterilize medical items?

- A. The sterility is not maintained during storage.
- B. It can only be used for heat tolerant devices.
- C. It requires a contact time of at least 12 hours.
- D. It does not kill the spores.

Answer: A

Explanation:
The correct answer is B, "The sterility is not maintained during storage," as this represents a key limitation of using liquid chemical sterilants to sterilize medical items. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines and standards from the Association for the Advancement of Medical Instrumentation (AAMI), liquid chemical sterilants, such as glutaraldehyde or peracetic acid, are effective for sterilizing heat-sensitive medical devices by eliminating all forms of microbial life, including spores, when used according to manufacturer instructions (CBIC Practice Analysis, 2022, Domain III:
Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment).
However, a significant limitation is that sterility is not guaranteed after the items are removed from the sterilant and stored, as the

sterile barrier can be compromised by environmental contamination, improper packaging, or handling (AAMI ST58:2013, Chemical Sterilization and High-Level Disinfection in Health Care Facilities).
Option A (it does not kill the spores) is incorrect because liquid chemical sterilants are designed to achieve sterilization, including the destruction of bacterial spores, provided the contact time, concentration, and conditions specified by the manufacturer are met. Option C (it requires a contact time of at least 12 hours) is not a universal limitation; while some liquid sterilants require extended contact times (e.g., 10-12 hours for certain formulations), this is a procedural requirement rather than an inherent limitation, and shorter times may be sufficient with other agents or automated systems. Option D (it can only be used for heat tolerant devices) is incorrect because liquid chemical sterilants are specifically intended for heat-sensitive devices that cannot withstand steam or dry heat sterilization.
The limitation of sterility not being maintained during storage underscores the need for immediate use of sterilized items or the use of proper sterile packaging and storage protocols to prevent recontamination. This aligns with CBIC's focus on ensuring the safety and efficacy of reprocessed medical equipment in infection prevention (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). Healthcare facilities must implement strict post-sterilization handling and storage practices to mitigate this limitation.
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment. AAMI ST58:2013, Chemical Sterilization and High-Level Disinfection in Health Care Facilities.

NEW QUESTION # 140
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. Blood culture
- D. Nasopharyngeal swab

Answer: D

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 # 141
Following an outbreak of Hepatitis A, the water supply is sampled. A high count of which of the following isolates would indicate that the water was a potential source?

- A. Pseudomonads
- B. Coliforms
- C. Legionella
- D. Acinetobacter

Answer: B

Explanation:
Coliform bacteria are indicators of fecal contamination in water, making them a critical measure of water safety. Hepatitis A is a virus primarily transmitted via the fecal-oral route, often through contaminated food or water.
Step-by-Step Justification:
* Fecal Contamination and Hepatitis A:
* Hepatitis A virus (HAV) spreads through ingestion of water contaminated with fecal matter. High coliform counts indicate fecal contamination and increase the risk of HAV outbreaks.
* Use of Coliforms as Indicators:
* Public health agencies use total coliforms and Escherichia coli (E. coli) as primary indicators of water safety because they signal fecal pollution.
* Waterborne Transmission of Hepatitis A:
* Hepatitis A outbreaks have been traced to contaminated drinking water, ice, and improperly treated wastewater. Coliform detection signals a need for immediate action.
Why Other Options Are Incorrect:
* B. Pseudomonads:
* Pseudomonads (e.g., Pseudomonas aeruginosa) are environmental bacteria but are not indicators of fecal contamination.
* C. Legionella:
* Legionella species cause Legionnaires' disease through inhalation of contaminated aerosols, not through fecal-oral transmission.
* D. Acinetobacter:
* Acinetobacter species are opportunistic pathogens in healthcare settings but are not indicators of waterborne fecal contamination.
CBIC Infection Control References:
* APIC Text, "Water Systems and Infection Control Measures".
* APIC Text, "Hepatitis A Transmission and Waterborne Outbreaks".

NEW QUESTION # 142
Peripherally inserted central catheter (PICC)-associated bloodstream infections (BSIs) have been increasing over the past four months. Which of the following interventions is MOST likely to have contributed to the increase?

- A. Replacement of the intravenous administration sets every 72 hours
- B. Use of chlorhexidine skin antisepsis during insertion of the PICC
- C. Daily bathing adult intensive care unit patients with chlorhexidine
- D. Use of a positive pressure device on the PICC

Answer: A

Explanation:
Peripherally inserted central catheter (PICC)-associated bloodstream infections (BSIs) are a significant concern in healthcare settings, and identifying factors contributing to their increase is critical for infection prevention. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the
"Surveillance and Epidemiologic Investigation" and "Prevention and Control of Infectious Diseases" domains, which align with the Centers for Disease Control and Prevention (CDC) guidelines for preventing intravascular catheter-related infections. The question asks for the intervention most likely to have contributed to the rise in PICC-associated BSIs over four months, requiring an evaluation of each option based on evidence-based practices.
Option C, "Replacement of the intravenous administration sets every 72 hours," is the most likely contributor to the increase. The CDC's "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017) recommend that intravenous

administration sets (e.g., tubing for fluids or medications) be replaced no more frequently than every 72-96 hours unless clinically indicated (e.g., contamination or specific therapy requirements). Frequent replacement, such as every 72 hours as a routine practice, can introduce opportunities for contamination during the change process, especially if aseptic technique is not strictly followed. Studies cited in the CDC guidelines, including those by O'Grady et al. (2011), indicate that unnecessary manipulation of catheter systems increases the risk of introducing pathogens, potentially leading to BSIs. A change to a 72- hour replacement schedule, if not previously standard, could explain the observed increase over the past four months.
Option A, "Use of chlorhexidine skin antisepsis during insertion of the PICC," is a recommended practice to reduce BSIs. Chlorhexidine, particularly in a 2% chlorhexidine gluconate with 70% alcohol solution, is the preferred skin antiseptic for catheter insertion due to its broad-spectrum activity and residual effect, as supported by the CDC (2017). This intervention should decrease, not increase, infection rates, making it an unlikely contributor. Option B, "Daily bathing adult intensive care unit patients with chlorhexidine," is another evidence-based strategy to reduce healthcare-associated infections, including BSIs, by decolonizing the skin of pathogens like Staphylococcus aureus. The CDC and SHEA (Society for Healthcare Epidemiology of America) guidelines (2014) endorse chlorhexidine bathing in intensive care units, suggesting it should lower, not raise, BSI rates. Option D, "Use of a positive pressure device on the PICC," aims to prevent catheter occlusion and reduce the need for frequent flushing, which could theoretically decrease infection risk by minimizing manipulation. However, there is no strong evidence linking positive pressure devices to increased BSIs; if improperly used or maintained, they might contribute marginally, but this is less likely than the impact of frequent tubing changes.
The CBIC Practice Analysis (2022) and CDC guidelines highlight that deviations from optimal catheter maintenance practices, such as overly frequent administration set replacements, can increase infection risk.
Given the four-month timeframe and the focus on an intervention's potential negative impact, Option C stands out as the most plausible contributor due to the increased manipulation and contamination risk associated with routine 72-hour replacements.
References:
CBIC Practice Analysis, 2022.
CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.
O'Grady, N. P., et al. (2011). Guidelines for the Prevention of Intravascular Catheter-Related Infections.
Clinical Infectious Diseases.
SHEA Compendium, Strategies to Prevent Central Line-Associated Bloodstream Infections, 2014.

NEW QUESTION # 143
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