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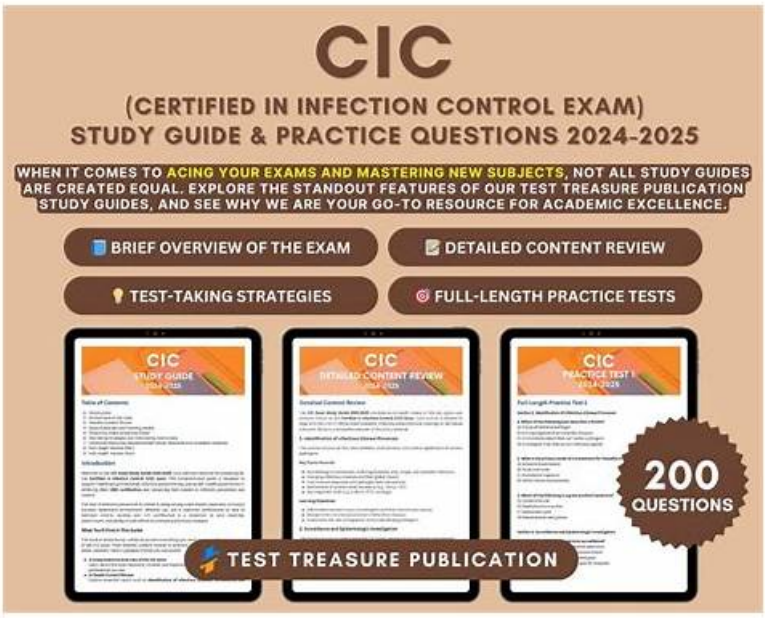

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CBIC Certified Infection Control Exam Sample Questions (Q125-Q130):

NEW QUESTION # 125
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. A tuberculin skin test now and in ten weeks.
- B. A review of the phlebotomist's hepatitis B vaccine status.
- C. Work furlough from day ten to day 21 after exposure.
- D. Prophylactic rifampin plus isoniazid.

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 # 126
Which of the following represents the most effective strategy for preventing Clostridioides difficile transmission in a healthcare facility?

- A. Daily environmental cleaning with quaternary ammonium compounds.
- B. Strict antimicrobial stewardship to limit unnecessary antibiotic use.
- C. Universal C. difficile screening on admission for high-risk patients.
- D. Routine use of alcohol-based hand rub for hand hygiene after patient contact.

Answer: B

Explanation:
* Antimicrobial stewardship is the most effective strategy to reduce C. difficile infections (CDI) by limiting the use of broad-spectrum antibiotics.
* Quaternary ammonium disinfectants (A) are ineffective against C. difficile spores; bleach-based disinfectants are preferred.
* Routine screening (C) is not cost-effective for prevention.

* Alcohol-based hand rubs (D) do not kill C. difficile spores; soap and water should be used.
CBIC Infection Control References:
* APIC Text, "C. difficile Prevention Strategies," Chapter 9.

NEW QUESTION # 127
What are three categories of surveillance that can be conducted?

- A. Whole house, targeted, or combination
- B. Prospective, retrospective, and baseline
- C. Baseline, whole house, and targeted
- D. Baseline, benchmark, and regulatory requirements

Answer: A

Explanation:
The Certification Study Guide (6th edition) describes surveillance in infection prevention as a systematic method for collecting, analyzing, and interpreting health data, and it categorizes surveillance approaches based on scope and focus. The three recognized categories of surveillance are whole house surveillance, targeted surveillance, and a combination of both, making option D the correct answer.
Whole house surveillance involves monitoring infections across the entire healthcare facility. This approach provides a broad overview of infection trends but may lack depth in high-risk areas. Targeted surveillance, on the other hand, focuses on specific populations, locations, procedures, or devices-such as CLABSI in ICUs or SSIs following orthopedic surgery-where risk is highest or where prevention efforts are prioritized. A combination approach integrates both methods, allowing facilities to maintain broad situational awareness while dedicating resources to high-impact areas.
The study guide emphasizes that infection prevention programs should select surveillance categories based on risk assessment, available resources, regulatory requirements, and organizational priorities. CIC exam questions often test understanding of surveillance structure rather than timing (prospective vs. retrospective) or purpose (baseline vs. benchmark), which are surveillance methods or uses, not categories.
Recognizing whole house, targeted, and combination surveillance as the core categories reflects foundational infection prevention principles and supports effective program design, evaluation, and regulatory compliance.
Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION # 128
A nutrition support team wants to determine whether patients who receive total parenteral nutrition (TPN) at home are at increased risk of central line-associated bloodstream infection (CLABSI) compared with patients who receive TPN in the hospital. The BEST way to compare these two groups is to calculate the:

- A. Infections per 1,000 central line days in each group.
- B. Ratio of infected to noninfected central lines in each group.
- C. Number of infections in each group this year compared to last year.
- D. Percentage of patients in each group who became infected.

Answer: A

Explanation:
The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that accurate comparison of healthcare-associated infection risk between groups requires use of standardized, exposure-based rates. For central line-associated bloodstream infections (CLABSIs), the recommended metric is infections per 1,000 central line days, which accounts for the amount of time patients are actually exposed to the risk factor-in this case, the presence of a central venous catheter.
Patients receiving TPN at home and those receiving TPN in the hospital may differ substantially in duration of catheter use, care practices, and patient acuity. Simply comparing percentages or raw numbers of infections fails to adjust for differences in central line utilization and can result in misleading conclusions. By using central line days as the denominator, infection rates are normalized and allow for valid comparisons between populations and settings.
Option A does not account for differences in exposure time. Option C compares different time periods rather than comparing risk between groups. Option D provides a ratio but lacks standardization and is not consistent with accepted surveillance methodology.
The Study Guide reinforces that device-associated infection surveillance-such as CLABSI monitoring- must use device days to assess true risk and guide prevention strategies. Understanding and applying correct epidemiologic measures is a core competency for infection preventionists and a frequently tested concept on the CIC exam.

NEW QUESTION # 129
Which of the following patients with human immunodeficiency virus infection requires Airborne precautions?

- A. 28-year-old female with Mycobacterium avium in sputum
- B. 46-year-old female with a cavitary lesion in upper lobe
- C. 36-year-old male with cryptococcal meningitis
- D. 24-year-old male newly diagnosed with a CD4 count of 70

Answer: B

Explanation:
HIV patients require Airborne Precautions if they have tuberculosis (TB). A cavitary lesion in the upper lobe is highly suggestive of active pulmonary TB, which requires Airborne Precautions due to aerosolized transmission.
Why the Other Options Are Incorrect?
* A. 24-year-old male newly diagnosed with a CD4 count of 70 - Low CD4 count alone does not warrant Airborne Precautions unless there is active TB or another airborne pathogen.
* B. 28-year-old female with Mycobacterium avium in sputum - Mycobacterium avium complex (MAC) is not airborne, and standard precautions are sufficient.
* C. 36-year-old male with cryptococcal meningitis - Cryptococcus neoformans is not transmitted via the airborne route, so Airborne Precautions are unnecessary.
CBIC Infection Control Reference
Patients with HIV and suspected TB require Airborne Precautions until TB is ruled out.

NEW QUESTION # 130
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