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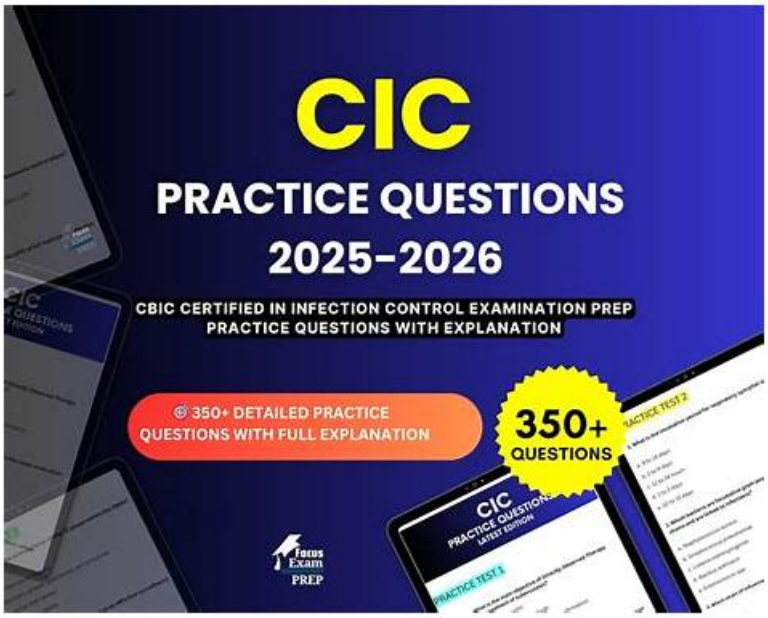


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## CBIC Certified Infection Control Exam Sample Questions (Q157-Q162):

**NEW QUESTION # 157**
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 tuberculin skin test now and in ten weeks.
- C. Work furlough from day ten to day 21 after exposure.
- D. A review of the phlebotomist's hepatitis B vaccine status.

**Answer: C**

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 # 158**
Which of the following options describes a best practice for avoiding occupational health hazards in a healthcare facility?

- A. The facility should exclude asymptomatic Bordetella pertussis-exposed healthcare personnel from duty.
- B. The facility is required to conduct varicella post-vaccination testing for healthcare personnel.
- C. The facility is required to conduct annual tuberculosis (TB) testing for healthcare personnel.
- D. The facility should provide Neisseria meningitidis pre-exposure vaccination to laboratory personnel.

**Answer: D**

Explanation:
The Certification Study Guide (6th edition) emphasizes that occupational health hazard prevention is based on risk assessment and targeted protection strategies, particularly for personnel with predictable, high-risk exposures. Providing pre-exposure vaccination against Neisseria meningitidis to laboratory personnel is a recognized best practice because laboratorians who routinely handle N. meningitidis isolates are at increased risk for aerosol or droplet exposure, which can result in rapidly progressive and potentially fatal

disease.
The study guide highlights that pre-exposure immunization is preferred over post-exposure management when exposure risk is ongoing and well defined. This strategy aligns with evidence-based occupational health principles and recommendations from public health authorities, making it a proactive and preventive measure rather than a reactive one.
The other options are incorrect because they either reflect outdated practices or inappropriate control measures. Routine annual TB testing is no longer universally required and should be based on facility risk assessment. Post-vaccination varicella serologic testing is not recommended because commercial assays may not reliably detect vaccine-induced immunity. Excluding asymptomatic pertussis-exposed healthcare personnel from duty is not routinely recommended if appropriate prophylaxis is provided.
This question reflects a common CIC exam theme: best practices focus on targeted, evidence-based prevention, especially vaccination strategies for high-risk occupational groups.
Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 6: Employee /Occupational Health.

**NEW QUESTION # 159**
An infection preventionist plans to evaluate 12 months of prospectively collected intensive care unit (ICU) surveillance data on ventilator-associated events. The MOST effective visual representation of these data is a:

- A. Pareto chart
- B. Control chart
- C. Scatter gram
- D. Pie chart

**Answer: B**

Explanation:
The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that surveillance data collected over time are best evaluated using statistical process control methods. A control chart is the most effective visual tool for analyzing 12 months of prospectively collected ICU surveillance data on ventilator- associated events (VAEs) because it displays data sequentially over time and distinguishes between normal process variation and significant changes that may require intervention.
Control charts allow infection preventionists to identify trends, shifts, or special cause variation by plotting event rates against calculated control limits. This enables timely recognition of sustained increases or decreases in VAEs and supports data-driven decision-making. Control charts are especially valuable for ongoing surveillance and performance improvement because they demonstrate whether prevention efforts are having a measurable impact.
The other options are less appropriate for this purpose. A Pareto chart is used to prioritize causes contributing to a problem, not to track rates over time. A pie chart shows proportional distribution at a single point in time and does not reflect trends. A scatter gram is used to assess relationships between two variables rather than monitor process stability.
For CIC exam preparation, it is critical to recognize that when evaluating infection surveillance data longitudinally-particularly for healthcare-associated events-control charts are the preferred and most effective visualization method, aligning with epidemiologic principles and quality improvement methodology outlined in the Study Guide.

**NEW QUESTION # 160**
A patient with a history of Clostridioides difficile is admitted to the hospital. The patient is asymptomatic for diarrheal symptoms; however, the provider prescribes an antibiotic. What type of antimicrobial therapy is applied in this scenario?

- A. Empiric
- B. Targeted
- C. Prophylactic
- D. Inappropriate

**Answer: C**

Explanation:
The CBIC Certified Infection Control Exam Study Guide (6th edition) defines prophylactic antimicrobial therapy as the use of antibiotics to prevent infection in the absence of clinical signs or symptoms of active disease. In this scenario, the patient has a history of Clostridioides difficile infection but is currently asymptomatic for diarrhea or other CDI manifestations. The antibiotic is therefore not being used to treat active infection.
Empiric therapy (Option A) is initiated when infection is suspected but the causative organism has not yet been identified-this does not apply here, as the patient has no symptoms suggesting infection. Targeted therapy (Option D) requires laboratory confirmation of a specific pathogen, which is also not present. While prescribing antibiotics in patients with prior CDI may be clinically questionable

depending on indication and stewardship principles, the type of therapy being applied is best categorized as prophylactic, not inappropriate, based on standard antimicrobial definitions.
The Study Guide emphasizes that antimicrobial stewardship programs carefully evaluate prophylactic antibiotic use because unnecessary exposure can disrupt normal flora and increase the risk of CDI recurrence.
However, from a classification standpoint, antibiotics given without signs of active infection fall under prophylactic use.
For CIC exam preparation, it is important to correctly identify antimicrobial intent, even when clinical appropriateness may be debatable.

**NEW QUESTION # 161**
An infection preventionist (IP) is informed of a measles outbreak in a nearby community. What is the IP's FIRST priority when working with Occupational Health?

- A. Verify that employees in high-risk exposure areas of the facility have adequate immunity to measles.
- B. Set up a mandatory vaccination clinic in collaboration with Occupational Health and local public health partners.
- C. Isolate employees who have recently traveled to areas with measles outbreaks.
- D. Reassign employees who are pregnant from caring for patients with suspected measles.

**Answer: A**

Explanation:
When an infection preventionist (IP) is informed of a measles outbreak in a nearby community, the immediate priority is to protect healthcare workers and patients from potential exposure, particularly in a healthcare setting where vulnerable populations are present. Working with Occupational Health, the IP must follow a structured approach to mitigate the risk of transmission, guided by principles from the Certification Board of Infection Control and Epidemiology (CBIC) and public health guidelines. Let's evaluate each option to determine the first priority:
A). Isolate employees who have recently traveled to areas with measles outbreaks: Isolating employees who may have been exposed to measles during travel is an important infection control measure to prevent transmission within the facility. However, this action assumes that exposure has already occurred and requires identification of affected employees first. Without knowing the immunity status of the workforce, this step is reactive rather than preventive and cannot be the first priority.
B). Reassign employees who are pregnant from caring for patients with suspected measles: Reassigning pregnant employees is a protective measure due to the severe risks measles poses to fetuses (e.g., congenital rubella syndrome risks, though measles itself is more about maternal complications). This action is specific to a subset of employees and depends on identifying patients with suspected measles, which may not yet be confirmed. It is a secondary step that follows assessing overall immunity and exposure risks, making it inappropriate as the first priority.
C). Verify that employees in high-risk exposure areas of the facility have adequate immunity to measles:
Verifying immunity is the foundational step in preventing measles transmission in a healthcare setting.
Measles is highly contagious, and healthcare workers in high-risk areas (e.g., emergency departments, pediatric wards) are at increased risk of exposure. The CBIC and CDC recommend ensuring that all healthcare personnel have documented evidence of measles immunity (e.g., two doses of MMR vaccine, laboratory evidence of immunity, or prior infection) as a primary infection control strategy during outbreaks.
This step allows the IP to identify vulnerable employees, implement targeted interventions, and comply with occupational health regulations. It is the most proactive and immediate priority when an outbreak is reported in the community.
D). Set up a mandatory vaccination clinic in collaboration with Occupational Health and local public health partners: Establishing a vaccination clinic is a critical long-term strategy to increase immunity and control the outbreak. However, this requires planning, resource allocation, and coordination, which take time. It is a subsequent step that follows verifying immunity status to identify those who need vaccination. While important, it cannot be the first priority due to its logistical demands.
The first priority is C, as verifying immunity among employees in high-risk areas establishes a baseline to prevent transmission before reactive measures (e.g., isolation, reassignment) or broader interventions (e.g., vaccination clinics) are implemented. This aligns with CBIC's focus on proactive risk assessment and occupational health safety during infectious disease outbreaks, ensuring a rapid response to protect the healthcare workforce and patients.
CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III:
Prevention and Control of Infectious Diseases, which prioritizes immunity verification during outbreaks.
CBIC Examination Content Outline, Domain IV: Environment of Care, which includes ensuring employee immunity as part of outbreak preparedness.
CDC Guidelines for Measles Prevention (2023), which recommend verifying healthcare worker immunity as the initial step during a measles outbreak.

**NEW QUESTION # 162**

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