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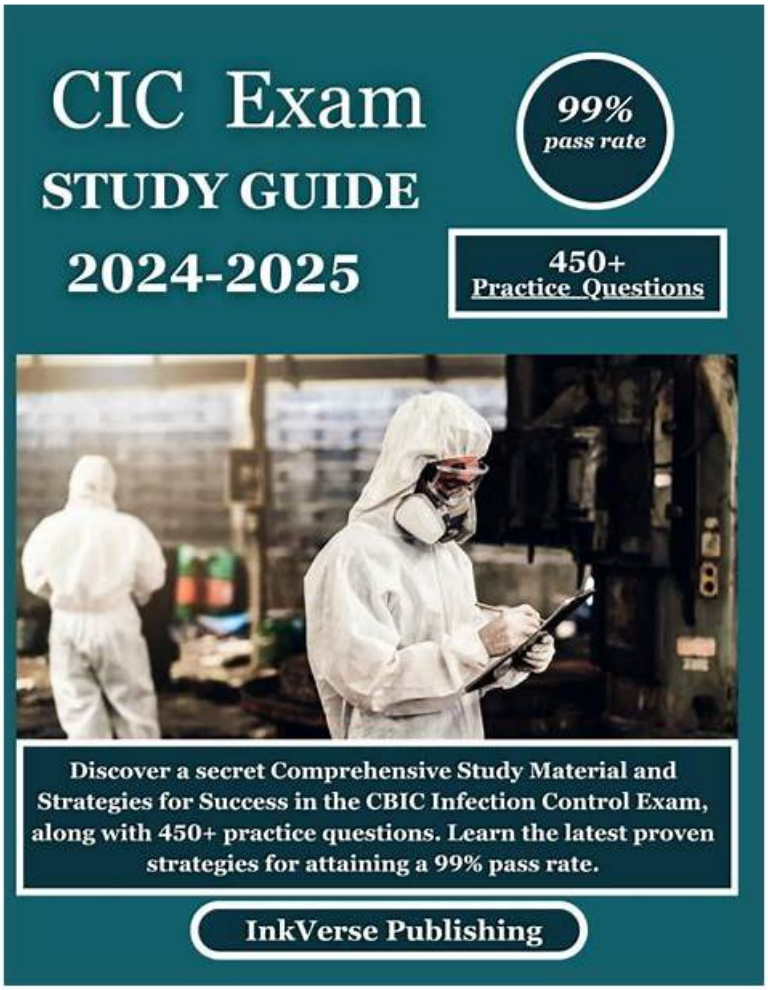

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CBIC Certified Infection Control Exam Sample Questions (Q74-Q79):

NEW QUESTION # 74
During the past week, three out of four blood cultures from a febrile neonate in an intensive care unit grew coagulase-negative staphylococci. This MOST likely indicates:

- A. Contamination.
- B. Laboratory error.
- C. Colonization.
- D. Infection.

Answer: A

Explanation:
The scenario involves a febrile neonate in an intensive care unit (ICU) with three out of four blood cultures growing coagulase-negative staphylococci (CoNS) over the past week. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes accurate interpretation of microbiological data in the
"Identification of Infectious Disease Processes" domain, aligning with the Centers for Disease Control and Prevention (CDC) guidelines for healthcare-associated infections. Determining whether this represents a true infection, contamination, colonization, or laboratory error requires evaluating the clinical and microbiological context.
Option B, "Contamination," is the most likely indication. Coagulase-negative staphylococci, such as Staphylococcus epidermidis, are common skin flora and frequent contaminants in blood cultures, especially in neonates where skin preparation or sampling technique may be challenging. The CDC's "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017) and the Clinical and Laboratory Standards Institute (CLSI) note that multiple positive cultures (e.g., two or more) are typically required to confirm true bacteremia, particularly with CoNS, unless accompanied by clear clinical signs of infection (e.g., worsening fever, hemodynamic instability) and no other explanation. The inconsistency (three out of four cultures) and the neonate's ICU setting-where contamination from skin or catheter hubs is common-suggest that the positive cultures likely result from contamination during blood draw rather than true infection. Studies, such as those in the Journal of Clinical Microbiology (e.g., Beekmann et al., 2005), indicate that CoNS in blood cultures is contaminated in 70-80% of cases when not supported by robust clinical correlation.
Option A, "Laboratory error," is possible but less likely as the primary explanation. Laboratory errors (e.g., mislabeling or processing mistakes) could occur, but the repeated growth in three of four cultures suggests a consistent finding rather than a random error, making contamination a more plausible cause. Option C,
"Colonization," refers to the presence of microorganisms on or in the body without invasion or immune response. While CoNS can colonize the skin or catheter sites, colonization does not typically result in positive blood cultures unless there is an invasive process, which is not supported by the data here. Option D,
"Infection," is the least likely without additional evidence. True CoNS bloodstream infections (e.g., catheter- related) in neonates are serious but require consistent positive cultures, clinical deterioration (e.g., persistent fever, leukocytosis), and often imaging or catheter removal confirmation. The febrile state alone, with inconsistent culture results, does not meet the CDC's criteria for diagnosing infection (e.g., at least two positive cultures from separate draws).
The CBIC Practice Analysis (2022) and CDC guidelines stress differentiating contamination from infection to avoid unnecessary treatment, which can drive antibiotic resistance. Given the high likelihood of contamination with CoNS in this context, Option B is the most accurate answer.
References:
* CBIC Practice Analysis, 2022.
* CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.
* Beekmann, S. E., et al. (2005). Coagulase-Negative Staphylococci in Blood Cultures. Journal of Clinical Microbiology.
* CLSI Guidelines on Blood Culture Interpretation, 2018.

NEW QUESTION # 75
Which of the following descriptions accurately describes a single-use medical device?

- A. A device used one time on a patient during a procedure and then discarded
- B. A device which can be used on a single patient
- C. A device used on a patient and reprocessed prior to being used again
- D. A device that is sterilized and can be used again on the same patient

Answer: A

Explanation:
The correct answer is D, "A device used one time on a patient during a procedure and then discarded," as this accurately describes a single-use medical device. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, a single-use device (SUD), also known as a disposable device, is labeled by the manufacturer for one-time use on a patient and is

intended to be discarded afterward to prevent cross-contamination and ensure patient safety. This definition is consistent with regulations from the Food and Drug Administration (FDA), which designate SUDs as devices that should not be reprocessed or reused due to risks of infection, material degradation, or failure to restore sterility (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). Examples include certain syringes, catheters, and gloves, which are designed for single use to eliminate the risk of healthcare-associated infections (HAIs).
Option A (a device which can be used on a single patient) is too vague and could apply to both single-use and reusable devices, as reusable devices are also often used on a single patient per procedure before reprocessing.
Option B (a device that is sterilized and can be used again on the same patient) describes a reusable device, not a single-use device, as sterilization and reuse are not permitted for SUDs. Option C (a device used on a patient and reprocessed prior to being used again) refers to a reusable device that undergoes reprocessing (e.
g., sterilization), which is explicitly prohibited for SUDs under manufacturer and regulatory guidelines.
The focus on discarding after one use aligns with CBIC's emphasis on preventing infection through adherence to device labeling and safe reprocessing practices, ensuring that healthcare facilities avoid the risks associated with improper reuse of SUDs (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This practice is critical to maintaining a sterile and safe healthcare environment.
References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.3 - Ensure safe reprocessing of medical equipment, 3.5 - Evaluate the environment for infection risks. FDA Guidance on Reprocessing of Single-Use Devices, 2016.

NEW QUESTION # 76
Working with public health agencies to collect and analyze indicators that might signal an increase in community illness is an example of which type of surveillance?

- A. Active
- B. Targeted
- C. Syndromic
- D. Passive

Answer: C

Explanation:
Surveillance is a critical tool in infection prevention and control, used to monitor disease trends and guide public health responses. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the "Surveillance and Epidemiologic Investigation" domain, which aligns withthe Centers for Disease Control and Prevention (CDC) "Principles of Epidemiology in Public Health Practice" (3rd Edition, 2012). The question describes a process of collecting and analyzing indicators to signal an increase in community illness, requiring identification of the appropriate surveillance type among the options provided.
Option C, "Syndromic," is the correct answer. Syndromic surveillance involves monitoring non-specific health indicators or symptoms (e.g., fever, respiratory complaints, or gastrointestinal issues) that may precede a formal diagnosis, aiming to detect potential outbreaks or increases in community illness early. The CDC defines syndromic surveillance as the real-time or near-real-time collection, analysis, and interpretation of health-related data to provide actionable information, often in collaboration with public health agencies. This approach uses data from sources like emergency department visits, over-the-counter medication sales, or absenteeism reports to identify trends before laboratory confirmation, making it well-suited to the described scenario of signaling community illness increases.
Option A, "Passive," involves healthcare providers or laboratories reporting cases to public health authorities on a voluntary or mandatory basis without active prompting (e.g., routine notifiable disease reporting). While passive surveillance contributes to baseline data, it is less proactive and not specifically designed to signal early increases in illness, making it less fitting. Option B, "Active," entails public health officials actively seeking data from healthcare facilities or providers (e.g., calling to confirm cases during an outbreak). This is more resource-intensive and typically used for specific investigations rather than ongoing community trend monitoring, which aligns better with syndromic methods. Option D, "Targeted," refers to surveillance focused on a specific population, disease, or event (e.g., monitoring TB in a high-risk group). The scenario's broad focus on community illness indicators does not suggest a targeted approach.
The CBIC Practice Analysis (2022) and CDC guidelines highlight syndromic surveillance as a key strategy for early detection of community-wide health threats, often involving collaboration with public health agencies. Option C best matches the described activity of analyzing indicators to signal illness increases, making it the correct choice.
References:
CBIC Practice Analysis, 2022.
CDC Principles of Epidemiology in Public Health Practice, 3rd Edition, 2012.
CDC Syndromic Surveillance Systems, 2020.

NEW QUESTION # 77
A hospital experiencing an increase in catheter-associated urinary tract infections (CAUTI) implements a quality improvement initiative. Which of the following interventions is MOST effective in reducing CAUTI rates?

- A. Implementing nurse-driven protocols for early catheter removal.
- B. Routine urine cultures for all catheterized patients every 48 hours.
- C. Replacing indwelling urinary catheters with condom catheters for all male patients.
- D. Using antibiotic-coated catheters in all ICU patients.

Answer: A

Explanation:
* Nurse-driven catheter removal protocols have been shown to significantly reduce CAUTI rates by minimizing unnecessary catheter use.
* Routine urine cultures (A) lead to overtreatment of asymptomatic bacteriuria.
* Condom catheters (C) are helpful in certain cases but are not universally effective.
* Antibiotic-coated catheters (D) have mixed evidence regarding their effectiveness.
CBIC Infection Control References:
* APIC Text, "CAUTI Prevention Strategies," Chapter 10.

NEW QUESTION # 78
Following recent renovations on an oncology unit, three patients were identified with Aspergillus infections.
The infections were thought to be facility-acquired. Appropriate environmental microbiological monitoring would be to culture the:

- A. Carpet
- B. Air
- C. Ice
- D. Aerators

Answer: B

Explanation:
The scenario describes an outbreak of Aspergillus infections among three patients on an oncology unit following recent renovations, with the infections suspected to be facility-acquired. Aspergillus is a mold commonly associated with environmental sources, particularly airborne spores, and its presence in immunocompromised patients (e.g., oncology patients) poses a significant risk. The infection preventionist must identify the appropriate environmental microbiological monitoring strategy, guided by the Certification Board of Infection Control and Epidemiology (CBIC) and CDC recommendations. Let's evaluate each option:
* A. Air: Aspergillus species are ubiquitous molds that thrive in soil, decaying vegetation, and construction dust, and they are primarily transmitted via airborne spores. Renovations can disturb these spores, leading to aerosolization and inhalation by vulnerable patients. Culturing the air using methods such as settle plates, air samplers, or high-efficiency particulate air (HEPA) filtration monitoring is a standard practice to detect Aspergillus during construction or post-renovation in healthcare settings, especially oncology units where patients are at high risk for invasive aspergillosis. This aligns with CBIC's emphasis on environmental monitoring for airborne pathogens, making it the most appropriate choice.
* B. Ice: Ice can be a source of contamination with bacteria (e.g., Pseudomonas, Legionella) or other pathogens if improperly handled or stored, but it is not a typical reservoir for Aspergillus, which is a mold requiring organic material and moisture for growth. While ice safety is important in infection control, culturing ice is irrelevant to an Aspergillus outbreak linked to renovations and is not a priority in this context.
* C. Carpet: Carpets can harbor dust, mold, and other microorganisms, especially in high-traffic or poorly maintained areas. Aspergillus spores could theoretically settle in carpet during renovations, but carpets are not a primary source of airborne transmission unless disturbed (e.g., vacuuming). Culturing carpet might be a secondary step if air sampling indicates widespread contamination, but it is less direct and less commonly recommended as the initial monitoring site compared to air sampling.
* D. Aerators: Aerators (e.g., faucet aerators) can harbor waterborne pathogens like Pseudomonas or Legionella due to biofilm formation, but Aspergillus is not typically associated with water systems unless there is significant organic contamination or aerosolization from water sources (e.g., cooling towers). Culturing aerators is relevant for waterborne outbreaks, not for an Aspergillus outbreak linked to renovations, making this option inappropriate.
The best answer is A, culturing the air, as Aspergillus is an airborne pathogen, and renovations are a known risk factor for spore dispersal in healthcare settings. This monitoring strategy allows the infection preventionist to confirm the source, assess the extent of contamination, and implement control measures (e.g., enhanced filtration, construction barriers) to protect patients. This is consistent with CBIC and CDC guidelines for managing fungal outbreaks in high-risk units.
References:

* CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV: Environment of Care, which recommends air sampling for Aspergillus during construction-related outbreaks.
* CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes environmental monitoring for facility-acquired infections.
* CDC Guidelines for Environmental Infection Control in Healthcare Facilities (2022), which advocate air culturing to detect Aspergillus post-renovation in immunocompromised patient areas.

NEW QUESTION # 79
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