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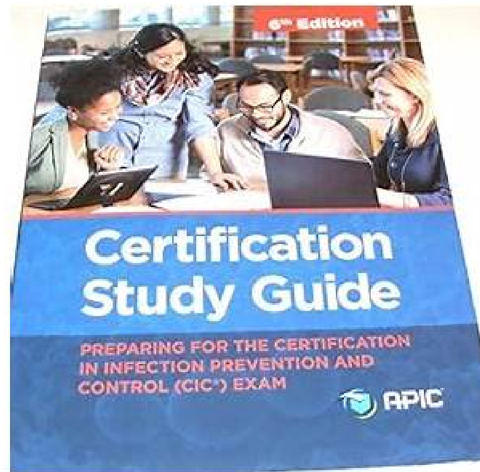


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## CBIC Certified Infection Control Exam Sample Questions (Q207-Q212):

**NEW QUESTION # 207**
A hospital is experiencing an increase in multidrug-resistant Acinetobacter baumannii infections in the intensive care unit (ICU). The infection preventionist's FIRST action should be to:

- A. Perform environmental sampling to detect Acinetobacter on surfaces.
- B. Implement universal contact precautions for all ICU patients.

* C. Initiate decolonization protocols for all ICU patients.
* D. Conduct an epidemiologic investigation to identify potential sources.

**Answer: D**

Explanation:
Epidemiologic Investigation:
* The first step in an outbreak response is to characterize cases by person, place, and time.
* Identifying common exposures (e.g., ventilators, catheters, or contaminated surfaces) helps determine the source.
* Why Other Options Are Incorrect:
* A. Universal contact precautions: Premature; precautions should be tailored based on transmission patterns.
* C. Environmental sampling: Should be done after identifying epidemiologic links.
* D. Decolonization protocols: Not routinely recommended for Acinetobacter outbreaks.
CBIC Infection Control References:
* CIC Study Guide, "Epidemiologic Investigations in Outbreaks," Chapter 4.

**NEW QUESTION # 208**
The infection preventionist recognizes that construction barriers are a key component of the Infection Control Risk Assessment (ICRA). The MOST important factor to consider is that construction barriers should:

* A. Have walk-off mats that are changed daily.
* B. Be constructed to withstand normal heating, ventilation, and air conditioning (HVAC) airflow rates.
* C. Provide sealed covers for air intakes and exhausts.
* D. Be able to contain dust or infectious microorganisms generated by the project.

**Answer: D**

Explanation:
The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that the primary purpose of construction barriers within an Infection Control Risk Assessment (ICRA) is to prevent the dissemination of dust and potentially infectious microorganisms generated during construction, renovation, or maintenance activities. Construction activities can aerosolize fungal spores (such as Aspergillus), bacteria, and other particulate matter that pose a significant risk to immunocompromised patients and other vulnerable populations.
Barriers must therefore be designed and maintained to effectively contain dust and microorganisms at the source, preventing their migration into occupied patient care areas. This containment function is the cornerstone of infection prevention during construction and directly aligns with ICRA goals of risk reduction and patient safety.
While the other options describe supportive or secondary considerations, they are not the most critical factor.
Withstanding HVAC airflow (Option A) is important, but it serves the larger goal of containment. Sealing air intakes and exhausts (Option B) is a specific engineering control that may be used as part of containment strategies but does not define the primary purpose of barriers. Walk-off mats (Option D) are useful adjunctive controls but are insufficient alone to prevent airborne transmission of contaminants.
For CIC exam preparation, it is essential to recognize that containment of dust and infectious agents is the defining function of construction barriers within an ICRA, and all other measures support this central objective.

**NEW QUESTION # 209**
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. Work furlough from day ten to day 21 after exposure.
* B. A tuberculin skin test now and in ten weeks.
* C. Prophylactic rifampin plus isoniazid.
* D. A review of the phlebotomist's hepatitis B vaccine status.

**Answer: A**

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 TBconsiderations are secondary and managed separately.
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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 # 210**
Given the formula for calculating incidence rates, the Y represents which of the following?

- A. Number of events
- B. Population served
- C. Number of infected patients
- D. Population at risk

**Answer: D**

Explanation:
Incidence rate is a fundamental epidemiological measure used to quantify the frequency of new cases of a disease within a specified population over a defined time period. The Certification Board of Infection Control and Epidemiology (CBIC) supports the use of such metrics in the "Surveillance and Epidemiologic Investigation" domain, aligning with the Centers for Disease Control and Prevention (CDC) "Principles of Epidemiology in Public Health Practice" (3rd Edition, 2012). The formula provided, XY×K=Rate\frac{X}
{Y} \times K = RateYX×K=Rate, represents the standard incidence rate calculation, where KKK is a constant (e.g., 1,000 or 100,000) to express the rate per unit population, and the question asks what YYY represents among the given options.

In the incidence rate formula, XXX typically represents the number of new cases (or events) of the disease occurring during a specific period, and YYY represents the population at risk during that same period. The ratio XY\frac{X}{Y}YX yields the rate per unit of population, which is then multiplied by KKK to standardize the rate (e.g., cases per 1,000 persons). The CDC defines the denominator (YYY) as the population at risk, which includes individuals susceptible to the disease over the observation period. Option B ("Number of infected patients") might suggest XXX if it specified new cases, but as the denominator YYY, it is incorrect because incidence focuses on new cases relative to the at-risk population, not the total number of infected individuals (which could include prevalent cases). Option C ("Population at risk") correctly aligns with YYY, representing the base population over which the rate is calculated.
Option A, "Population served," is a broader term that might include the total population under care (e.g., in a healthcare facility), but it is not specific to those at risk for new infections, making it less precise. Option D,
"Number of events," could align with XXX (new cases or events), but as the denominator YYY, it does not fit the formula's structure. The CBIC Practice Analysis (2022) and CDC guidelines reinforce that the denominator in incidence rates is the population at risk, ensuring accurate measurement of new disease occurrence.
References:
CBIC Practice Analysis, 2022.
CDC Principles of Epidemiology in Public Health Practice, 3rd Edition, 2012.

**NEW QUESTION # 211**
The intensive care unit has noted an increase in patients with ventilator-associated events (VAEs). Which of the following may be contributing to the increase in these events?

- A. Daily oral care with chlorhexidine
- B. Daily weaning assessment
- C. Supine position during transport
- D. Daily sedation vacation

**Answer: C**

Explanation:
Ventilator-associated events (VAEs) are complications that occur in patients receiving mechanical ventilation and include conditions such as ventilator-associated pneumonia (VAP), pulmonary edema, and atelectasis.
The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that patient positioning plays a critical role in preventing aspiration and subsequent respiratory complications in mechanically ventilated patients.
Maintaining patients in a supine position, particularly during transport, increases the risk of aspiration of gastric contents and oropharyngeal secretions. Aspiration is a well-recognized contributing factor to the development of VAEs because it can lead to infection, inflammation, and worsening oxygenation. The Study Guide recommends maintaining the head of the bed elevated (generally 30-45 degrees) whenever feasible, including during care activities and transport, to reduce aspiration risk.
The other options listed-daily sedation vacation, daily weaning assessment, and daily oral care with chlorhexidine-are evidence-based prevention strategies that are part of ventilator care bundles. These interventions are designed to reduce the duration of mechanical ventilation, improve pulmonary function, and decrease microbial colonization, all of which lower the risk of VAEs rather than contribute to them.
Therefore, supine positioning during transport is the most likely factor contributing to an increase in ventilator-associated events and represents a deviation from recommended infection prevention practices.

**NEW QUESTION # 212**
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