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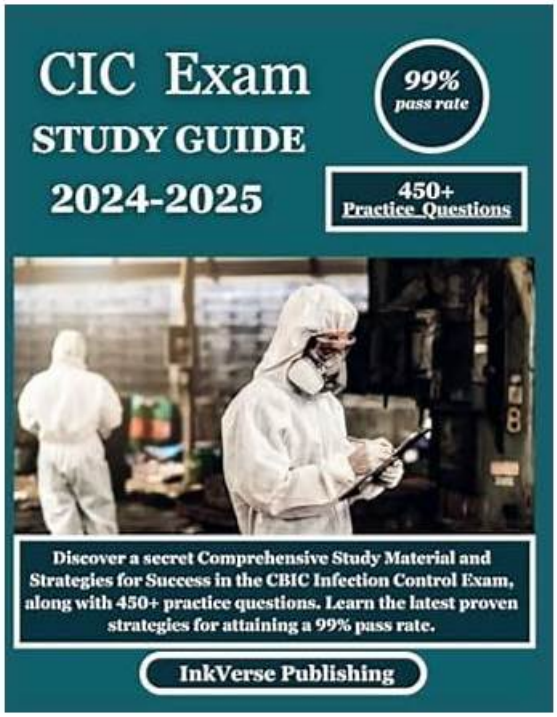

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CBIC Certified Infection Control Exam Sample Questions (Q64-Q69):

NEW QUESTION # 64
An infection control manager is training a new infection preventionist. In discussing surveillance strategies, which of the following types of hospital infection surveillance usually provides maximum benefit with minimum resources?

- A. Antibiotic monitoring
- B. Prevalence surveys
- C. Nursing care plan review
- D. High-risk patient focus

Answer: D

Explanation:
A high-risk patient focus maximizes benefits while minimizing resource use in infection surveillance.
Step-by-Step Justification:
* Efficiency of High-Risk Surveillance:
* Targeting ICU, immunocompromised patients, or surgical units helps detect infections where the risk is highest, leading to earlier interventions.
* Resource Allocation:
* Full hospital-wide surveillance is resource-intensive; focusing on high-risk groups is more efficient.
* Why Other Options Are Incorrect:
* B. Antibiotic monitoring:
* Important for stewardship, but not the primary focus of infection surveillance.
* C. Prevalence surveys:
* Snapshot data only; does not provide ongoing monitoring.
* D. Nursing care plan review:
* Less direct in identifying infection trends.
CBIC Infection Control References:
* APIC Text, "Surveillance Strategies for Infection Prevention".

NEW QUESTION # 65
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. Use of chlorhexidine skin antisepsis during insertion of the PICC
- B. Replacement of the intravenous administration sets every 72 hours
- C. Use of a positive pressure device on the PICC
- D. Daily bathing adult intensive care unit patients with chlorhexidine

Answer: B

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 # 66
An infection preventionist is evaluating a new catheter that may decrease the rate of catheter-associated urinary tract infections.
Which of the following provides the BEST information to support the selection of this catheter?

- A. Value analysis and information provided by the manufacturer
- B. Cost benefit analysis and safety considerations
- C. Staff member preference and product availability
- D. Product materials and vendor information

Answer: A

Explanation:
The correct answer is D, "Cost benefit analysis and safety considerations," as this provides the best information to support the selection of a new catheter aimed at decreasing the rate of catheter-associated urinary tract infections (CAUTIs). According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, selecting medical devices like catheters for infection prevention involves a comprehensive evaluation that balances efficacy, safety, and economic impact. A cost-benefit analysis assesses the financial implications (e.g., reduced infection rates leading to lower treatment costs) against the cost of the new catheter, while safety considerations ensure the device minimizes patient risk, such as reducing biofilm formation or irritation that contributes to CAUTIs (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This dual focus provides evidence-based data to justify the catheter's adoption, aligning with the goal of improving patient outcomes and reducing healthcare-associated infections (HAIs).
Option A (staff member preference and product availability) is subjective and logistical rather than evidence- based, making it insufficient for a decision that impacts infection rates. Option B (product materials and vendor information) offers technical details but lacks the broader context of efficacy and cost-effectiveness needed for a comprehensive evaluation. Option C (value analysis and information provided by the manufacturer) includes a structured assessment of value, but it may be biased toward the manufacturer's claims and lacks the independent safety and cost-benefit perspective critical for infection prevention decisions.
The emphasis on cost-benefit analysis and safety considerations reflects CBIC's priority on using data-driven and patient-centered approaches to select interventions that enhance infection control (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.5 - Use data to guide infection prevention and control strategies). This approach ensures the catheter's selection is supported by robust evidence, optimizing both clinical and economic outcomes in the prevention of CAUTIs.
References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.5 - Use data to guide infection prevention and control strategies; Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment.

NEW QUESTION # 67
An 84-year-old male with a gangrenous foot is admitted to the hospital from an extended-care facility (ECF).
The ECF is notified that the wound grew Enterococcus faecium with the following antibiotic sensitivity results:

ampicillin - R
vancomycin - R
penicillin - R
linezolid - S
This is the fourth Enterococcus species cultured from residents within the same ECF wing in the past month.
The other cultures were from two urine specimens and a draining wound. The Infection Preventionist (IP) should immediately:

- A. Notify the nursing administrator to close the wing to new admissions.
- B. Compare the four culture reports and sensitivity patterns.
- C. Notify the medical director of the outbreak.
- D. Conduct surveillance cultures for this organism in all residents.

Answer: C

Explanation:
The scenario describes a potential outbreak of multidrug-resistant Enterococcus faecium in an extended-care facility (ECF) wing, indicated by four positive cultures (including the current case and three prior cases from urine and a draining wound) within a month. The organism exhibits resistance to ampicillin, vancomycin, and penicillin, but sensitivity to linezolid, suggesting a possible vancomycin-resistant Enterococcus (VRE) strain, which is a significant concern in healthcare settings. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the importance of rapid outbreak detection and response in the "Surveillance and Epidemiologic Investigation" domain, aligning with Centers for Disease Control and Prevention (CDC) guidelines for managing multidrug-resistant organisms (MDROs).
Option A, "Notify the medical director of the outbreak," is the most immediate and critical action. Identifying an outbreak-defined by the CDC as two or more cases of a similar illness linked by time and place-requires prompt notification to the facility's leadership (e.g., medical director) to initiate a coordinated response. The presence of four Enterococcus cases, including a multidrug-resistant strain, within a single ECF wing over a month suggests a potential cluster, necessitating urgent action to assess the scope, implement control measures, and allocate resources. The CDC's "Management of Multidrug-Resistant Organisms in Healthcare Settings" (2006) recommends immediate reporting to facility leadership as the first step to activate an outbreak investigation team, making this the priority.
Option B, "Compare the four culture reports and sensitivity patterns," is an important subsequent step in outbreak investigation. Analyzing the antibiotic susceptibility profiles and culture sources can confirm whether the cases are epidemiologically linked (e.g., clonal spread of VRE) and guide treatment and control strategies. However, this is a detailed analysis that follows initial notification and should not delay alerting the medical director. Option C, "Conduct surveillance cultures for this organism in all residents," is a proactive measure to determine the prevalence of Enterococcus faecium, especially VRE, within the wing. The CDC recommends targeted surveillance during outbreaks, but this requires prior authorization and planning by the outbreak team, making it a secondary action after notification. Option D, "Notify the nursing administrator to close the wing to new admissions," may be a control measure to prevent further spread, as suggested by the CDC for MDRO outbreaks. However, closing a unit is a significant decision that should be guided by the medical director and infection control team after assessing the situation, not an immediate independent action by the IP.
The CBIC Practice Analysis (2022) and CDC guidelines prioritize rapid communication with leadership to initiate a structured outbreak response, including resource allocation and policy adjustments. Given the multidrug-resistant nature and cluster pattern, notifying the medical director (Option A) is the most immediate and appropriate action to ensure a comprehensive response.
References:
* CBIC Practice Analysis, 2022.
* CDC Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006.

NEW QUESTION # 68
The primary source of organisms that cause surgical silo infections is the

- A. healthcare personnel's hands.
- B. operating room environment.
- C. patient's endogenous flora
- D. operating room personnel.

Answer: C

Explanation:
The primary source of organisms causing surgical site infections (SSIs) is the patient's own endogenous flora. Bacteria from the skin, mucous membranes, or gastrointestinal tract contaminate the surgical site, leading to infection. Common pathogens include Staphylococcus aureus, coagulase-negative staphylococci, and Enterobacteriaceae.

Why the Other Options Are Incorrect?
* A. Operating room environment - While environmental contamination can contribute, it is not the primary source.
* B. Operating room personnel - Infection control measures (hand hygiene, gloves, masks) reduce transmission from personnel.
* D. Healthcare personnel's hands - Although hand contamination is a risk, it is secondary to the patient's endogenous flora.
CBIC Infection Control Reference
According to APIC guidelines, the patient's own flora is the primary source of SSIs.

NEW QUESTION # 69
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