

CBIC.CIC.v2026-06-15.q123

Exam Code:	CIC
Exam Name:	CBIC Certified Infection Control Exam
Certification Provider:	CBIC
Free Question Number:	123
Version:	v2026-06-15
# of views:	187
# of Questions views:	1230
https://www.freepdfdumps.com/CBIC.CIC.v2026-06-15.q123.html	

NEW QUESTION: 1

The rate of catheter-associated urinary tract infections (CAUTIs) has decreased following recent practice changes. To present these results to the Quality Committee, the infection preventionist should use:

- A. An affinity diagram.
- B. A root cause analysis.
- C. A run chart.
- D. A fishbone diagram.

Answer: (SHOW ANSWER)

To communicate that CAUTI rates decreased after practice changes, the best tool is a run chart, which displays a measure over time and helps determine whether observed changes represent real improvement rather than random variation. The Institute for Healthcare Improvement (IHI) describes run charts as graphs of data over time and emphasizes that improvement and sustainability are demonstrated by observing patterns and shifts over time.

Run charts are especially appropriate for infection prevention metrics because they allow a Quality Committee to see: (1) the baseline period before interventions, (2) the timing of practice changes, and (3) whether there is a sustained downward trend or "shift" in CAUTI rates. Patient safety measurement guidance likewise notes that run charts are a standard quality tool to display trends in patient-safety measures over time and evaluate whether process changes are leading to improvement.

By contrast, an affinity diagram organizes ideas/themes, and fishbone diagrams and root cause analyses are primarily for analyzing causes of a problem-not for clearly presenting a time-based improvement result to leadership. A run chart is therefore the most appropriate communication method.

NEW QUESTION: 2

To understand how their hospital-acquired infection rates compare to other health care settings, an infection preventionist (IP) plans to use benchmarking.

Which of the following criteria is important to ensure accurate benchmarking of surveillance data?

- A. Data collectors are trained on how to collect data
- B. Collecting data on a small population to ensure accuracy of data collection
- C. Denominator rates are selected based on an organizational risk assessment
- D. Using case definitions that are adjusted for the patient population being studied

Answer: D (LEAVE A REPLY)

Benchmarking compares infection rates across healthcare facilities. For accurate benchmarking, case definitions must be standardized and adjusted for patient demographics, severity of illness, and other risk factors.

Why the Other Options Are Incorrect?

- * A. Data collectors are trained on how to collect data - Training is necessary, but it does not directly ensure comparability between facilities.
- * B. Collecting data on a small population - A larger sample size increases accuracy and reliability in benchmarking.
- * C. Denominator rates selected based on an organizational risk assessment - Risk assessment is important, but standardized case definitions are critical for comparison.

CBIC Infection Control Reference

According to APIC, accurate benchmarking relies on using standardized case definitions that account for differences in patient populations.

NEW QUESTION: 3

An infection preventionist wishes to compare central line infection rates with those of a national database.

What consideration is of prime importance in making this comparison?

- A. Comparable skin preparation prior to insertion
- B. Use of identical types of central lines
- C. Similar sizes of facilities in the database
- D. Same definition of central line infection

Answer: D (LEAVE A REPLY)

The Certification Study Guide (6th edition) stresses that valid comparison of infection rates requires consistent surveillance definitions and methodologies. When comparing a facility's central line-associated bloodstream infection (CLABSI) rates to those reported in a national database, the single most important consideration is the use of the same case definition for central line infection. Without standardized definitions, rate comparisons are unreliable and may lead to incorrect conclusions about performance.

National databases rely on precise, standardized criteria for what constitutes a CLABSI, including timing, clinical signs, laboratory confirmation, and attribution to a central line. If a facility applies different criteria- such as alternative timing windows, inclusion/exclusion

rules, or diagnostic thresholds-the resulting rates may be artificially higher or lower than benchmark data. The study guide emphasizes that comparability hinges on alignment of numerators (cases) and denominators (central line days) using identical definitions.

The other options, while relevant to prevention practices or contextual understanding, are not primary requirements for valid comparison. Skin preparation methods and types of lines influence risk but do not ensure comparability of reported rates. Facility size can affect risk profiles, but standardized definitions allow for risk adjustment within databases. This question reflects a core CIC exam principle: benchmarking is meaningful only when surveillance definitions are consistent. Ensuring alignment with national definitions is foundational to accurate performance evaluation and quality improvement.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION: 4

In order to ensure accurate calculation of central line days, which of the following is TRUE?

- A.** Tunneled catheters and ports should be excluded.
- B.** A catheter should be in place for longer than 24 hours to be counted.
- C.** A patient with more than one device is counted as 1 device day.
- D.** Peripheral lines should be included in ICU data.

Answer: (SHOW ANSWER)

The CBIC Certified Infection Control Exam Study Guide (6th edition) follows the standardized surveillance methodology used for calculating central line days, which is essential for accurate reporting of central line-associated bloodstream infection (CLABSI) rates. A central line day is counted for each patient who has one or more central lines in place at the time of the daily count, regardless of the number of central lines present. Therefore, if a patient has more than one central line, the patient is still counted as one central line day, making option C the correct statement. This approach ensures consistency and comparability of CLABSI rates across units and facilities.

Option A is incorrect because tunneled central venous catheters and implanted ports are included in central line counts if they meet the definition of a central line. Option B is incorrect because a central line is counted on any day it is present, even if it has been in place for less than 24 hours. Option D is incorrect because peripheral intravenous lines are not central lines and must never be included in central line day counts.

Accurate calculation of device days is a foundational surveillance competency for infection preventionists.

Understanding these definitions is critical for valid CLABSI rate calculation, benchmarking, and performance improvement and is a frequently tested concept on the CIC exam.

NEW QUESTION: 5

Which of the following is an example of an outcome measure?

- A.** Hand hygiene compliance rate

- B.** Adherence to Environmental Cleaning
- C.** Rate of multi-drug resistant organisms acquisition
- D.** Timing of preoperative antibiotic administration

Answer: C (LEAVE A REPLY)

The correct answer is C, "Rate of multi-drug resistant organisms acquisition," as it represents an example of an outcome measure. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, outcome measures are indicators that reflect the impact or result of infection prevention and control interventions on patient health outcomes or the incidence of healthcare-associated infections (HAIs).

The rate of multi-drug resistant organisms (MDRO) acquisition directly measures the incidence of new infections caused by resistant pathogens, which is a key outcome affected by the effectiveness of infection control practices (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.4 - Evaluate the effectiveness of infection prevention and control interventions).

Option A (hand hygiene compliance rate) is an example of a process measure, which tracks adherence to specific protocols or practices intended to prevent infections, rather than the resulting health outcome. Option B (adherence to environmental cleaning) is also a process measure, focusing on the implementation of cleaning protocols rather than the end result, such as reduced infection rates. Option D (timing of preoperative antibiotic administration) is another process measure, assessing the timeliness of an intervention to prevent surgical site infections, but it does not directly indicate the outcome (e.g., infection rate) of that intervention.

Outcome measures, such as the rate of MDRO acquisition, are critical for evaluating the success of infection prevention programs and are often used to guide quality improvement initiatives. This aligns with CBIC's emphasis on using surveillance data to assess the effectiveness of interventions and inform decision-making (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.5 - Use data to guide infection prevention and control strategies). The focus on MDRO acquisition specifically highlights a significant healthcare challenge, making it a prioritized outcome measure in infection control.

References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competencies 2.4 - Evaluate the effectiveness of infection prevention and control interventions, 2.5 - Use data to guide infection prevention and control strategies.

NEW QUESTION: 6

A 22-year-old male has a splenectomy secondary to trauma. Which of the following vaccines is MOST important for this patient?

- A.** Haemophilus influenzae type B
- B.** Pneumococcal
- C.** Hepatitis B
- D.** Varicella

Answer: (SHOW ANSWER)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that patients who have undergone splenectomy are at significantly increased risk for overwhelming postsplenectomy infection (OPSI), a rapidly progressive and potentially fatal condition. The spleen plays a critical role in clearing encapsulated organisms, and its absence markedly increases susceptibility to infections caused by these pathogens. Among encapsulated bacteria, *Streptococcus pneumoniae* is the most common and most deadly cause of OPSI, making pneumococcal vaccination the single most important immunization for asplenic patients.

Pneumococcal disease in individuals without a spleen can progress rapidly to sepsis, meningitis, or death, even in young and otherwise healthy adults. Therefore, ensuring pneumococcal vaccination—using the appropriate conjugate and polysaccharide vaccines according to age and immunization history—is a top priority.

While *Haemophilus influenzae* type B (Option A) and meningococcal vaccines are also recommended for asplenic patients, pneumococcal vaccination provides the greatest immediate protection against the most common cause of severe infection. Hepatitis B (Option C) and varicella (Option D) are important routine immunizations but are not specifically related to the increased infection risk associated with asplenia.

For the CIC exam, it is critical to recognize that loss of splenic function necessitates prioritization of vaccines targeting encapsulated organisms, with pneumococcal vaccination being the most important.

NEW QUESTION: 7

An infection preventionist (IP) meets with the operating room staff to discuss an increased number of patients with infections caused by different organisms after joint replacement surgeries. After reviewing case records, the operating room staff members note compliance with operating room standards. Which of the following options BEST explains this discrepancy?

- A. The operating room data collectors are inexperienced.
- B. The IP is unfamiliar with operating room processes.
- C. Process indicators may not explain outcomes.
- D. The time frames for the data collection are different.

Answer: C (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) clearly differentiates between process measures and outcome measures in infection prevention and quality improvement. Process indicators measure whether specific practices or standards are being followed, such as adherence to operating room protocols, environmental controls, or sterile technique. Outcome indicators, on the other hand, reflect the end result, such as the occurrence of surgical site infections (SSIs).

In this scenario, operating room staff demonstrate compliance with established standards, yet an increase in post-joint replacement infections is observed. This discrepancy is best

explained by the principle that process compliance alone does not guarantee desired outcomes. Even when processes appear to be correctly followed, infections may still occur due to factors outside the measured processes, such as patient-related risk factors, organism virulence, antimicrobial resistance, or unmeasured system variables.

Options A and B incorrectly focus on personnel competency rather than measurement limitations. Option D may affect data interpretation but does not explain why compliant processes fail to correlate with outcomes.

The Study Guide emphasizes that outcome measures are influenced by multiple interacting variables, and therefore a single set of process indicators may not fully explain infection trends.

For the CIC exam, it is critical to understand that process measures support improvement but do not always predict outcomes, highlighting the need for comprehensive analysis when infection rates rise despite apparent compliance.

NEW QUESTION: 8

Which of the following community-acquired infections has the greatest potential public health impact?

- A.** Cryptosporidium enteritis
- B.** Fifth disease (parvovirus B-19)
- C.** Clostridial myositis (gas gangrene)
- D.** Cryptococcal meningitis

Answer: A (LEAVE A REPLY)

The correct answer is A, "Cryptosporidium enteritis," as it has the greatest potential public health impact among the listed community-acquired infections. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the public health impact of an infection is determined by factors such as its transmissibility, severity, population at risk, and potential for outbreaks. Cryptosporidium enteritis, caused by the protozoan parasite *Cryptosporidium*, is a waterborne illness that spreads through contaminated water or food, leading to severe diarrhea, particularly in immunocompromised individuals. Its significant public health impact stems from its high transmissibility in community settings (e.g., via recreational water or daycare centers), the difficulty in eradicating the oocysts with standard chlorination, and the potential to cause large-scale outbreaks affecting vulnerable populations, such as children or the elderly (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology). This is exemplified by notable outbreaks, such as the 1993 Milwaukee outbreak affecting over 400,000 people.

Option B (Fifth disease, caused by parvovirus B-19) is a viral infection primarily affecting children, causing a mild rash and flu-like symptoms. While it can pose risks to pregnant women (e.g., fetal anemia), it is generally self-limiting and has limited community-wide transmission potential, reducing its public health impact. Option C (clostridial myositis, or gas gangrene, caused by *Clostridium perfringens*) is a severe but rare infection typically

associated with traumatic wounds or surgery, with limited person-to-person spread, making its public health impact low due to its sporadic nature. Option D (cryptococcal meningitis, caused by *Cryptococcus neoformans*) primarily affects immunocompromised individuals (e.g., those with HIV/AIDS) and is not highly transmissible in the general community, confining its impact to specific at-risk groups rather than the broader population.

The selection of *Cryptosporidium* enteritis aligns with CBIC's focus on identifying infections with significant epidemiological implications, enabling infection preventionists to prioritize surveillance and control measures for diseases with high outbreak potential (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.1 - Conduct surveillance for healthcare-associated infections and epidemiologically significant organisms). This is supported by CDC data highlighting waterborne pathogens as major public health concerns (CDC Parasites - *Cryptosporidium*, 2023).

References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology; Domain II: Surveillance and Epidemiologic Investigation, Competency 2.1 - Conduct surveillance for healthcare-associated infections and epidemiologically significant organisms. CDC Parasites - *Cryptosporidium*, 2023.

NEW QUESTION: 9

A ventilator-associated pneumonia rate in the ICU has increased from 8.1 infections/1,000 ventilator days to

15.4 infections/1,000 ventilator days over the past two months. To determine the root cause for this increase, the MOST appropriate tool for a performance improvement team is a:

- A.** Fishbone diagram
- B.** Pareto chart
- C.** Flow diagram
- D.** Control chart

Answer: A (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) identifies the fishbone diagram, also known as a cause-and-effect diagram or Ishikawa diagram, as the most appropriate tool for conducting root cause analysis when investigating an increase in adverse outcomes such as ventilator-associated pneumonia (VAP). This tool is specifically designed to systematically explore multiple contributing factors that may be driving a problem.

A fishbone diagram helps a multidisciplinary performance improvement team organize potential causes into logical categories, commonly including people, processes, equipment, environment, materials, and policies. In the case of rising VAP rates, the team might examine factors such as ventilator care practices, oral hygiene compliance, head-of-bed elevation, sedation practices, staffing levels, equipment maintenance, and adherence to prevention bundles. By visually mapping these contributors, the team can identify

underlying system issues rather than focusing on isolated events or individual performance.

The other tools listed are less appropriate for root cause determination. A Pareto chart is useful for prioritizing the most frequent contributors after causes are identified, but it does not identify causes itself. A flow diagram maps process steps but does not analyze why failures occur. A control chart monitors variation over time but does not explain causation. For CIC exam preparation, it is essential to recognize that fishbone diagrams are the primary tool for identifying root causes in performance improvement investigations involving increased infection rates.

NEW QUESTION: 10

Which of the following correctly characterizes endovaginal ultrasound probes?

- A.** They must be sterilized with a liquid chemical sterilant after use.
- B.** They are protected from viral contamination if covered by a sheath.
- C.** They are critical items based on the Spaulding Classification System.
- D.** They may be contaminated with human papillomavirus pre-examination.

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) classifies endovaginal ultrasound probes as semi-critical devices because they come into contact with mucous membranes. As such, they require high-level disinfection (HLD) between patients, not sterilization, unless the manufacturer specifically requires it. This immediately eliminates option A, which incorrectly states sterilization is required.

Option B is incorrect because probe covers or sheaths do not eliminate the risk of contamination. Numerous studies referenced in infection prevention literature and reflected in the study guide demonstrate that probe covers can fail, tear, or leak, allowing microorganisms-including viruses-to contaminate the probe surface.

Therefore, HLD is required regardless of sheath use.

Option C is incorrect because critical items, by definition, enter sterile tissue or the vascular system.

Endovaginal probes contact mucous membranes only and are therefore not critical items under the Spaulding Classification System.

Option D is correct because endovaginal probes may be contaminated with human papillomavirus (HPV) prior to examination, even when probe covers are used. HPV is particularly concerning due to its resistance to some low-level disinfectants and its ability to persist on surfaces. The study guide highlights HPV as a key organism driving strict reprocessing requirements for these probes.

This question reflects a high-yield CIC exam concept: probe covers do not replace high-level disinfection, and viral contamination-including HPV-remains a significant risk.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 10: Cleaning, Sterilization, Disinfection, and Asepsis.

NEW QUESTION: 11

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

Answer: C (LEAVE A REPLY)

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: 12

An infection preventionist recommended incorporating the *Mycobacterium tuberculosis* (MTB) conversion rate as part of the facility's annual risk assessment. Occupational Health provided the number of conversions among healthcare personnel (HCP) during the last year. Which additional information is needed to calculate the HCP conversion rate?

- A.** Number of HCP tested for MTB during the last year
- B.** Number of HCP that cared for patients with MTB in the last year
- C.** Number of HCP with unprotected exposure to patients with MTB in the last year
- D.** Number of HCP with positive tuberculin skin test or interferon gamma release assay in the last year

Answer: A (LEAVE A REPLY)

The Certification Study Guide (6th edition) defines the MTB conversion rate among healthcare personnel as a surveillance metric used in tuberculosis risk assessments to evaluate potential occupational exposure within a healthcare facility. A conversion represents a change from a previously negative TB screening test (such as a tuberculin skin test or interferon gamma release assay) to a positive result within a defined time period, typically one year.

To calculate a conversion rate, two elements are required: a numerator and a denominator. In this scenario, Occupational Health has already provided the numerator-the number of documented MTB conversions among HCP during the last year. The missing component is the denominator, which is the total number of HCP tested for MTB during that same time period. Without knowing how many personnel were screened, it is not possible to calculate a meaningful rate or trend.

The other options do not provide the appropriate denominator. Knowing how many HCP cared for TB patients or had unprotected exposures may inform risk evaluation but does not allow calculation of a rate. The number of HCP with positive tests reflects prevalence, not conversion, and does not account for baseline negative status.

The study guide emphasizes that accurate TB risk assessments rely on proper rate calculations, not raw counts. This concept is frequently tested on the CIC exam to ensure infection preventionists can correctly interpret occupational health surveillance data.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 6: Employee

/Occupational Health; Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION: 13

One of the elements of antibiotic stewardship is controlling antibiotic use. Which of the following BEST describes a closed formulary?

- A.** Requires the prescribing physician to obtain some form of approval before the antibiotic will be dispensed.
- B.** Automatic switching from broad-spectrum empiric therapy to narrower-spectrum agents.
- C.** Practice of rotating two or more classes of formulary drugs on a regular basis.
- D.** Limits the number of antibiotics available for physicians to prescribe.

Answer: (SHOW ANSWER)

Antibiotic stewardship programs are designed to optimize antimicrobial use, improve patient outcomes, reduce antimicrobial resistance, and decrease unnecessary costs. The CBIC Certified Infection Control Exam Study Guide (6th edition) identifies formulary restriction and preauthorization as key core strategies within effective antimicrobial stewardship programs. A closed formulary specifically refers to a system in which access to certain antibiotics is restricted and requires prior approval before dispensing.

In a closed formulary model, prescribers must obtain authorization-often from infectious diseases specialists, pharmacy, or an antimicrobial stewardship team-before selected antimicrobial agents can be used. This approach ensures that high-risk, broad-spectrum, or high-cost antibiotics are used only when clinically appropriate. By requiring approval, the organization promotes judicious antibiotic selection, prevents unnecessary exposure, and supports resistance prevention efforts.

Option B describes de-escalation, which is another stewardship strategy but does not define a closed formulary. Option C refers to antibiotic cycling, a controversial and less-

supported strategy. Option D is incorrect because a closed formulary does not merely limit availability; rather, it controls access through approval mechanisms.

For the CIC exam, it is critical to distinguish between stewardship strategies. A closed formulary is best characterized by mandatory approval prior to dispensing, making option A the most accurate answer according to the Study Guide's antimicrobial stewardship framework.

NEW QUESTION: 14

Which of the following management activities should be performed FIRST?

- A.** Evaluate project results
- B.** Establish goals
- C.** Plan and organize activities
- D.** Assign responsibility for projects

Answer: ([SHOW ANSWER](#))

To determine which management activity should be performed first, we need to consider the logical sequence of steps in effective project or program management, particularly in the context of infection control as guided by CBIC principles. Management activities typically follow a structured process, and the order of these steps is critical to ensuring successful outcomes.

A). Evaluate project results: Evaluating project results involves assessing the outcomes and effectiveness of a project after its implementation. This step relies on having completed the project or at least reached a stage where outcomes can be measured.

Performing this activity first would be premature, as there would be no results to evaluate without prior planning, goal-setting, and execution. Therefore, this cannot be the first step.

B). Establish goals: Establishing goals is the foundational step in any management process. Goals provide direction, define the purpose, and set the criteria for success. In the context of infection control, as emphasized by CBIC, setting clear objectives (e.g., reducing healthcare-associated infections by a specific percentage) is essential before any other activities can be planned or executed. This step aligns with the initial phase of strategic planning, making it the logical first activity. Without established goals, subsequent steps lack focus and purpose.

C). Plan and organize activities: Planning and organizing activities involve developing a roadmap to achieve the goals, including timelines, resources, and tasks. This step depends on having clear goals to guide the planning process. In infection control, this might include designing interventions to meet infection reduction targets. While critical, it cannot be the first step because planning requires a predefined objective to be effective.

D). Assign responsibility for projects: Assigning responsibility involves delegating tasks and roles to individuals or teams. This step follows the establishment of goals and planning, as responsibilities need to be aligned with the specific objectives and organized activities. In an infection control program, this might mean assigning staff to monitor compliance with

hand hygiene protocols. Doing this first would be inefficient without a clear understanding of the goals and plan.

The correct sequence in management, especially in a structured field like infection control, begins with establishing goals to provide a clear target. This is followed by planning and organizing activities, assigning responsibilities, and finally evaluating results. The CBIC framework supports this approach by emphasizing the importance of setting measurable goals as part of the infection prevention and control planning process, which is a prerequisite for all subsequent actions.

CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain V:

Management and Communication, which highlights the importance of setting goals as the initial step in managing infection control programs.

CBIC Examination Content Outline, Domain V: Leadership and Program Management, which underscores the need for goal-setting prior to planning and implementation of infection control initiatives.

NEW QUESTION: 15

Which of the following activities will BEST prepare a newly hired infection preventionist to present information at the facility's orientation program?

- A.** Observing other departments' orientation presentations
- B.** Meeting with the facility's leadership
- C.** Reviewing principles of adult learning
- D.** Administering tuberculin skin tests to orientees

Answer: ([SHOW ANSWER](#))

The correct answer is C, "Reviewing principles of adult learning," as this activity will best prepare a newly hired infection preventionist to present information at the facility's orientation program. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, effective education delivery, especially for healthcare professionals during orientation, relies on understanding adult learning principles (e.g., andragogy), which emphasize learner-centered approaches, relevance to practice, and active participation.

Reviewing these principles equips the infection preventionist (IP) to design and deliver content that addresses the specific needs, experiences, and motivations of the audience—such as new staff learning infection control protocols—enhancing engagement and retention (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs). This preparation ensures the presentation is tailored, impactful, and aligned with the goal of promoting infection prevention behaviors. Option A (observing other departments' orientation presentations) can provide insights into presentation styles or facility norms, but it is less focused on the IP's specific educational role and may not address the unique content of infection prevention. Option B (meeting with the facility's leadership) is valuable for understanding organizational priorities and

gaining support, but it is more about collaboration and context- setting rather than direct preparation for presenting educational material. Option D (administering tuberculin skin tests to orientees) is a clinical task related to TB screening, not a preparatory activity for designing or delivering an educational presentation.

The focus on reviewing adult learning principles aligns with CBIC's emphasis on evidence-based education strategies to improve infection control practices among healthcare personnel (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs).

This approach enables the IP to effectively communicate critical information, such as hand hygiene or isolation protocols, during the orientation program.

References: CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competencies 4.1 - Develop and implement educational programs, 4.2 - Evaluate the effectiveness of educational programs.

NEW QUESTION: 16

An environmental services staff member sustained a needle-stick injury while collecting garbage and immediately called the Occupational Health (OH) department for further direction. What should the OH department recommend FIRST?

- A.** Administer first aid treatment
- B.** Schedule an appointment with the OH department
- C.** Discuss the exposure incident with staff to decide on the level of risk
- D.** Obtain and assess immune status to bloodborne pathogens

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) emphasizes that immediate first aid is the first and most critical step following an occupational exposure to blood or body fluids, including needle-stick injuries. First aid measures include promptly washing the affected area with soap and water and flushing mucous membranes with water if exposed. This immediate action helps reduce the microbial load at the exposure site and may lower the risk of transmission of bloodborne pathogens such as hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

The study guide outlines a clear sequence for managing occupational exposures. Initial wound care always precedes risk assessment, documentation, immune status evaluation, and post-exposure prophylaxis decisions.

Delaying first aid to gather information or schedule appointments is inconsistent with best practice and increases potential risk to the exposed worker.

The other options represent appropriate subsequent steps, not first actions. Scheduling an OH appointment and assessing immune status are important but occur after immediate wound care. Discussing the exposure to determine risk level is also essential, but only after first aid has been provided.

CIC exam questions frequently assess understanding of prioritization and sequencing in occupational exposure management. Recognizing that immediate first aid is always the

first intervention reflects sound infection prevention practice and aligns with established occupational health protocols.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 6: Employee /Occupational Health.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 17

Which of the following factors is important in assessing the risk of Mycobacterium tuberculosis (MTB) exposure at a healthcare facility?

- A.** The number of cases of active MTB in the community served by the facility.
- B.** The number of airborne infection isolation rooms available within the facility.
- C.** The rate of healthcare personnel at the facility with positive MTB screening tests.
- D.** The compliance rate for annual N-95 fit testing among healthcare personnel at the facility.

Answer: A (LEAVE A REPLY)

The Certification Study Guide (6th edition) explains that assessment of Mycobacterium tuberculosis (MTB) risk in healthcare settings begins with evaluating the likelihood that patients with active TB will present to the facility. One of the most important determinants of this likelihood is the incidence of active TB disease in the community served by the healthcare facility. Facilities serving populations with higher TB prevalence are at increased risk of exposure events and must tailor their TB prevention and control programs accordingly.

The study guide emphasizes that TB risk assessments are population-based and epidemiologic in nature.

Community TB rates directly influence the frequency with which undiagnosed or unsuspected infectious TB patients may enter the healthcare system, potentially exposing healthcare personnel (HCP) and other patients.

This factor drives decisions regarding surveillance intensity, education, respiratory protection programs, and engineering controls.

The other options represent control measures or outcomes, not primary risk determinants. The number of airborne infection isolation rooms reflects facility preparedness, not exposure risk. Rates of positive HCP screening tests may indicate past exposure but are

not used to assess initial risk. Compliance with N-95 fit testing is a program performance indicator, not a measure of TB exposure likelihood.

CIC exam questions commonly distinguish between risk assessment inputs versus mitigation strategies.

Recognizing community TB incidence as the foundational risk factor is essential for accurate TB program planning and compliance with recommended infection prevention standards.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 6: Employee

/Occupational Health; Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION: 18

An infection preventionist has been asked to participate in a process improvement team to standardize disinfection and sterilization practices. Team activities should include all of the following EXCEPT:

- A.** Observing disinfection and sterilization practices.
- B.** Asking central supply and operating room managers to join the team.
- C.** Performing a literature review on central supply and sterilization.
- D.** Developing a baseline measurement after all changes are implemented.

Answer: (SHOW ANSWER)

In quality improvement, a baseline measurement is collected before implementing changes so the team can compare performance over time and determine whether interventions produced improvement. Creating the baseline after changes are implemented defeats the purpose of baseline data because it removes the "pre- intervention" reference point needed to evaluate impact and sustainment. Quality improvement measurement guidance emphasizes capturing a baseline and then continuing measurement at regular intervals to judge the effect of an intervention.

The other activities listed are appropriate for standardizing disinfection and sterilization practices. Direct observation (A) is a common process-assessment method to identify gaps between policy and actual practice.

Including central sterile/central supply and OR leaders (B) supports multidisciplinary engagement and ensures changes are operationally feasible where reprocessing occurs. Performing a literature and guidance review (C) helps align local practice with authoritative recommendations (e.g., CDC disinfection/sterilization guidance and monitoring expectations).

NEW QUESTION: 19

The operating room director asks the infection preventionist (IP) to join a team focusing on the purchase of robotic surgical equipment. What item will the IP review FIRST?

- A.** Cost of the equipment
- B.** Effect of equipment on length of surgery

C. Storage of the equipment between surgical cases

D. Manufacturer's instructions for use

Answer: D (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that when evaluating new medical or surgical equipment, the first priority for the infection preventionist is reviewing the manufacturer's instructions for use (IFU). The IFU provides critical information regarding cleaning, disinfection, sterilization, handling, storage, and maintenance requirements, all of which directly impact infection prevention and patient safety.

Robotic surgical equipment often includes complex components, lumens, joints, and reusable instruments that may require specialized reprocessing methods. The IP must ensure that the facility has the infrastructure, staffing, competency, and resources to meet the IFU requirements before purchase. Failure to comply with manufacturer instructions places the organization at risk for ineffective reprocessing, device contamination, healthcare-associated infections, and regulatory noncompliance.

The other options are secondary considerations. Cost (Option A) and operative time impact efficiency and budgeting but do not address infection risk. Storage between cases (Option C) is important but cannot be properly evaluated without first understanding IFU requirements. Length of surgery (Option B) may influence infection risk but is not within the primary evaluative scope of infection prevention during equipment selection.

For the CIC exam, it is essential to recognize that IFU review is the foundational step in product evaluation.

Infection preventionists must confirm that equipment can be safely and consistently reprocessed according to manufacturer specifications before any operational or financial considerations are addressed.

NEW QUESTION: 20

Which of the following individuals should be excluded from receiving live attenuated influenza virus?

A. Pregnant persons

B. Healthy persons aged 2 to 49

C. Persons with allergies to chicken feathers

D. Persons simultaneously receiving an inactivated vaccine

Answer: A (LEAVE A REPLY)

The correct answer is A, "Pregnant persons," as they should be excluded from receiving the live attenuated influenza virus (LAIV) vaccine. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, which align with recommendations from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP), the LAIV, commonly known as the nasal spray flu vaccine, contains a live attenuated form of the influenza virus. This vaccine is contraindicated in pregnant individuals due to the theoretical risk of the attenuated virus

replicating and potentially harming the fetus, despite limited evidence of adverse outcomes (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents).

Pregnant persons are instead recommended to receive the inactivated influenza vaccine (IIV), which is considered safe during pregnancy.

Option B (healthy persons aged 2 to 49) is incorrect because this group is generally eligible to receive LAIV, provided they have no other contraindications, as the vaccine is approved for healthy, non-pregnant individuals in this age range (CDC Immunization Schedules, 2024). Option C (persons with allergies to chicken feathers) is not a contraindication for LAIV; the vaccine is produced in eggs, and while egg allergy was historically a concern, current guidelines indicate that LAIV can be administered to persons with egg allergies if they can tolerate egg in their diet, with precautions managed by healthcare providers. Option D (persons simultaneously receiving an inactivated vaccine) is also incorrect, as LAIV can be co-administered with inactivated vaccines without issue, according to ACIP recommendations, as there is no significant interference between the two vaccine types.

The exclusion of pregnant persons reflects CBIC's emphasis on tailoring infection prevention strategies, including vaccination programs, to protect vulnerable populations while minimizing risks (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). This decision is based on precautionary principles outlined in CDC and ACIP guidelines to ensure maternal and fetal safety (CDC Prevention and Control of Seasonal Influenza with Vaccines, 2023).

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.1 - Collaborate with organizational leaders, 3.2 - Implement measures to prevent transmission of infectious agents. CDC Prevention and Control of Seasonal Influenza with Vaccines, 2023. CDC Immunization Schedules, 2024.

NEW QUESTION: 21

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 medical director of the outbreak.

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

Answer: A (LEAVE A REPLY)

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: 22

An infection preventionist receives a call from a healthcare personnel (HCP) who is in the first trimester of pregnancy and has cared for a patient with cytomegalovirus (CMV) pneumonitis. Which of the following actions is MOST appropriate?

- A.** Recommend the pregnant HCP receive immediate post-exposure follow-up.
- B.** Reassign the HCP to a low-risk patient care area until second trimester.
- C.** Emphasize consistent adherence to Standard Precautions.
- D.** Instruct the HCP to wear a mask during patient care activities.

Answer: ([SHOW ANSWER](#))

The CBIC Certified Infection Control Exam Study Guide (6th edition) states that cytomegalovirus (CMV) is a common virus transmitted through direct contact with body fluids, including saliva, urine, blood, and respiratory secretions. In healthcare settings, Standard Precautions are sufficient to prevent CMV transmission, even for pregnant healthcare personnel.

Importantly, routine reassignment, work restriction, or removal from patient care is not recommended for pregnant HCP caring for patients with CMV, including those in the first trimester. The Study Guide emphasizes that the most effective preventive measure is strict adherence to Standard Precautions, particularly hand hygiene and appropriate use of personal protective equipment when contact with body fluids is anticipated. These measures have been shown to significantly reduce the risk of CMV acquisition.

Option A is incorrect because there is no indication for immediate post-exposure evaluation in the absence of a recognized exposure such as a needlestick or mucous membrane contact. Option B is not supported by evidence or guidelines and may contribute to unnecessary workforce restrictions. Option D is insufficient and misleading, as CMV is not transmitted via the airborne route and masking alone does not address the primary transmission risks.

For CIC exam preparation, it is critical to recognize that education and reinforcement of Standard Precautions-not work exclusion-are the cornerstone of CMV prevention for pregnant healthcare workers.

NEW QUESTION: 23

In an outbreak of probable foodborne illness, a group of individuals develops watery diarrhea 48 hours after eating imported shellfish. The MOST likely causative organism is:

- A.** *Vibrio cholerae*

- B. Hepatitis A virus
- C. Staphylococcus aureus
- D. Listeria monocytogenes

Answer: A (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) highlights that consumption of raw or undercooked shellfish, particularly imported shellfish, is a well-recognized risk factor for waterborne and foodborne *Vibrio* infections, including *Vibrio cholerae*. The organism thrives in warm coastal waters and can contaminate shellfish harvested from endemic or inadequately regulated regions.

The clinical presentation described—profuse watery diarrhea occurring approximately 48 hours after exposure—is classic for *Vibrio cholerae*. The organism produces cholera toxin, which causes rapid fluid secretion into the intestinal lumen, resulting in large-volume watery stools. The incubation period typically ranges from a few hours to five days, making a 48-hour onset highly consistent with this pathogen.

The other options are less likely based on incubation period and symptom profile. Hepatitis A virus has an incubation period of weeks and presents with jaundice rather than acute watery diarrhea. *Staphylococcus aureus* food poisoning causes rapid onset (1-6 hours) due to preformed toxin and is commonly associated with vomiting. *Listeria monocytogenes* typically causes invasive disease rather than acute watery diarrhea and has a longer incubation period.

For CIC exam preparation, recognizing shellfish-associated watery diarrhea with short incubation as characteristic of *Vibrio cholerae* is essential, particularly in outbreak investigations involving imported seafood.

NEW QUESTION: 24

The infection preventionist (IP) is notified about the recall of certain ice machines because of a faulty filtration device. These ice machines are located on several units throughout the facility. What is the BEST action the IP should take?

- A. Culture all ice machines for *Legionella*
- B. Report a waterborne disease outbreak to Administration
- C. Identify all patients who have been served ice from these machines
- D. Supply an alternative source of ice while investigating further

Answer: D (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that when a device recall involves potential contamination risk, the infection preventionist's first priority is risk mitigation and prevention of further exposure. In this scenario, the recall of ice machines due to a faulty filtration device represents a potential waterborne contamination risk, even in the absence of confirmed infections.

The best immediate action is to remove the recalled ice machines from service and provide an alternative source of ice while further investigation and corrective actions are underway. This step promptly eliminates the exposure pathway and protects patients, staff, and

visitors from possible contamination. The Study Guide stresses that interruption of use is the most effective initial control measure when equipment safety is in question.

Option A is incorrect because culturing ice machines is not the first step and is not routinely recommended without clinical indication. Option B is inappropriate because there is no evidence of a confirmed outbreak.

Option C may be necessary later if exposure investigation becomes warranted, but it should not precede immediate risk control.

For the CIC exam, it is essential to recognize that eliminating exposure takes precedence over testing or notification activities. Supplying an alternative ice source while investigating further aligns with risk management principles, patient safety priorities, and evidence-based infection prevention practice.

NEW QUESTION: 25

What is the most effective early detection strategy for emerging public health threats?

- A.** Visit local, state, and federal public health websites on a regular schedule.
- B.** Subscribe to public health alerts at the local, state, and/or federal level.
- C.** Attend educational and professional webinars on global outbreaks.
- D.** Rely on information provided by the facility laboratory.

Answer: ([SHOW ANSWER](#))

Early detection of emerging public health threats depends on receiving timely, actionable information that can trigger rapid assessment and response within the facility. The Certification Study Guide emphasizes preparedness for biologic threats and emerging infectious diseases as part of core infection prevention practice (e.g., planning for an influx of patients with communicable diseases and responding to emerging infections).

Subscribing to public health alerts is the most effective option because alerts are designed to push critical updates (case definitions, exposure risks, recommended control measures, and reporting expectations) as soon as they are identified by public health authorities—minimizing delay compared with periodically checking websites.

Why the other options are incorrect:

A is reactive and can miss urgent updates between scheduled checks.

C supports ongoing education but is not a real-time early warning system.

D is important for facility-level detection, but emerging threats are often identified first through public health surveillance and communications beyond a single facility's lab.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 5, p. 100.

NEW QUESTION: 26

The primary source of organisms that cause surgical site infections is the

- A.** operating room environment.
- B.** operating room personnel.
- C.** patient's endogenous flora

D. healthcare personnel's hands.

Answer: (SHOW ANSWER)

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: 27

Which of the following BEST demonstrates the effectiveness of a program targeted at reducing central-line associated bloodstream infections (CLABSIs) in an intensive care unit (ICU)?

A. A 25% decrease in the length of stay in the ICU related to CLABSIs

B. A 25% reduction in the incidence of CLABSIs over 6 months

C. A 30% decrease in total costs related to treatment of CLABSIs over 12 months

D. A 30% reduction in the use of antibiotic-impregnated central catheters over 6 months

Answer: B (LEAVE A REPLY)

Evaluating the effectiveness of a program to reduce central-line associated bloodstream infections (CLABSIs) in an intensive care unit (ICU) requires identifying the most direct and relevant measure of success. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes outcome-based assessment in the "Performance Improvement" and "Surveillance and Epidemiologic Investigation" domains, aligning with the Centers for Disease Control and Prevention (CDC) guidelines for infection prevention. The primary goal of a CLABSI reduction program is to decrease the occurrence of these infections, with secondary benefits including reduced length of stay, costs, and resource use.

Option B, "A 25% reduction in the incidence of CLABSIs over 6 months," is the best demonstration of effectiveness. The incidence of CLABSIs-defined by the CDC as the number of infections per 1,000 central line days-directly measures the program's impact on the targeted outcome: preventing bloodstream infections associated with central lines. A 25% reduction over 6 months indicates a sustained decrease in infection rates, providing clear evidence that the intervention (e.g., improved insertion techniques, maintenance

bundles, or staff education) is working. The CDC's "Guidelines for the Prevention of Intravascular Catheter-Related Infections" (2017) and the National Healthcare Safety Network (NHSN) protocols prioritize infection rate reduction as the primary metric for assessing CLABSI prevention programs.

Option A, "A 25% decrease in the length of stay in the ICU related to CLABSIs," is a secondary benefit.

Reducing CLABSI-related length of stay can improve patient outcomes and bed availability, but it is an indirect measure dependent on infection incidence. A decrease in length of stay could also reflect other factors (e.g., improved discharge planning), making it less specific to program effectiveness. Option C, "A 30% decrease in total costs related to treatment of CLABSIs over 12 months," reflects a financial outcome, which is valuable for justifying resource allocation. However, cost reduction is a downstream effect of decreased infections and may be influenced by variables like hospital pricing or treatment protocols, diluting its direct link to program success. Option D, "A 30% reduction in the use of antibiotic-impregnated central catheters over 6 months," indicates a change in practice but not necessarily effectiveness. Antibiotic-impregnated catheters are one prevention strategy, and reducing their use could suggest improved standard practices (e.g., chlorhexidine bathing), but it could also increase infection rates if not offset by other measures, making it an ambiguous indicator.

The CBIC Practice Analysis (2022) and CDC guidelines emphasize that the primary measure of a CLABSI prevention program's success is a reduction in infection incidence, as it directly addresses patient safety and the program's core objective. Option B provides the most robust and specific evidence of effectiveness over a defined timeframe.

References:

* CBIC Practice Analysis, 2022.

* CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2017.

* NHSN CLABSI Surveillance Protocol, 2021.

NEW QUESTION: 28

Which of the following operating suite design features is LEAST important for the prevention of infection?

- A.** Type of floor material
- B.** Positive pressure air handling
- C.** Placement of sinks for surgical scrubs
- D.** Control of traffic and traffic flow patterns

Answer: (SHOW ANSWER)

The correct answer is A, "Type of floor material," as it is the least important operating suite design feature for the prevention of infection compared to the other options. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the design of operating suites plays a critical role in infection prevention, particularly for surgical site infections (SSIs). While the type of floor material (e.g., vinyl, tile, or epoxy) can affect ease

of cleaning and durability, its impact on infection prevention is secondary to other design elements that directly influence air quality, hygiene practices, and personnel movement (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). Modern flooring materials are generally designed to be non-porous and easily disinfected, mitigating their role as a primary infection risk factor when proper cleaning protocols are followed.

Option B (positive pressure air handling) is highly important because it prevents the influx of contaminated air into the operating suite, reducing the risk of airborne pathogens, including those causing SSIs. This is a standard feature in operating rooms to maintain a sterile environment (AORN Guidelines for Perioperative Practice, 2023). Option C (placement of sinks for surgical scrubs) is critical for ensuring that surgical staff can perform effective hand and forearm antisepsis, a key step in preventing SSIs by reducing microbial load before surgery. Option D (control of traffic and traffic flow patterns) is essential to minimize the introduction of contaminants from outside the operating suite, as excessive or uncontrolled movement can increase the risk of airborne and contact transmission (CDC Guidelines for Environmental Infection Control in Healthcare Facilities, 2019).

The relative unimportance of floor material type stems from the fact that infection prevention relies more on consistent cleaning practices and the aforementioned design features, which directly address pathogen transmission routes. This aligns with CBIC's focus on evaluating environmental risks based on their direct impact on infection control (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols).

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.4 - Implement environmental cleaning and disinfection protocols, 3.5 - Evaluate the environment for infection risks. AORN Guidelines for Perioperative Practice, 2023. CDC Guidelines for Environmental Infection Control in Healthcare Facilities, 2019.

NEW QUESTION: 29

The infection preventionist recognizes that facility renovation projects are associated with risk for healthcare-associated infections (HAIs). What is the primary rationale for this risk?

- A.** Increased numbers of construction staff resulting in congested workspaces
- B.** Improper training regarding hand hygiene for contracted workers
- C.** Trash removal using uncovered carts
- D.** Environmental dispersal of microorganisms

Answer: D (LEAVE A REPLY)

The Certification Study Guide (6th edition) identifies environmental dispersal of microorganisms as the primary reason healthcare construction and renovation activities increase the risk of healthcare-associated infections (HAIs). Construction activities such as demolition, drilling, and ceiling penetration disturb dust and building materials that may harbor fungal spores and other microorganisms, particularly *Aspergillus* species.

Once aerosolized, these organisms can spread through airflow to patient care areas if containment and ventilation controls are inadequate.

The study guide emphasizes that immunocompromised patients-such as those in oncology units, transplant units, and intensive care settings-are especially vulnerable to infections caused by airborne fungi released during construction. Numerous outbreaks of invasive aspergillosis have been linked directly to renovation and construction projects that lacked appropriate infection control risk assessment (ICRA) measures.

The incorrect options describe secondary or contributory issues but are not the primary mechanism of infection risk. While increased personnel traffic, hand hygiene training, and waste handling are important considerations, they do not represent the central hazard posed by construction. The fundamental risk is airborne dissemination of microorganisms from disrupted environmental reservoirs.

CIC exam questions frequently test knowledge of construction-related infection risks and the importance of engineering controls such as negative pressure containment, HEPA filtration, and dust barriers. Recognizing environmental dispersal as the primary risk underscores why rigorous planning and infection control oversight are essential during renovation projects.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 9: Environment of Care.

NEW QUESTION: 30

A hospital is experiencing an increase in vancomycin-resistant Enterococcus (VRE) infections in the hematology-oncology unit. Which of the following interventions is MOST effective in halting the spread of VRE in this high-risk setting?

- A.** Screening all patients on admission and placing positive patients in isolation.
- B.** Restricting the use of vancomycin for all patients in the hospital.
- C.** Implementing a hand hygiene compliance audit and feedback system.
- D.** Conducting environmental sampling for VRE contamination weekly.

Answer: C (LEAVE A REPLY)

Comprehensive and Detailed In-Depth Explanation:

Hand hygiene remains the single most effective intervention to prevent the spread of vancomycin-resistant Enterococcus (VRE) in healthcare settings. Implementing an audit and feedback system significantly improves compliance and reduces VRE transmission.

Step-by-Step Justification:

- * Hand Hygiene Compliance Audit and Feedback (Best Strategy)
- * Studies show that poor hand hygiene is the primary mode of VRE transmission in hospitals.
- * Implementing real-time auditing with feedback ensures sustained compliance and helps identify weak areas.
- * Why Other Options Are Incorrect:
- * A. Screening all patients and isolating VRE-positive patients:

- * While screening helps identify carriers, contact precautions alone are not sufficient without strong hand hygiene enforcement.
- * B. Restricting vancomycin use:
 - * While antimicrobial stewardship is crucial, vancomycin use alone does not drive VRE outbreaks-poor infection control practices do.
- * D. Conducting environmental sampling weekly:
 - * Routine sampling is not necessary; immediate terminal disinfection and improved hand hygiene are more effective.

CBIC Infection Control References:

- * APIC Text, "VRE Prevention and Hand Hygiene," Chapter 11.
- * APIC-JCR Workbook, "Antimicrobial Resistance and Infection Control Measures," Chapter 7.

NEW QUESTION: 31

Given the formula for calculating incidence rates, the Y represents which of the following?

$$\frac{X}{Y} \times K = \text{Rate}$$

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

Answer: (SHOW ANSWER)

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, $\frac{X}{Y} \times K = \text{Rate}$, represents the standard incidence rate calculation, where K is a constant (e.g., 1,000 or 100,000) to express the rate per unit population, and the question asks what Y represents among the given options.

In the incidence rate formula, X typically represents the number of new cases (or events) of the disease occurring during a specific period, and Y represents the population at risk during that same period. The ratio $\frac{X}{Y}$ yields the rate per unit of population, which is then multiplied by K to standardize the rate (e.g., cases per 1,000 persons). The CDC defines the denominator (Y) as the population at risk, which includes individuals susceptible to the disease over the observation period. Option B ("Number of infected patients") might suggest X if it specified new cases, but as the denominator Y , 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.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 32

Based on the compiled results of learner needs assessments, the staff has an interest in hepatitis B, wound care, and continuing education credits. What should be the infection preventionist's next step?

- A. Conduct personal interviews with the staff
- B. Offer a lecture on hepatitis B and wound care
- C. Write program goals and objectives
- D. Directly observe behavioral changes

Answer: C (LEAVE A REPLY)

The infection preventionist's (IP) next step, based on the compiled results of learner needs assessments indicating staff interest in hepatitis B, wound care, and continuing education credits, should be to write program goals and objectives. This step is critical in the educational planning process, as outlined by the Certification Board of Infection Control and Epidemiology (CBIC) guidelines. According to CBIC, effective infection prevention education programs begin with a structured approach that includes defining clear goals and objectives tailored to the identified needs of the learners (CBIC Practice Analysis, 2022, Domain IV:

Education and Research, Competency 4.1 - Develop and implement educational programs). Writing program goals and objectives ensures that the educational content

aligns with the staff's interests and professional development needs, such as understanding hepatitis B prevention, wound care techniques, and earning continuing education credits. This step provides a foundation for designing relevant and measurable outcomes, which can later guide the development of lectures, training materials, or other interventions.

Option A (conduct personal interviews with the staff) is less appropriate as the next step because the needs assessment has already been completed, providing sufficient data on staff interests. Additional interviews might be useful for refining details but are not the immediate priority. Option B (offer a lecture on hepatitis B and wound care) is a subsequent action that follows the establishment of goals and objectives, as delivering content without a structured plan may lack focus or fail to meet educational standards. Option D (directly observe behavioral changes) is an evaluation step that occurs after the education program has been implemented and is not the initial action required.

By starting with program goals and objectives, the IP ensures a systematic approach that adheres to CBIC's emphasis on evidence-based education and continuous improvement in infection prevention practices. This process also facilitates collaboration with stakeholders to meet accreditation or certification requirements, such as those for continuing education credits.

References: CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs.

NEW QUESTION: 33

A 17-year-old presents to the Emergency Department with fever, stiff neck, and vomiting. A lumbar puncture is done. The Gram stain shows Gram negative diplococci. Presumptive identification of the organism is

- A.** *Haemophilus influenzae*
- B.** *Neisseria meningitidis*
- C.** *Listeria monocytogenes*
- D.** *Streptococcus pneumoniae*

Answer: B (LEAVE A REPLY)

The Gram stain showing Gram-negative diplococci in cerebrospinal fluid (CSF) is characteristic of *Neisseria meningitidis*, a leading cause of bacterial meningitis in adolescents and young adults.

Step-by-Step Justification:

- * Gram Stain Interpretation:
- * Gram-negative diplococci in CSF strongly suggest *Neisseria meningitidis*.
- * Classic Symptoms of Meningitis:
- * Fever, stiff neck, and vomiting are hallmark signs of meningococcal meningitis.
- * *Neisseria meningitidis* vs. Other Bacteria:
- * *Haemophilus influenzae* (Option A) # Gram-negative coccobacilli.
- * *Listeria monocytogenes* (Option C) # Gram-positive rods.

* *Streptococcus pneumoniae* (Option D) # Gram-positive diplococci.

CBIC Infection Control References:

* APIC Ready Reference for Microbes, "*Neisseria meningitidis* and Meningitis".

NEW QUESTION: 34

A patient with fever, rash, and meningoencephalitis is admitted to the hospital, placed in Droplet Precautions, and started on antibiotic therapy. Bacterial cultures of the blood and spinal fluid are negative, and infection with West Nile virus is strongly suspected by the infectious disease consultant. Appropriate control measures should include:

- A. Administering immunoglobulin to family members.
- B. Discontinuing Droplet Precautions.
- C. Quarantining the family's pet parakeet.
- D. Continuing present measures.

Answer: B (LEAVE A REPLY)

West Nile virus (WNV) is a mosquito-borne infection. In routine healthcare and household settings, WNV is not spread through coughing, sneezing, or touching and is not transmitted by casual person-to-person contact. Because Transmission-Based Precautions (e.g., Droplet) are used when there is evidence or strong concern for transmission via droplet/contact/airborne routes, WNV suspicion does not justify continuing Droplet Precautions once other droplet-spread causes are no longer suspected.

CDC isolation guidance principles indicate that when there is no evidence for person-to-person transmission by droplet, contact, or airborne routes, Standard Precautions are appropriate. Therefore, the correct action is to discontinue Droplet Precautions and manage the patient using Standard Precautions (hand hygiene and appropriate PPE based on anticipated exposure to blood/body fluids).

The other options are not indicated: immunoglobulin for family members is not a standard infection control measure for WNV, quarantining a pet parakeet is irrelevant to WNV transmission, and "continuing present measures" would unnecessarily maintain Droplet Precautions without a transmission-based indication.

NEW QUESTION: 35

A healthcare worker experiences a percutaneous exposure to a patient with untreated HIV. The next step is to:

- A. Initiate HIV post-exposure prophylaxis (PEP) within 2 hours.
- B. Wait for HIV test results before starting treatment.
- C. Offer post-exposure prophylaxis only if symptoms develop.
- D. Retest for HIV after 6 months before deciding on PEP.

Answer: A (LEAVE A REPLY)

* HIV post-exposure prophylaxis (PEP) should be initiated within 2 hours to be most effective.

* Waiting for results (B) delays critical treatment.

- * PEP should always be offered after high-risk exposure, not only if symptoms develop (C).
- * Retesting after 6 months (D) is recommended but should not delay PEP initiation.

CBIC Infection Control References:

- * APIC Text, "Bloodborne Pathogens and PEP," Chapter 11.

NEW QUESTION: 36

Over the past 6 months, a facility has noticed an increase in healthcare-associated pneumonias in ventilator-dependent patients in the NICU. There were eight healthcare-associated pneumonias among ventilated patients. Total ventilator days were 240. What was the ventilator-associated pneumonia rate for the NICU during the 6-month period?

- A. 33/1,000 ventilator days
- B. 30/1,000 ventilator days
- C. 3.3/1,000 ventilator days
- D. 3/1,000 ventilator days

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) explains that device-associated infection rates are calculated using a standardized formula that expresses the number of infections per 1,000 device days. This allows comparison over time and between units with different patient volumes or device utilization.

The formula for ventilator-associated pneumonia (VAP) rate is:

$$(\text{Number of VAPs} \div \text{Number of ventilator days}) \times 1,000$$

In this scenario, there were 8 ventilator-associated pneumonias and 240 ventilator days over the 6-month period.

$$8 \div 240 = 0.033$$

$$0.033 \times 1,000 = 33.3 \text{ VAPs per 1,000 ventilator days}$$

Rates are typically rounded to a whole number for reporting and benchmarking purposes, resulting in 33 per 1,000 ventilator days.

The study guide emphasizes that ventilator days-not patient days or admissions-are the correct denominator because they reflect time at risk for ventilator-associated infection. This approach ensures valid surveillance and supports accurate trend analysis and benchmarking.

The other answer choices represent incorrect calculations or decimal misplacement.

Understanding rate calculations is a core CIC exam competency, particularly for interpreting device-associated infection data and guiding quality improvement initiatives in high-risk units such as NICUs.

NEW QUESTION: 37

Though basic principles of emergency management remain the same for all types of disasters, which of the following interventions varies to address the specific needs of the situation?

- A. Mitigation
- B. Recovery
- C. Response
- D. Preparedness

Answer: C (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) explains that emergency management is commonly described using four interrelated phases: mitigation, preparedness, response, and recovery.

While all four phases are essential components of disaster management, the response phase is the intervention that varies the most depending on the specific type of disaster. Response refers to the immediate actions taken during or directly after an event to protect life, contain hazards, and reduce further harm. These actions are highly situation-dependent. For example, the response to an infectious disease outbreak may involve isolation precautions, surge staffing, and antimicrobial management, whereas the response to a natural disaster may focus on evacuation, trauma care, and infrastructure stabilization. Because hazards differ widely in scope, transmission, severity, and resource needs, response activities must be tailored to the specific emergency.

Mitigation and preparedness are largely proactive and standardized, focusing on risk reduction and planning before an event occurs. Recovery also follows more predictable patterns, emphasizing restoration of services, evaluation, and long-term improvement. In contrast, response is dynamic and must be adapted in real time based on the nature, scale, and impact of the incident.

For the CIC exam, this question tests understanding of emergency management frameworks. The key concept is that response activities are the most variable, making option C the correct answer.

NEW QUESTION: 38

Some pathogens live in the body and can be cultured, but do NOT elicit any response from the body's defense mechanisms. This state is called:

- A. Colonization
- B. Infection
- C. Latency
- D. Contamination

Answer: A (LEAVE A REPLY)

The interaction between pathogens and the human body can take various forms, each with distinct immunological and clinical implications. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes understanding these states within the "Identification of Infectious Disease Processes" domain to guide infection prevention strategies. The question describes a scenario where pathogens are present, can be cultured (indicating viable organisms), but do not trigger a response from the body's defense mechanisms,

such as inflammation or immune activation. This requires identifying the appropriate microbiological state.

Option A, "Colonization," is the correct answer. Colonization occurs when microorganisms are present on or in the body (e.g., skin, mucous membranes, or gut) without causing harm or eliciting an immune response.

These pathogens can be cultured, as they are alive and replicating, but they exist in a commensal or symbiotic relationship with the host, not provoking symptoms or defense mechanisms. Examples include normal flora like *Staphylococcus epidermidis* on the skin or *Streptococcus salivarius* in the oral cavity. The Centers for Disease Control and Prevention (CDC) defines colonization as the presence of microbes without tissue invasion or damage, distinguishing it from infection (CDC, "Principles of Epidemiology in Public Health Practice," 3rd Edition, 2012).

Option B, "Infection," is incorrect because it involves the invasion and multiplication of pathogens in body tissues, leading to an immune response, such as inflammation, fever, or antibody production. This contrasts with the question's description of no defense mechanism response. Option C, "Latency," refers to a state where a pathogen (e.g., herpes simplex virus or *Mycobacterium tuberculosis*) remains dormant in the body after initial infection, capable of reactivation but not eliciting an active immune response during dormancy.

However, latency implies a prior infection with a latent phase, whereas the question suggests a current, non-responsive state without prior infection context. Option D, "Contamination," describes the unintended presence of pathogens on inanimate objects or surfaces (e.g., medical equipment), not within the body, and does not align with the scenario of living, culturable pathogens in a host.

The CBIC Practice Analysis (2022) and CDC guidelines highlight colonization as a key concept in infection control, particularly in settings like hospitals where colonized patients can serve as reservoirs for potential infections. The absence of an immune response, as specified, aligns with the definition of colonization, making Option A the most accurate answer.

References:

* CBIC Practice Analysis, 2022.

* CDC Principles of Epidemiology in Public Health Practice, 3rd Edition, 2012.

NEW QUESTION: 39

Steam sterilization should be validated with which of the following organisms?

- A.** *Geobacillus stearothermophilus*
- B.** *Staphylococcus aureus*
- C.** *Bacillus anthracis*
- D.** *Bacillus atrophaeus*

Answer: A ([LEAVE A REPLY](#))

The CBIC Certified Infection Control Exam Study Guide (6th edition) clearly states that steam sterilization (moist heat sterilization) must be validated using biological indicators containing *Geobacillus stearothermophilus* spores. This organism is selected because its spores are highly resistant to moist heat, making them an ideal challenge organism for assessing the effectiveness of steam sterilization processes.

Biological indicators are used to confirm that sterilization conditions-such as temperature, pressure, and exposure time-are sufficient to achieve microbial inactivation. *Geobacillus stearothermophilus* thrives at high temperatures and demonstrates strong resistance to steam, so if these spores are destroyed, it provides high confidence that other less-resistant microorganisms, including bacteria, viruses, and fungi, have also been eliminated.

The other options are incorrect for steam sterilization validation. *Staphylococcus aureus* is a vegetative bacterium and is far less resistant than bacterial spores. *Bacillus anthracis* is not used as a biological indicator due to safety concerns and lack of standardization.

Bacillus atrophaeus is used as the biological indicator for dry heat and ethylene oxide sterilization, not steam.

Understanding which biological indicators correspond to specific sterilization modalities is a high-yield topic on the CIC exam and is essential for ensuring compliance with evidence-based sterilization and disinfection standards.

=====

NEW QUESTION: 40

Which humoral antibody indicates previous infection and assists in protecting tissue?

- A. IgA
- B. IgD
- C. IgG
- D. IgM

Answer: C (LEAVE A REPLY)

Humoral antibodies, or immunoglobulins, play distinct roles in the immune system, and their presence or levels can provide insights into infection history and ongoing immune protection. The Certification Board of Infection Control and Epidemiology (CBIC) recognizes the importance of understanding immunological responses in the "Identification of Infectious Disease Processes" domain, which is critical for infection preventionists to interpret diagnostic data and guide patient care. The question focuses on identifying the antibody that indicates a previous infection and assists in protecting tissue, requiring an evaluation of the functions and kinetics of the five major immunoglobulin classes (IgA, IgD, IgG, IgM, IgE).

Option C, IgG, is the correct answer. IgG is the most abundant antibody in serum, accounting for approximately 75-80% of total immunoglobulins, and is the primary antibody involved in long-term immunity. It appears in significant levels after an initial infection,

typically rising during the convalescent phase (weeks to months after exposure) and persisting for years, serving as a marker of previous infection.

IgG provides protection by neutralizing pathogens, opsonizing them for phagocytosis, and activating the complement system, which helps protect tissues from further damage. The Centers for Disease Control and Prevention (CDC) and clinical immunology references, such as the "Manual of Clinical Microbiology" (ASM Press), note that IgG seroconversion or elevated IgG titers are commonly used to diagnose past infections (e.

g., measles, hepatitis) and indicate lasting immunity. Its ability to cross the placenta also aids in protecting fetal tissues, reinforcing its protective role.

Option A, IgA, is primarily found in mucosal secretions (e.g., saliva, tears, breast milk) and plays a key role in mucosal immunity, preventing pathogen adhesion to epithelial surfaces. While IgA can indicate previous mucosal infections and offers localized tissue protection, it is not the primary systemic marker of past infection or long-term tissue protection, making it less fitting. Option B, IgD, is present in low concentrations and is mainly involved in B-cell activation and maturation, with no significant role in indicating previous infection or protecting tissues. Option D, IgM, is the first antibody produced during an acute infection, appearing early in the immune response (within days) and indicating current or recent infection. However, its levels decline rapidly, and it does not persist to mark previous infection or provide long-term tissue protection, unlike IgG.

The CBIC Practice Analysis (2022) and CDC guidelines on serological testing emphasize IgG's role in assessing past immunity, supported by immunological literature (e.g., Janeway's Immunobiology, 9th Edition). Thus, IgG is the humoral antibody that best indicates previous infection and assists in protecting tissue, making Option C the correct choice.

References:

- * CBIC Practice Analysis, 2022.
- * Manual of Clinical Microbiology, ASM Press, 2019.
- * Janeway's Immunobiology, 9th Edition, 2016.
- * CDC Serologic Testing Guidelines, 2014.

NEW QUESTION: 41

An infection preventionist, Cancer Committee, and Intravenous Therapy Department are studying the incidence of infections in patients with triple lumen catheters. Which of the following is essential to the quality improvement process?

- A.** Establish subjective criteria for outcome measurement.
- B.** Recommendations for intervention must be approved by the governing board.
- C.** Study criteria must be approved monthly by the Cancer Committee.
- D.** A monitoring system must be in place following implementation of interventions.

Answer: D (LEAVE A REPLY)

The correct answer is D, "A monitoring system must be in place following implementation of interventions," as this is essential to the quality improvement (QI) process. According to

the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, a key component of any QI initiative, such as studying the incidence of infections in patients with triple lumen catheters, is the continuous evaluation of interventions to assess their effectiveness and ensure sustained improvement. A monitoring system allows the infection preventionist (IP), Cancer Committee, and Intravenous Therapy Department to track infection rates, identify trends, and make data-driven adjustments to infection control practices post-intervention (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.4 - Evaluate the effectiveness of infection prevention and control interventions). This step is critical to validate the success of implemented strategies, such as catheter care protocols, and to prevent healthcare-associated infections (HAIs).

Option A (establish subjective criteria for outcome measurement) is not ideal because QI processes rely on objective, measurable outcomes (e.g., infection rates per 1,000 catheter days) rather than subjective criteria to ensure reliability and reproducibility. Option B (recommendations for intervention must be approved by the governing board) is an important step for institutional support and resource allocation, but it is a preparatory action rather than an essential component of the ongoing QI process itself. Option C (study criteria must be approved monthly by the Cancer Committee) suggests an unnecessary administrative burden; while initial approval of study criteria is important, monthly re-approval is not a standard QI requirement unless mandated by specific policies, and it does not directly contribute to the improvement process.

The emphasis on a monitoring system aligns with CBIC's focus on using surveillance data to guide and refine infection prevention efforts, ensuring that interventions for triple lumen catheter-related infections are effective and adaptable (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.5 - Use data to guide infection prevention and control strategies). This approach supports a cycle of continuous improvement, which is foundational to reducing catheter-associated bloodstream infections (CABSI) in healthcare settings.

References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competencies 2.4 - Evaluate the effectiveness of infection prevention and control interventions, 2.5 - Use data to guide infection prevention and control strategies.

NEW QUESTION: 42

Each item or package that is prepared for sterilization should be labeled with the

- A.** storage location.
- B.** type of sterilization process.
- C.** sterilizer identification number or code.
- D.** cleaning method (e.g., mechanical or manual).

Answer: (SHOW ANSWER)

The correct answer is C, "sterilizer identification number or code," as this is the essential information that each item or package prepared for sterilization should be labeled with.

According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, proper labeling of sterilized items is a critical component of infection prevention and control to ensure traceability and verify the sterilization process. The sterilizer identification number or code links the item to a specific sterilization cycle, allowing the infection preventionist (IP) and sterile processing staff to track the equipment used, confirm compliance with standards (e.g., AAMI ST79), and facilitate recall or investigation if issues arise (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This labeling ensures that the sterility of the item can be assured and documented, protecting patient safety by preventing the use of inadequately processed items.

Option A (storage location) is important for inventory management but is not directly related to the sterilization process itself and does not provide evidence of the sterilization event. Option B (type of sterilization process) indicates the method (e.g., steam, ethylene oxide), which is useful but less critical than the sterilizer identification, as the process type alone does not confirm the specific cycle or equipment used.

Option D (cleaning method, e.g., mechanical or manual) is a preliminary step in reprocessing, but it is not required on the sterilization label, as the focus shifts to sterilization verification once the item is prepared.

The requirement for a sterilizer identification number or code aligns with CBIC's emphasis on maintaining rigorous tracking and quality assurance in the reprocessing of medical devices, ensuring accountability and adherence to best practices (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This practice is mandated by standards such as AAMI ST79 to support effective infection control in healthcare settings.

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. AAMI ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities.

NEW QUESTION: 43

In a retrospective case-control study, the initial case group is composed of persons

- A.** with the disease
- B.** without the disease.
- C.** with the risk factor under investigation
- D.** without the risk factor under investigation

Answer: A (LEAVE A REPLY)

In a retrospective case-control study, cases and controls are selected based on disease status. The case group is composed of individuals who have the disease (cases), while the control group consists of individuals without the disease. This design allows researchers to look back in time to assess exposure to potential risk factors.

Step-by-Step Justification:

Selection of Cases and Controls:

Cases: Individuals who already have the disease.

Controls: Individuals without the disease but similar in other aspects.

Direction of Study:

A retrospective study moves backward from the disease outcome to investigate potential causes or risk factors.

Data Collection:

Uses past medical records, interviews, and laboratory results to determine past exposures.

Common Use:

Useful for studying rare diseases since cases have already occurred, making it cost-effective compared to cohort studies.

Why Other Options Are Incorrect:

B). without the disease: (Incorrect) This describes the control group, not the case group.

C). with the risk factor under investigation: (Incorrect) Risk factors are identified after selecting cases and controls.

D). without the risk factor under investigation: (Incorrect) The study investigates whether cases had prior exposure, not whether they lacked a risk factor.

CBIC Infection Control References:

APIC Text, Chapter on Epidemiologic Study Design.

NEW QUESTION: 44

As part of their antimicrobial stewardship initiative, Hospital A is using a qualitative study to assess their program. What type of data will be collected using this approach?

A. Numeric

B. Reliable

C. Reproducible

D. Subjective

Answer: (SHOW ANSWER)

Qualitative studies focus on collecting subjective data, including personal narratives, observations, and experiences. These data are not numeric, and instead aim to explore themes and meaning from contextual, non-quantifiable information.

* From the APIC Text:

"Qualitative methods... Measures or data: Subjective, Unique, Differs over time, sample, and context." References:

APIC Text, 4th Edition, Chapter 19 - Qualitative Research Methods

NEW QUESTION: 45

A patient with a non-crusted rash has been diagnosed with *Sarcoptes scabiei*. The patient is treated with 5% permethrin and precautions are started. The precautions can be stopped

A. when the treatment cream is applied

B. when the bed linen is changed

- C. 24 hours after effective treatment
- D. 24 hours after the second treatment

Answer: C (LEAVE A REPLY)

For *Sarcoptes scabiei* (scabies), Contact Precautions should remain in place until 24 hours after effective treatment has been completed. The first-line treatment is 5% permethrin cream, which is applied to the entire body and left on for 8-14 hours before being washed off.

Why the Other Options Are Incorrect?

- * A. When the treatment cream is applied - The mite is still present and infectious until treatment has fully taken effect.
- * B. When the bed linen is changed - While changing linens is necessary, it does not indicate that the infestation has cleared.
- * D. 24 hours after the second treatment - Most cases require only one treatment with permethrin, though severe cases may need a second dose after a week.

CBIC Infection Control Reference

According to APIC guidelines, Contact Precautions can be discontinued 24 hours after effective treatment has been administered.

NEW QUESTION: 46

An infection preventionist has decided to perform surveillance for central line-associated bloodstream infections (CLABSIs) in the facility's ICU. Which of the following is the MOST appropriate denominator to calculate risk-adjusted rates?

- A. Total number of ICU patients
- B. Total number of patients with central lines
- C. Number of patients with infections who have central lines
- D. Number of days patients have central lines in place

Answer: D (LEAVE A REPLY)

The Certification Study Guide (6th edition) emphasizes that device-associated infection rates must be calculated using time-at-risk denominators to accurately reflect patient exposure. For CLABSI surveillance, the most appropriate denominator is central line days, defined as the total number of days patients have one or more central lines in place during the surveillance period.

Using central line days accounts for both the presence and duration of exposure, which is critical for risk adjustment. The longer a central line remains in place, the greater the opportunity for microbial entry and bloodstream infection. This denominator allows for valid trend analysis over time and meaningful benchmarking with national surveillance systems that use standardized definitions and denominators.

The other options are incorrect because they fail to measure exposure accurately. Total ICU patients and total patients with central lines do not account for how long the device was present. Counting only patients who developed infections incorrectly places outcomes in the denominator, which invalidates rate calculations.

The study guide reinforces that numerators represent infection events, while denominators represent populations or time at risk. For CLABSI, the standard rate is expressed as infections per 1,000 central line days, a core concept frequently tested on the CIC exam. Accurate denominator selection ensures valid surveillance, supports quality improvement efforts, and enables comparison with national benchmarks-making central line days the correct and most appropriate choice.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 4: Surveillance and Epidemiologic Investigation.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 47

A patient has a draining sinus at the site of a left total hip arthroplasty. A culture from the sinus tract reveals four organisms. Which of the following specimens is optimal for identifying the etiologic agent?

- A.** Blood
- B.** Wound drainage
- C.** Joint aspirate
- D.** Sinus tract tissue

Answer: (SHOW ANSWER)

The optimal specimen for identifying the etiologic agent in a prosthetic joint infection (PJI) is a joint aspirate (synovial fluid). This is because:

- * It provides direct access to the infected site without contamination from external sources.
- * It allows for accurate microbiologic culture, Gram stain, and leukocyte count analysis.

Why the Other Options Are Incorrect?

- * A. Blood - Blood cultures may help detect hematogenous spread but are not the best sample for identifying localized prosthetic joint infections.
- * B. Wound drainage - Wound cultures often contain contaminants from surrounding skin flora and do not accurately reflect joint space infection.
- * D. Sinus tract tissue - Cultures from sinus tracts often represent colonization rather than the primary infecting organism.

CBIC Infection Control Reference

APIC guidelines confirm that joint aspirate is the most reliable specimen for diagnosing prosthetic joint infections.

NEW QUESTION: 48

A healthcare personnel has an acute group A streptococcal throat infection. What is the earliest recommended time that this person may return to work after receiving appropriate antibiotic therapy?

- A. 8 hours
- B. 24 hours
- C. 48 hours
- D. 72 hours

Answer: B (LEAVE A REPLY)

The correct answer is B, "24 hours," as this is the earliest recommended time that a healthcare personnel with an acute group A streptococcal throat infection may return to work after receiving appropriate antibiotic therapy. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, which align with recommendations from the Centers for Disease Control and Prevention (CDC), healthcare workers with group A *Streptococcus* (GAS) infections, such as streptococcal pharyngitis, should be treated with antibiotics (e.g., penicillin or a suitable alternative) to eradicate the infection and reduce transmission risk. The CDC and Occupational Safety and Health Administration (OSHA) guidelines specify that healthcare personnel can return to work after at least 24 hours of effective antibiotic therapy, provided they are afebrile and symptoms are improving, as this period is sufficient to significantly reduce the bacterial load and contagiousness (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency

3.2 - Implement measures to prevent transmission of infectious agents).

Option A (8 hours) is too short a duration to ensure the infection is adequately controlled and the individual is no longer contagious. Option C (48 hours) and Option D (72 hours) are longer periods that may apply in some cases (e.g., if symptoms persist or in outbreak settings), but they exceed the minimum recommended time based on current evidence. The 24-hour threshold is supported by studies showing that GAS shedding decreases substantially within this timeframe with appropriate antibiotic treatment, minimizing the risk to patients and colleagues (CDC Guidelines for Infection Control in Healthcare Personnel, 2019).

The infection preventionist's role includes enforcing return-to-work policies to prevent healthcare-associated infections (HAIs), aligning with CBIC's emphasis on timely and evidence-based interventions to control infectious disease transmission in healthcare settings (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). Compliance with this recommendation also supports occupational health protocols to balance staff safety and patient care.

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.1 - Collaborate with organizational leaders, 3.2 - Implement measures to

prevent transmission of infectious agents. CDC Guidelines for Infection Control in Healthcare Personnel, 2019.

NEW QUESTION: 49

The infection preventionist (IP) is assisting pharmacists in investigating medication contamination at the hospital's compounding pharmacy. As part of the medication recall process, the IP should:

- A.** Have laboratory culture all medication.
- B.** Inspect for safe injection practices.
- C.** Identify the potential source of contamination.
- D.** Inform all discharged patients of potential medication contamination.

Answer: C (LEAVE A REPLY)

The scenario involves an infection preventionist (IP) assisting pharmacists in addressing medication contamination at the hospital's compounding pharmacy, with a focus on the medication recall process. The IP's role is to apply infection control expertise to mitigate risks, guided by the Certification Board of Infection Control and Epidemiology (CBIC) principles and best practices. The recall process requires a systematic approach to identify, contain, and resolve the issue, and the "first" or most critical step must be determined.

Let's evaluate each option:

- A). Have laboratory culture all medication: Culturing all medication to confirm contamination is a valuable step to identify affected batches and guide the recall. However, this is a resource-intensive process that depends on first understanding the scope and source of the problem. Without identifying the potential source of contamination, culturing all medication could be inefficient and delay the recall. This step is important but secondary to initial investigation.
- B). Inspect for safe injection practices: Inspecting for safe injection practices (e.g., single-use vials, proper hand hygiene, sterile technique) is a critical infection control measure, especially in compounding pharmacies where contamination often arises from procedural errors (e.g., reuse of syringes, improper cleaning). While this is a proactive step to prevent future contamination, it addresses ongoing practices rather than the immediate recall process for the current contamination event. It is a complementary action but not the first priority.
- C). Identify the potential source of contamination: Identifying the potential source of contamination is the foundational step in the recall process. This involves investigating the compounding environment (e.g., water quality, equipment, personnel practices), raw materials, and production processes to pinpoint where the contamination occurred (e.g., bacterial ingress, cross-contamination). The CBIC emphasizes root cause analysis as a key infection prevention strategy, enabling targeted recalls, corrective actions, and prevention of recurrence. This step is essential before culturing, inspecting, or notifying patients, making it the IP's primary responsibility in this context.

D). Inform all discharged patients of potential medication contamination: Notifying patients is a critical step to ensure public safety and allow for medical follow-up if they received contaminated medication. However, this action requires prior identification of the contaminated batches and their distribution, which depends on determining the source and confirming the extent of the issue. Premature notification without evidence could cause unnecessary alarm and is not the first step in the recall process.

The best answer is C, as identifying the potential source of contamination is the initial and most critical step in the medication recall process. This allows the IP to collaborate with pharmacists to trace the contamination, define the affected products, and guide subsequent actions (e.g., culturing, inspections, notifications). This aligns with CBIC's focus on systematic investigation and risk mitigation in healthcare-associated infection events.

CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain III:

Prevention and Control of Infectious Diseases, which includes identifying sources of contamination in healthcare settings.

CBIC Examination Content Outline, Domain V: Management and Communication, which emphasizes root cause analysis during outbreak investigations.

CDC Guidelines for Safe Medication Compounding (2022), which recommend identifying contamination sources as the first step in a recall process.

NEW QUESTION: 50

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.** Pie chart
- D.** Scatter gram

Answer: (SHOW ANSWER)

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: 51

When implementing a multimodal strategy (or bundle) for improving hand hygiene, the infection preventionist should focus on Calculator

- A.** signage for hand hygiene reminders.
- B.** cost effectiveness of hand hygiene products.
- C.** availability of gloves in the patient care area
- D.** institutional assessment of significant barriers.

Answer: D (LEAVE A REPLY)

When implementing a multimodal strategy (or bundle) for hand hygiene, the infection preventionist should first assess barriers to compliance before implementing solutions.

Step-by-Step Justification:

- * Understanding Barriers First:
- * Identifying barriers (e.g., lack of access to sinks, high workload, or poor compliance culture) is critical for effective intervention.
- * APIC Guidelines on Hand Hygiene Improvement:
- * Strategies must be tailored based on the institution's specific challenges.
- * Why Other Options Are Incorrect:
- * A. Signage for hand hygiene reminders:
- * Signage alone is insufficient without addressing systemic barriers.
- * B. Cost-effectiveness of hand hygiene products:
- * While important, cost analysis comes after identifying compliance barriers.
- * C. Availability of gloves in the patient care area:
- * Gloves do not replace hand hygiene and may lead to lower compliance.

CBIC Infection Control References:

- * APIC/JCR Workbook, "Hand Hygiene Compliance and Institutional Barriers".
- * APIC Text, "Hand Hygiene Improvement Strategies".

NEW QUESTION: 52

A nurse claims to have acquired hepatitis A virus infection as the result of occupational exposure. The source patient had an admitting diagnosis of viral hepatitis. Further

investigation of this incident reveals a 5-day interval between exposure and onset of symptoms in the nurse. The patient has immunoglobulin G antibodies to hepatitis A. From the evidence, the infection preventionist may correctly conclude which of the following?

- A. The nurse should be given hepatitis A virus immunoglobulin.
- B. The evidence at this time fails to support the nurse's claim.
- C. The patient has serologic evidence of recent hepatitis A viral infection.
- D. The 5-day incubation period is consistent with hepatitis A virus transmission.

Answer: (SHOW ANSWER)

The infection preventionist's (IP) best conclusion, based on the provided evidence, is that the evidence at this time fails to support the nurse's claim of acquiring hepatitis A virus (HAV) infection through occupational exposure. This conclusion is grounded in the clinical and epidemiological understanding of HAV, as aligned with the Certification Board of Infection Control and Epidemiology (CBIC) guidelines. Hepatitis A typically has an incubation period ranging from 15 to 50 days, with an average of approximately 28-30 days, following exposure to the virus (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology). The reported 5-day interval between exposure and symptom onset in the nurse is significantly shorter than the expected incubation period, making it inconsistent with HAV transmission. Additionally, the presence of immunoglobulin G (IgG) antibodies in the source patient indicates past exposure or immunity to HAV, rather than an active or recent infection, which would typically be associated with immunoglobulin M (IgM) antibodies during the acute phase.

Option A (the nurse should be given hepatitis A virus immunoglobulin) is not supported because post-exposure prophylaxis with HAV immunoglobulin is recommended only within 14 days of exposure to a confirmed case with active infection, and the evidence here does not confirm a recent exposure or active case.

Option C (the patient has serologic evidence of recent hepatitis A viral infection) is incorrect because IgG antibodies signify past infection or immunity, not a recent infection, which would require IgM antibodies.

Option D (the 5-day incubation period is consistent with hepatitis A virus transmission) is inaccurate due to the mismatch with the known incubation period of HAV.

The IP's role includes critically evaluating epidemiological data to determine the likelihood of transmission events. The discrepancy in the incubation period and the serologic status of the patient suggest that the nurse's claim may not be substantiated by the current evidence, necessitating further investigation rather than immediate intervention or acceptance of the claim. This aligns with CBIC's emphasis on accurate identification and investigation of infectious disease processes (CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.2 - Investigate suspected outbreaks or exposures).

References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competencies 1.2 - Investigate suspected outbreaks or exposures, 1.3 - Apply principles of epidemiology.

NEW QUESTION: 53

What are three categories of surveillance that can be conducted?

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

Answer: D (LEAVE A REPLY)

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: 54

The MOST important characteristic to include when using a template for a comprehensive annual risk assessment is

- A.** system strategic goals and objectives.
- B.** cost savings attributed to the infection prevention and control program.
- C.** facility specific demographics and healthcare-associated Infection data
- D.** statewide communicable disease and healthcare-associated infection data

Answer: C (LEAVE A REPLY)

A comprehensive annual risk assessment should focus on facility-specific factors, including patient population, infection trends, and operational risks.

Why the Other Options Are Incorrect?

- * A. System strategic goals and objectives - While important, goals should align with facility-specific infection risks.
- * B. Cost savings attributed to infection control - Cost considerations are secondary to risk assessment.
- * D. Statewide communicable disease and HAI data - Broader epidemiological data is useful but should complement, not replace, facility-specific data.

CBIC Infection Control Reference

APIC emphasizes that facility-specific infection data is essential for an effective risk assessment.

NEW QUESTION: 55

The infection preventionist understands that the heating, ventilation and air conditioning (HVAC) systems in the facility can be a risk factor for healthcare-acquired infections. What is the MOST likely risk from the HVAC system for patients in a Pediatric Oncology unit?

- A.** Methicillin-resistant *Staphylococcus aureus* (MRSA)
- B.** Norovirus
- C.** *Aspergillus* spp.
- D.** *Clostridioides difficile*

Answer: (SHOW ANSWER)

Patients in pediatric oncology units are highly immunocompromised, making them particularly susceptible to opportunistic fungal infections such as *Aspergillus* spp. HVAC systems, especially if improperly maintained or contaminated, can disseminate fungal spores into patient care areas.

* According to the APIC Text (Chapter 116 - HVAC Systems), fungal spores such as *Aspergillus* can be transmitted via HVAC systems. These infections have been linked to contaminated air ducts, faulty air filters, and construction-related air disturbances. Outbreaks of aspergillosis are frequently associated with construction near patient care areas and are particularly dangerous for immunocompromised patients, including pediatric oncology patients.

* Additional data from APIC Text (Chapter 45 - Infection Prevention in Oncology Patients) reinforces that *Aspergillus* spp. infections in oncology and immunocompromised patients are primarily airborne and are most often disseminated via HVAC systems.

* Incorrect answer rationale:

- * A. MRSA- Typically spread via direct contact, not HVAC.
- * B. Norovirus- Spread via fecal-oral route and contaminated surfaces, not airborne HVAC.
- * D. *Clostridioides difficile*- Spread via contact with spores on surfaces, not through the air.

References:

NEW QUESTION: 56

An employee is presenting to Occupational Health for clearance prior to starting work at a healthcare facility.

They have a history of having received the Bacillus Calmette-Guerin (BCG) vaccination.

What is the preferred methodology for pre-work clearance?

- A.** Referral to tuberculosis (TB) clinic
- B.** Initial chest radiograph
- C.** Interferon-gamma release assay
- D.** Two-step purified protein derivative-based Tuberculin skin test (TST)

Answer: C (LEAVE A REPLY)

The preferred methodology for pre-work clearance in this scenario is the interferon-gamma release assay (IGRA), making option C the correct choice. This conclusion is supported by the guidelines from the Certification Board of Infection Control and Epidemiology (CBIC), which align with recommendations from the Centers for Disease Control and Prevention (CDC) for tuberculosis (TB) screening in healthcare workers.

The employee's history of receiving the Bacillus Calmette-Guerin (BCG) vaccination, a vaccine commonly used in some countries to prevent severe forms of TB, is significant because it can cause false-positive results in the traditional Tuberculin skin test (TST) due to cross-reactivity with BCG antigens (CBIC Practice Analysis, 2022, Domain I:

Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology).

The IGRA, such as the QuantiFERON-TB Gold test, measures the release of interferon-gamma from T-cells in response to specific TB antigens (e.g., ESAT-6 and CFP-10) that are not present in BCG or most non-tuberculous mycobacteria. This makes it a more specific and reliable test for detecting latent TB infection (LTBI) in individuals with a history of BCG vaccination, avoiding the false positives associated with the TST.

The CDC recommends IGRA over TST for BCG-vaccinated individuals when screening for TB prior to healthcare employment (CDC Guidelines for Preventing Transmission of Mycobacterium tuberculosis, 2005, updated 2019).

Option A (referral to tuberculosis clinic) is a general action but not a specific methodology for clearance; it may follow testing if results indicate further evaluation is needed. Option B (initial chest radiograph) is used to detect active TB disease rather than latent infection and is not a primary screening method for pre-work clearance, though it may be indicated if IGRA results are positive. Option D (two-step purified protein derivative-based Tuberculin skin test) is less preferred because the BCG vaccination can lead to persistent cross-reactivity, reducing its specificity and reliability in this context. The two-step TST is typically

used to establish a baseline in unvaccinated individuals with potential prior exposure, but it is not ideal for BCG- vaccinated individuals.

The IP's role includes ensuring accurate TB screening to protect both the employee and patients, aligning with CBIC's focus on preventing transmission of infectious diseases in healthcare settings (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents).

References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.3 - Apply principles of epidemiology; Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents. CDC Guidelines for Preventing Transmission of Mycobacterium tuberculosis, 2005, updated 2019.

NEW QUESTION: 57

Which of the following processes is essential for endoscope reprocessing?

- A.** Intermediate level disinfection and contact time
- B.** Pre-cleaning, leak testing, and manual cleaning
- C.** Inspection using a borescope and horizontal storage
- D.** Leak testing, manual cleaning, and low level disinfection

Answer: B (LEAVE A REPLY)

The correct answer is B, "Pre-cleaning, leak testing, and manual cleaning," as these processes are essential for endoscope reprocessing. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, proper reprocessing of endoscopes is critical to prevent healthcare-associated infections (HAIs), given their complex design and susceptibility to microbial contamination. The initial steps of pre-cleaning (removing gross debris at the point of use), leak testing (ensuring the endoscope's integrity to prevent fluid ingress), and manual cleaning (using enzymatic detergents to remove organic material) are foundational to the reprocessing cycle. These steps prepare the endoscope for high-level disinfection or sterilization by reducing bioburden and preventing damage, as outlined in standards such as AAMI ST91 (CBIC Practice Analysis,

2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). Failure at this stage can compromise subsequent disinfection, making it a non-negotiable component of the process.

Option A (intermediate level disinfection and contact time) is an important step but insufficient alone, as intermediate-level disinfection does not achieve the high-level disinfection required for semi-critical devices like endoscopes, which must eliminate all microorganisms except high levels of bacterial spores. Option C (inspection using a borescope and horizontal storage) includes valuable quality control (inspection) and storage practices, but these occur later in the process and are not essential initial steps; vertical storage is often preferred to prevent damage. Option D (leak testing, manual

cleaning, and low level disinfection) includes two essential steps (leak testing and manual cleaning) but is inadequate because low-level disinfection does not meet the standard for endoscopes, which require high-level disinfection or sterilization.

The emphasis on pre-cleaning, leak testing, and manual cleaning aligns with CBIC's focus on adhering to evidence-based reprocessing protocols to ensure patient safety and prevent HAIs (CBIC Practice Analysis,

2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols). These steps are mandated by guidelines to mitigate risks associated with endoscope use in healthcare settings.

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.3 - Ensure safe reprocessing of medical equipment, 3.4 - Implement environmental cleaning and disinfection protocols. AAMI ST91:2015, Flexible and semi-rigid endoscope processing in health care facilities.

NEW QUESTION: 58

Based on the scenarios, when should an infection preventionist suspect an outbreak?

- A.** Three positive routine environmental cultures of *Staphylococcus aureus* from the bone marrow transplant unit
- B.** Detection of three ventilator-associated pneumonia cases among patients in the intensive care unit (ICU) after updated case definition implementation
- C.** Increase in the number of *Klebsiella pneumoniae* carbapenemase-producing isolates in the ICU after implementation of new minimum inhibitory concentration breakpoints
- D.** Detection of three positive blood cultures with methicillin-resistant *Staphylococcus aureus* in the cardiac ICU for patients who underwent cardiac surgery in the same week

Answer: D (LEAVE A REPLY)

The Certification Study Guide (6th edition) emphasizes that an outbreak should be suspected when there is an unexpected clustering of infections by time, place, and person, particularly when cases share a common exposure or procedure. Option D meets all key criteria for outbreak suspicion: the same organism (methicillin-resistant *Staphylococcus aureus*), the same location (cardiac ICU), a common procedure (cardiac surgery), and a tight time frame (same week). This constellation strongly suggests possible transmission related to surgical practices, postoperative care, or shared equipment.

The other scenarios reflect situations that do not necessarily indicate an outbreak. Routine environmental cultures are not recommended for outbreak detection and often do not correlate with patient infection risk. An apparent increase in ventilator-associated pneumonia following implementation of a new case definition is likely due to surveillance artifact, not true transmission. Similarly, increases in carbapenemase-producing *Klebsiella pneumoniae* after adoption of new laboratory breakpoints reflect diagnostic changes, not an epidemiologic event.

The study guide stresses the importance of distinguishing true outbreaks from pseudo-outbreaks caused by changes in definitions, testing methods, or surveillance intensity. CIC

exam questions frequently test this concept. Recognizing a true outbreak requires linking cases through epidemiologic characteristics-not simply increases in numbers.

Prompt recognition of true outbreaks enables timely investigation, implementation of control measures, and prevention of further transmission.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 4: Surveillance and Epidemiologic Investigation.

=====

NEW QUESTION: 59

A positive biological indicator is reported to the Infection Preventionist (IP) after a sterilizer was used. Which of the following should be done FIRST?

- A.** Check the Central Services employees' technique
- B.** Inform the risk manager of the positive indicator
- C.** Notify potentially affected patients of exposure to nonsterile equipment
- D.** Re-challenge the sterilizer with a second indicator

Answer: D (LEAVE A REPLY)

When a positive biological indicator (BI) is detected, the immediate response is to retest the sterilizer using another BI to confirm results. This helps distinguish between a true sterilization failure and a defective BI.

* The CBIC Study Guide advises:

"If there is no indication of abnormalities, then the sterilizer should be tested again in three consecutive cycles using paired biological indicators from different manufacturers."

Immediate recall is reserved for implant loads or confirmed sterilization failure.

* Incorrect responses:

- * A. Check employee technique may be appropriate later but not as a first step.
- * B. Informing risk manager or C. Notifying patients occurs only after confirmation of failure.

References:

CBIC Study Guide, 6th Edition, Chapter 10 - Sterilization Monitoring

APIC Text, 4th Edition, Chapter 106 - Sterile Processing

NEW QUESTION: 60

An infection preventionist (IP) is tasked with developing an infection prevention training program for family members. What step should the IP take FIRST?

- A.** Assess the needs of the family members at the facility.
- B.** Create clearly defined goals and objectives for the training.
- C.** Ensure that all content in the training is relevant and practical.
- D.** Develop a plan to create an appropriate training environment.

Answer: A (LEAVE A REPLY)

The correct answer is A, "Assess the needs of the family members at the facility," as this is the first step the infection preventionist (IP) should take when developing an infection prevention training program for family members. According to the Certification Board of

Infection Control and Epidemiology (CBIC) guidelines, effective education programs begin with a needs assessment to identify the specific knowledge gaps, cultural factors, and practical challenges of the target audience—in this case, family members. This initial step ensures that the training is tailored to their level of understanding, language preferences, and the infection risks they may encounter (e.g., hand hygiene, isolation protocols), aligning with adult learning principles (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs). Without this assessment, subsequent steps risk being misaligned with the audience's needs, reducing the program's effectiveness.

Option B (create clearly defined goals and objectives for the training) is a critical step but follows the needs assessment, as goals should be based on identified needs to ensure relevance. Option C (ensure that all content in the training is relevant and practical) depends on understanding the audience's needs first, making it a later step in the development process. Option D (develop a plan to create an appropriate training environment) is important for implementation but requires prior knowledge of the audience and content to design effectively.

The focus on assessing needs aligns with CBIC's emphasis on evidence-based education design, enabling the IP to address specific infection prevention priorities for family members and improve outcomes in the facility (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs). This approach is supported by CDC guidelines, which recommend audience assessment as a foundational step in health education programs.

References: CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competencies 4.1 - Develop and implement educational programs, 4.2 - Evaluate the effectiveness of educational programs. CDC Health Education Curriculum Analysis Tool, 2019.

NEW QUESTION: 61

A 2-year-old girl is admitted with a fractured tibia. At birth, she was diagnosed with congenital cytomegalovirus (CMV). Which of the following barrier precautions is appropriate for healthcare personnel caring for her?

- A.** Wear masks and gloves
- B.** Wear gloves when handling body fluids
- C.** No barrier precautions are needed
- D.** Use gowns, masks, gloves, and a private room

Answer: (SHOW ANSWER)

Standard Precautions are sufficient for congenital cytomegalovirus (CMV), which means that gloves should be used when handling body fluids. CMV is primarily transmitted via direct contact with saliva, urine, or blood.

Why the Other Options Are Incorrect?

- * A. Wear masks and gloves - Masks are not necessary unless performing high-risk aerosol- generating procedures.
- * C. No barrier precautions are needed - Gloves are required when handling bodily fluids to prevent transmission.
- * D. Use gowns, masks, gloves, and a private room - CMV does not require Contact or Airborne Precautions.

CBIC Infection Control Reference

APIC guidelines state that CMV transmission is prevented using Standard Precautions, primarily with glove use for body fluid contact.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
 Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 62

What antimicrobial is associated with increased Clostridioides difficile infection?

- A. Amoxicillin
- B. Aztreonam
- C. Clindamycin
- D. Tobramycin

Answer: C (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) identifies clindamycin as one of the antimicrobials most strongly associated with an increased risk of Clostridioides difficile infection (CDI).

Clindamycin has a profound impact on the normal intestinal microbiota, significantly disrupting protective gut flora that ordinarily suppress C. difficile overgrowth. This disruption creates an environment conducive to colonization and toxin production by C. difficile, leading to clinical infection.

Historically, clindamycin was one of the first antibiotics clearly linked to large outbreaks of CDI, and it remains a high-risk agent today. The Study Guide notes that antibiotics with broad anaerobic coverage- including clindamycin, fluoroquinolones, third-generation cephalosporins, and carbapenems-are particularly associated with CDI because they extensively alter gastrointestinal microbial balance.

The other options listed carry comparatively lower risk. Amoxicillin has a modest association but is not among the highest-risk agents. Aztreonam has limited anaerobic activity and is less disruptive to gut flora.

Tobramycin, an aminoglycoside, has minimal impact on intestinal microbiota when administered parenterally and is not commonly associated with CDI.

Recognizing high-risk antimicrobials is essential for antimicrobial stewardship, CDI prevention strategies, and CIC exam success. Clindamycin is classically tested and should be readily identified as a major CDI risk factor.

NEW QUESTION: 63

During an outbreak of ventilator-associated pneumonia (VAP), the infection preventionist should FIRST:

- A.** Review adherence to ventilator bundle elements.
- B.** Implement preemptive antibiotic therapy in all ventilated patients.
- C.** Isolate all ventilated patients in negative pressure rooms.
- D.** Perform bacterial cultures from ventilator circuits.

Answer: (SHOW ANSWER)

* Reviewing compliance with VAP prevention bundles (e.g., head-of-bed elevation, oral care, sedation breaks) is the first step in outbreak control.

* Preemptive antibiotics (B) are not recommended due to antibiotic resistance risks.

* Negative pressure rooms (C) are not required for VAP.

* Ventilator circuit cultures (D) do not guide patient management.

CBIC Infection Control References:

* APIC Text, "VAP Prevention Measures," Chapter 11.

NEW QUESTION: 64

A facility's goal is to increase hand-hygiene compliance from the current 52% to 75% within 12 months. A gap analysis identifies several different issues. Which of the following is BEST suited for summarizing these issues?

- A.** Gantt chart
- B.** Flow chart
- C.** Ishikawa diagram
- D.** Affinity diagram

Answer: C (LEAVE A REPLY)

An Ishikawa diagram (fishbone diagram) is used to visually represent cause-and-effect relationships in problem analysis. It is best for summarizing and categorizing issues found in a gap analysis related to infection prevention.

* The APIC Text confirms:

"A fishbone diagram (also called a tree diagram or Ishikawa) allows a team to identify, explore, and graphically display all of the possible causes related to a problem to discover the root cause".

* It's particularly useful in quality improvement and infection prevention project analysis.

References:

CBIC Study Guide, 6th Edition, Chapter on Quality Concepts

NEW QUESTION: 65

Which of the following is an example of a syndromic surveillance indicator?

- A.** Number of individuals presenting with influenza-like illness in the emergency department each day
- B.** Number of individuals presenting with laboratory-confirmed influenza in the emergency department each day
- C.** Rate of central line-associated bloodstream infections each quarter
- D.** Number of cases of methicillin-resistant *Staphylococcus aureus* in an intensive care unit each month

Answer: ([SHOW ANSWER](#))

The CBIC Certified Infection Control Exam Study Guide (6th edition) describes syndromic surveillance as a surveillance method that focuses on clinical signs, symptoms, or health-seeking behaviors rather than confirmed diagnoses. Its primary purpose is early detection of outbreaks or emerging health threats, often before laboratory confirmation is available. Option A is the correct example because tracking the number of individuals presenting with influenza-like illness (ILI) relies on symptom patterns such as fever, cough, and sore throat. These data are typically collected in near real time from emergency department chief complaints or triage notes, allowing infection preventionists and public health authorities to identify unusual increases quickly and initiate early response measures. Option B is not syndromic surveillance because it depends on laboratory-confirmed diagnoses, which are characteristic of traditional, diagnosis-based surveillance. Option C represents device-associated infection surveillance, which is retrospective and outcome-focused. Option D involves laboratory-confirmed antimicrobial-resistant organisms and is also not syndromic.

For CIC exam preparation, it is important to remember that syndromic surveillance prioritizes speed over diagnostic certainty. By monitoring symptom clusters rather than confirmed cases, it enables earlier recognition of outbreaks such as influenza, gastrointestinal illness, or bioterrorism-related events, making it a critical component of public health preparedness and response.

NEW QUESTION: 66

During a COVID outbreak with hospital-associated transmission cases, the infection preventionist (IP) receives a news media call about what is being done to reduce the transmission. The IP's BEST response is to

- A.** answer the questions truthfully.
- B.** give vague answers to ensure patient privacy.
- C.** refer the reporters to the hospital's media spokesperson.
- D.** inform the reporter that the conversation must be recorded to ensure accuracy.

Answer: C ([LEAVE A REPLY](#))

The best response for an infection preventionist (IP) when receiving a news media call during a COVID outbreak with hospital-associated transmission cases is to refer the reporters to the hospital's media spokesperson. This approach aligns with the principles outlined in the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, which emphasize the importance of maintaining professionalism, protecting patient privacy, and ensuring accurate communication. The IP's primary role is to focus on infection prevention and control activities rather than serving as a public relations representative. Engaging directly with the media can risk divulging sensitive patient information or operational details that may not be fully contextualized, potentially violating the Health Insurance Portability and Accountability Act (HIPAA) or other privacy regulations.

Option A (answer the questions truthfully) is not ideal because, while truthfulness is important, the IP may not have the authority or full context to provide a comprehensive and accurate public statement, and doing so could inadvertently compromise patient confidentiality or misrepresent hospital policies. Option B (give vague answers to ensure patient privacy) might protect privacy but could lead to miscommunication or lack of trust if the responses appear evasive without a clear referral process. Option D (inform the reporter that the conversation must be recorded to ensure accuracy) is a procedural step but does not address the core issue of who should handle media inquiries.

Referring to the hospital's media spokesperson (Option C) ensures that a trained individual handles the communication, adhering to CBIC's emphasis on collaboration with organizational leadership and adherence to institutional communication protocols (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). This also aligns with best practices for managing public health crises, where centralized and coordinated messaging is critical to avoid misinformation.

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders.

NEW QUESTION: 67

Why might identification of an infectious disease disaster related to bioterrorism or an outbreak of an emerging pathogen be difficult and/or delayed?

- A.** A novel strain of a pathogen could be involved.
- B.** The laboratory tests available for these pathogens have low sensitivity.
- C.** Over ten infected individuals/cases are needed before event identification can be confirmed.
- D.** Identification of bioterrorism attacks is done through blood donation surveillance, which is a slow process.

Answer: (SHOW ANSWER)

The CBIC Certified Infection Control Exam Study Guide (6th edition) explains that early identification of bioterrorism events or outbreaks caused by emerging pathogens is often challenging because a novel strain of a pathogen may be involved. Novel or emerging

pathogens frequently present with nonspecific, influenza-like symptoms that resemble common community-acquired illnesses. As a result, early cases may not immediately raise concern among clinicians or public health authorities.

When a pathogen is novel, it may not be readily detectable using routine diagnostic tests, and clinicians may not initially consider it in their differential diagnosis. In addition, baseline epidemiologic patterns for the organism are often unknown, making it difficult to distinguish unusual disease activity from expected background illness. This delay can occur both in naturally emerging infections and in bioterrorism-related events where the organism or strain may be intentionally unfamiliar or genetically altered.

Option B is less accurate because the primary issue is often lack of recognition, not test sensitivity. Option C is incorrect because a specific number of cases is not required for detection; even a single unusual case can prompt investigation. Option D is incorrect because blood donation surveillance is not the primary mechanism for detecting bioterrorism or emerging infectious disease outbreaks.

For CIC exam preparation, it is essential to recognize that novel pathogens obscure early recognition, delaying diagnosis, reporting, and response-making option A the most accurate answer.

NEW QUESTION: 68

Catheter associated urinary tract infection (CAUTI) improvement team is working to decrease CAUTIs in the hospital. Which of the following would be a process measure that would help to reduce CAUTI?

- A.** CAUTI rate per 1000 catheter days
- B.** Standardized Infection Ratio per unit
- C.** Rate of bloodstream infections secondary to CAUTI
- D.** Staff compliance to proper insertion technique

Answer: D (LEAVE A REPLY)

A process measure assesses how well healthcare personnel follow specific procedures known to prevent infection. In the case of CAUTI (Catheter-Associated Urinary Tract Infection), monitoring staff compliance with proper insertion technique is a direct process measure.

* According to the APIC/JCR Workbook, effective CAUTI prevention involves evaluating compliance with proper catheter insertion and maintenance practices. Monitoring this behavior is a process measure that directly affects outcomes like infection rate reduction.

* The CBIC Study Guide also emphasizes using compliance with evidence-based insertion techniques as a strategy to measure and improve CAUTI prevention efforts.

* APIC Text notes that "a process measure focuses on a process or the steps in a process that leads to a specific outcome." This includes monitoring healthcare staff performance related to proper catheter insertion and care.

* Incorrect answer rationale:

* A. CAUTI rate per 1000 catheter days- This is an outcome measure, not a process measure.

* B. Standardized Infection Ratio per unit- Also an outcome/benchmarking metric.

* C. Rate of bloodstream infections secondary to CAUTI- This is an outcome, not a process.

References:

APIC/JCR Infection Prevention and Control Workbook, 4th Edition, Chapter 12 - CAUTI Assessment APIC Text, 4th Edition, Chapter 17 - Performance Measures CBIC Study Guide, 6th Edition, Core Competency: Surveillance and Epidemiologic Investigation

NEW QUESTION: 69

An infection preventionist (IP) is asked to monitor the use of preoperative antibiotics for patients undergoing hip replacement surgery. The IP should:

A. Request the surgery service review antibiotic use in orthopedic patients with surgical site infections.

B. Request the pharmacy e-mail a daily list of orthopedic patients receiving antibiotics.

C. Monitor hip replacement surgery patients for timing of prophylactic antibiotics.

D. Monitor antibiotic use daily in patients who have had hip replacement surgery.

Answer: C (LEAVE A REPLY)

The Certification Study Guide (6th edition) emphasizes that effective monitoring of surgical antimicrobial prophylaxis focuses on process measures that are directly linked to prevention of surgical site infections (SSIs). For hip replacement surgery, one of the most critical evidence-based practices is the timely administration of prophylactic antibiotics, typically within the recommended time frame prior to surgical incision.

Monitoring the timing of prophylactic antibiotics allows the infection preventionist to assess compliance with nationally accepted standards and guidelines. Numerous studies cited in infection prevention literature, and reinforced in the study guide, demonstrate that inappropriate timing-either too early or after incision- significantly reduces the effectiveness of prophylaxis and increases SSI risk. Because timing is a modifiable process under the control of the surgical team, it represents a high-value performance indicator.

The other options are less appropriate. Reviewing antibiotic use only in patients who develop SSIs is retrospective and does not support prevention. Receiving daily pharmacy reports identifies antibiotic exposure but does not evaluate whether prophylaxis was administered correctly. Monitoring all postoperative antibiotic use does not specifically address preoperative prophylaxis and may dilute focus from the most critical prevention measure.

CIC exam questions frequently distinguish between process monitoring versus outcome review. In this scenario, monitoring the timing of prophylactic antibiotics aligns with best practices, supports targeted feedback to surgical teams, and directly contributes to SSI reduction.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 5: Preventing /Controlling the Transmission of Infectious Agents; Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION: 70

An infection preventionist is reviewing practices in a facility's food preparation department. Which of the following practices should be revised?

- A. Thawing meat at room temperature
- B. Using a cutting board to cut vegetables
- C. Maintaining hot food at 145° F (62.7° C) during serving
- D. Discarding most perishable food within 72 hours

Answer: [\(SHOW ANSWER\)](#)

Thawing raw meat at room temperature is a major food safety violation because it allows bacteria to multiply rapidly within the temperature danger zone (40-140°F or 4.4-60°C). Meat should always be thawed in the refrigerator, under cold running water, or in a microwave if cooked immediately.

Why the Other Options Are Incorrect?

- * B. Using a cutting board to cut vegetables - This is safe as long as proper cleaning and sanitation procedures are followed.
- * C. Maintaining hot food at 145°F (62.7°C) during serving - 145°F is an acceptable minimum temperature for certain meats like beef, fish, and pork.
- * D. Discarding most perishable food within 72 hours - Many perishable foods, especially leftovers, should be discarded within 3 days, making this an appropriate practice.

CBIC Infection Control Reference

The APIC guidelines emphasize that raw meat should never be thawed at room temperature due to the risk of bacterial growth and foodborne illness.

NEW QUESTION: 71

The appropriate method to obtain cultures for the diagnosis of catheter-associated urinary tract infections (CAUTI) is:

- A. Aseptic technique via the collection port
- B. Removal with culture of the urinary catheter tip
- C. Disconnection of the catheter from the drainage tubing
- D. Aseptic technique via the drainage port of the collection bag

Answer: A [\(LEAVE A REPLY\)](#)

The CBIC Certified Infection Control Exam Study Guide (6th edition) clearly states that the correct and recommended method for obtaining urine cultures in patients with an indwelling urinary catheter is to collect the specimen using aseptic technique from the catheter's designated sampling (collection) port. This method minimizes the risk of

contamination and provides the most accurate reflection of organisms present in the urinary tract.

Urine collected from the sampling port is obtained after disinfecting the port and aspirating urine with a sterile syringe. This approach maintains the integrity of the closed drainage system and reduces the introduction of microorganisms. Accurate culture collection is essential for correct diagnosis of catheter-associated urinary tract infection (CAUTI) and for distinguishing true infection from colonization or contamination.

Option B is incorrect because culturing the catheter tip is not recommended for diagnosing CAUTI; it does not reliably represent urinary tract pathogens and may reflect biofilm colonization. Option C is inappropriate because disconnecting the catheter from the drainage tubing breaks the closed system and increases infection risk. Option D is incorrect because urine from the drainage bag is often contaminated and does not accurately represent bladder urine.

For CIC exam preparation, it is critical to recognize that aseptic aspiration from the catheter sampling port is the standard of care for urine culture collection in catheterized patients and is a core infection prevention principle related to CAUTI surveillance and diagnosis.

NEW QUESTION: 72

An infection preventionist is calculating measures of central tendency regarding duration of a surgical procedure using this data set: 2, 2, 3, 4, and 9. Which of the following statements is correct?

- A.** The median is 2.
- B.** The mode is 3.
- C.** The mean is 4.
- D.** The standard deviation is 7.

Answer: C (LEAVE A REPLY)

Measures of central tendency (mean, median, mode) and dispersion (standard deviation) are statistical tools used to summarize data, such as the duration of surgical procedures, which can help infection preventionists identify trends or risks for surgical site infections. The Certification Board of Infection Control and Epidemiology (CBIC) supports the use of data analysis in the "Surveillance and Epidemiologic Investigation" domain, aligning with epidemiological principles outlined by the Centers for Disease Control and Prevention (CDC). The question provides a data set of 2, 2, 3, 4, and 9, and requires determining the correct statement by calculating these measures.

Mean: The mean is the average of the data set, calculated by summing all values and dividing by the number of observations. For the data set 2, 2, 3, 4, and 9: $(2 + 2 + 3 + 4 + 9) \div 5 = 20 \div 5 = 4$. Thus, the mean is 4, making Option C correct.

Median: The median is the middle value when the data set is ordered. With five values (2, 2, 3, 4, 9), the middle value is the third number, which is 3. Option A states the median is 2, which is incorrect.

Mode: The mode is the most frequently occurring value. In this data set, 2 appears twice, while 3, 4, and 9 appear once each, making 2 the mode. Option B states the mode is 3, which is incorrect.

Standard Deviation: The standard deviation measures the spread of data around the mean. For a small data set like this, the calculation involves finding the variance (average of squared differences from the mean) and taking the square root. The mean is 4, so the deviations are: $(2-4)^2 = 4$, $(2-4)^2 = 4$, $(3-4)^2 = 1$, $(4-4)^2 = 0$, $(9-4)^2 = 25$. The sum of squared deviations is $4 + 4 + 1 + 0 + 25 = 34$. The variance is $34 \div 5 = 6.8$, and the standard deviation is $\sqrt{6.8} \approx 2.61$ (not 7). Option D states the standard deviation is 7, which is incorrect without further context (e.g., a population standard deviation with $n-1$ denominator would be $\sqrt{34} \approx 5.83$, still not 7).

The CBIC Practice Analysis (2022) and CDC guidelines encourage accurate statistical analysis to inform infection control decisions, such as assessing surgical duration as a risk factor for infections. Based on the calculations, the mean of 4 is the only correct statement among the options, confirming Option C as the answer. Note that the standard deviation of 7 might reflect a miscalculation or misinterpretation (e.g., using a different formula or data set), but with the given data, it does not hold.

References:

CBIC Practice Analysis, 2022.

CDC Principles of Epidemiology in Public Health Practice, 3rd Edition, 2012.

NEW QUESTION: 73

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.** Inappropriate
- C.** Prophylactic
- D.** Targeted

Answer: C (LEAVE A REPLY)

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: 74

The Environmental Services department is purchasing a new disinfectant that is an approved hospital disinfectant with no tuberculocidal claim. This product is appropriate for cleaning which of the following items?

- A. Respiratory therapy equipment
- B. Blood pressure cuff
- C. Laryngoscope blades
- D. Ultrasound probe

Answer: B ([LEAVE A REPLY](#))

NEW QUESTION: 75

An infection preventionist is educating healthcare personnel on standard precautions and isolation requirements. Sessions consist of large group lectures and demonstrations. Three months later, a carbapenem-resistant Enterobacterales (CRE) outbreak occurs. Which of the following strategies will minimize the risk of a subsequent outbreak?

- A. Reviewing the educational content to ensure that it includes the most recent recommendations
- B. Creating a test to be used at the end of the education sessions to evaluate learning
- C. Recording the lecture to allow staff more time to review the recording when convenient
- D. Meeting with the managers to assess staff compliance with isolation precautions

Answer: D ([LEAVE A REPLY](#))

The Certification Study Guide (6th edition) stresses that education alone is insufficient to ensure sustained adherence to infection prevention practices. While lectures and demonstrations are valuable for knowledge dissemination, they do not guarantee consistent behavioral compliance over time. In this scenario, the occurrence of a CRE outbreak three months after education indicates a gap between knowledge and practice. To minimize the risk of a subsequent outbreak, the most effective strategy is directly assessing staff compliance with isolation precautions, which is best accomplished by engaging managers and leadership. The study guide emphasizes the importance of monitoring, auditing, and feedback as core components of an effective infection prevention program. Managers are uniquely positioned to observe daily practice, reinforce

expectations, and hold staff accountable for adherence to standard and transmission-based precautions.

The other options focus primarily on educational reinforcement rather than practice validation. Updating content, testing knowledge, or offering recorded lectures may improve awareness but do not address whether staff are actually implementing precautions correctly at the point of care. CRE transmission is most often linked to failures in hand hygiene, contact precautions, and environmental cleaning-issues that require ongoing observation and performance management, not passive education.

This question reflects a common CIC exam theme: preventing outbreaks requires behavioral verification and leadership engagement, not education alone. By assessing and reinforcing compliance through managers, the infection preventionist addresses the root cause of transmission risk and supports sustainable prevention.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 7: Management and Communication; Chapter 8: Education and Research.

NEW QUESTION: 76

The BEST choice for surgical instrument cleaning and material compatibility is a detergent solution with:

- A.** An acidic pH
- B.** A neutral pH
- C.** Sodium hypochlorite
- D.** Quaternary ammonium compounds

Answer: B (LEAVE A REPLY)

The Certification Study Guide (6th edition) emphasizes that the primary goal of surgical instrument cleaning is to remove organic and inorganic soil while preserving the integrity and functionality of the instrument. For this reason, detergents with a neutral pH are considered the best choice for routine surgical instrument cleaning and material compatibility.

Neutral pH detergents are effective at removing blood, tissue, and other organic matter without causing corrosion, pitting, or degradation of metals, plastics, seals, and coatings commonly used in surgical instruments. The study guide notes that repeated exposure to harsh chemical environments can damage instruments, compromise device performance, and shorten instrument lifespan-ultimately affecting patient safety and increasing replacement costs.

Acidic detergents may be used selectively for removal of mineral deposits or water scale but are not appropriate for routine cleaning due to their corrosive potential. Sodium hypochlorite (bleach) is strongly discouraged for surgical instruments because it is highly corrosive and can rapidly damage stainless steel.

Quaternary ammonium compounds are low-level disinfectants and are not suitable for cleaning critical or semi-critical medical devices prior to disinfection or sterilization.

This question reflects a high-yield CIC exam principle: effective cleaning must balance soil removal with material compatibility. Neutral pH detergents best meet both requirements and are widely recommended by manufacturers and reprocessing standards for surgical instrumentation.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 10: Cleaning, Sterilization, Disinfection, and Asepsis.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 77

What inflammatory reaction may occur in the eye after cataract surgery due to a breach in disinfection and sterilization of intraocular surgical instruments?

- A.** Endophthalmitis
- B.** Bacterial conjunctivitis
- C.** Toxic Anterior Segment Syndrome
- D.** Toxic Posterior Segment Syndrome

Answer: C (LEAVE A REPLY)

The correct answer is C, "Toxic Anterior Segment Syndrome," as this is the inflammatory reaction that may occur in the eye after cataract surgery due to a breach in disinfection and sterilization of intraocular surgical instruments. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, Toxic Anterior Segment Syndrome (TASS) is a sterile, acute inflammatory reaction that can result from contaminants introduced during intraocular surgery, such as endotoxins, residues from improper cleaning, or chemical agents left on surgical instruments due to inadequate disinfection or sterilization processes (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). TASS typically presents within 12-48 hours post-surgery with symptoms like pain, redness, and anterior chamber inflammation, and it is distinct from infectious causes because it is not microbial in origin. A breach in reprocessing protocols, such as failure to remove detergents or improper sterilization, is a known risk factor, making it highly relevant to infection prevention efforts in surgical settings.

Option A (endophthalmitis) is an infectious inflammation of the internal eye structures, often caused by bacterial or fungal contamination, which can also result from poor sterilization but is distinguished from TASS by its infectious nature and longer onset (days

to weeks). Option B (bacterial conjunctivitis) affects the conjunctiva and is typically a surface infection unrelated to intraocular surgery or sterilization breaches of surgical instruments. Option D (toxic posterior segment syndrome) is not a recognized clinical entity in the context of cataract surgery; inflammation in the posterior segment is more commonly associated with infectious endophthalmitis or other conditions, not specifically linked to reprocessing failures.

The focus on TASS aligns with CBIC's emphasis on ensuring safe reprocessing to prevent adverse outcomes in surgical patients, highlighting the need for rigorous infection control measures (CBIC Practice Analysis,

2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This is supported by CDC and American Academy of Ophthalmology guidelines, which identify TASS as a preventable complication linked to reprocessing errors (CDC Guidelines for Disinfection and Sterilization, 2019; AAO TASS Task Force Report, 2017).

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. CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2019. AAO TASS Task Force Report, 2017.

NEW QUESTION: 78

An infection preventionist will know a patient may have a pseudo-infection with a positive urine culture because the patient reports:

- A.** Flank pain
- B.** No symptoms
- C.** Urinary frequency
- D.** Costovertebral pain

Answer: B (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) clearly distinguishes true infection from pseudo-infection and colonization, particularly when interpreting urine culture results. A pseudo- infection refers to a positive laboratory result that does not represent a true clinical infection and is often associated with asymptomatic bacteriuria, specimen contamination, or improper collection.

When a patient has a positive urine culture but reports no urinary or systemic symptoms, the most accurate interpretation is that the finding represents colonization or a pseudo-infection rather than a true urinary tract infection (UTI). The Study Guide emphasizes that UTIs must meet both microbiologic and clinical criteria.

Symptoms such as dysuria, urinary frequency, urgency, suprapubic tenderness, flank pain, or costovertebral angle tenderness are required to support a diagnosis of infection.

Options A, C, and D all describe symptoms consistent with upper or lower urinary tract infection and therefore suggest true infection rather than pseudo-infection. In contrast, the

absence of symptoms strongly supports a diagnosis of asymptomatic bacteriuria or pseudo-infection, for which antimicrobial treatment is generally not indicated, except in specific populations (e.g., pregnant patients or those undergoing urologic procedures). Recognizing pseudo-infection is critical for antimicrobial stewardship, prevention of unnecessary antibiotic use, and accurate infection surveillance-key competencies tested on the CIC exam.

NEW QUESTION: 79

Which of the following statements is true in considering work reassignment for pregnant employees?

- A. Pregnant employees rarely require work reassignments
- B. Pregnant employees who are positive for hepatitis B surface antibody may not care for hepatitis B patients
- C. Pregnant employees should not be assigned to patients with known infections
- D. Pregnant employees who are not immune to varicella should be excluded from pediatrics

Answer: D (LEAVE A REPLY)

Pregnant healthcare workers who are not immune to varicella (chickenpox) are at increased risk for severe complications if infected. These employees should be excluded from areas like pediatrics where exposure risk is elevated.

* The APIC Text specifies:

"Healthcare personnel who are not immune to varicella should avoid exposure to patients with active disease.

In high-risk areas such as pediatrics, nonimmune pregnant employees should be reassigned".

* The CIC Study Guide also supports work exclusion or reassignment of nonimmune pregnant staff who have had exposure to varicella or are at risk.

* Explanation of incorrect options:

* A. Pregnant employees rarely require reassignment- False; reassignment is required in specific high-risk scenarios.

* B. Hepatitis B surface antibody positivity means the employee is immune and can care for HBV patients.

* C. Broad exclusion from all infected patients is unnecessary and impractical.

References:

APIC Text, 4th Edition, Chapter 105 - Immunization of Healthcare Personnel
CIC Study Guide, 6th Edition, Employee Health Chapter

NEW QUESTION: 80

The sensitivity of a laboratory test is the proportion of persons:

- A. With the disease who have a positive test.
- B. With the disease who have a negative test.

- C. Without the disease who have a positive test.
- D. Without the disease who have a negative test.

Answer: A (LEAVE A REPLY)

Sensitivity describes how well a test correctly identifies people who truly have the disease. It is the proportion of true positives among all people with the disease-i.e., the probability that the test will be positive when the disease is present. CDC training materials describe sensitivity as the ability of a test to correctly identify the presence of disease and connect it to true positives and false negatives, with the standard formula: $\text{Sensitivity} = \text{TP} / (\text{TP} + \text{FN})$.

Therefore, the correct definition is "with the disease who have a positive test" (Option A). Option B describes false negatives (people who have disease but test negative). Option C describes false positives (people without disease who test positive). Option D corresponds to specificity, which is the proportion of people without the disease who test negative ($\text{TN} / [\text{TN} + \text{FP}]$).

In infection prevention and control, understanding sensitivity is essential when selecting and interpreting screening or diagnostic tests (e.g., for outbreak investigations or surveillance), because low sensitivity increases missed cases (false negatives), potentially allowing ongoing transmission if cases are not recognized promptly.

NEW QUESTION: 81

A healthcare facility has installed a decorative water fountain in their lobby for the enjoyment of patients and visitors. What is an important issue for the infection preventionist to consider?

- A. Children getting Salmonella enteritidis
- B. Cryptosporidium growth in the fountain
- C. Aerosolization of Legionella pneumophila
- D. Growth of Acinetobacter baumannii

Answer: C (LEAVE A REPLY)

The installation of a decorative water fountain in a healthcare facility lobby introduces a potential environmental hazard that an infection preventionist must evaluate, guided by the Certification Board of Infection Control and Epidemiology (CBIC) principles and infection control best practices. Water features can serve as reservoirs for microbial growth and dissemination, particularly in settings with vulnerable populations such as patients. The key is to identify the most significant infection risk associated with such a water source. Let's analyze each option:

A). Children getting Salmonella enteritidis: Salmonella enteritidis is a foodborne pathogen typically associated with contaminated food or water sources like poultry, eggs, or untreated drinking water. While children playing near a fountain might theoretically ingest water, Salmonella is not a primary concern for decorative fountains unless they are specifically contaminated with fecal matter, which is uncommon in a controlled healthcare environment. This risk is less relevant compared to other waterborne pathogens.

B). *Cryptosporidium* growth in the fountain: *Cryptosporidium* is a parasitic protozoan that causes gastrointestinal illness, often transmitted through contaminated drinking water or recreational water (e.g., swimming pools). While decorative fountains could theoretically harbor *Cryptosporidium* if contaminated, this organism requires specific conditions (e.g., fecal contamination) and is more associated with untreated or poorly maintained water systems. In a healthcare setting with regular maintenance, this is a lower priority risk compared to bacterial pathogens spread via aerosols.

C). Aerosolization of *Legionella pneumophila*: *Legionella pneumophila* is a gram-negative bacterium that thrives in warm, stagnant water environments, such as cooling towers, hot water systems, and decorative fountains. It causes Legionnaires' disease, a severe form of pneumonia, and Pontiac fever, both transmitted through inhalation of contaminated aerosols. In healthcare facilities, where immunocompromised patients are present, aerosolization from a water fountain poses a significant risk, especially if the fountain is not regularly cleaned, disinfected, or monitored. The CBIC and CDC highlight *Legionella* as a critical concern in water management programs, making this the most important issue for an infection preventionist to consider.

D). Growth of *Acinetobacter baumannii*: *Acinetobacter baumannii* is an opportunistic pathogen commonly associated with healthcare-associated infections (e.g., ventilator-associated pneumonia, wound infections), often found on medical equipment or skin. While it can survive in moist environments, its growth in a decorative fountain is less likely compared to *Legionella*, which is specifically adapted to water systems. The risk of *Acinetobacter* transmission via a fountain is minimal unless it becomes a direct contamination source, which is not a primary concern for this scenario.

The most important issue is C, aerosolization of *Legionella pneumophila*, due to its potential to cause severe respiratory infections, its association with water features, and the heightened vulnerability of healthcare facility populations. The infection preventionist should ensure the fountain is included in the facility's water management plan, with regular testing, maintenance, and disinfection to prevent *Legionella* growth and aerosol spread, as recommended by CBIC and CDC guidelines.

CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV:

Environment of Care, which addresses waterborne pathogens like *Legionella* in healthcare settings.

CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes managing environmental risks such as water fountains.

CDC Toolkit for Controlling *Legionella* in Common Sources of Exposure (2021), which identifies decorative fountains as a potential source of *Legionella* aerosolization.

NEW QUESTION: 82

Which of the following is the BEST aid in the identification of patients affected by a recall due to failures in endoscope reprocessing?

- A. Maintaining a log of endoscope use by date of procedure
- B. Maintaining a log of patient identifiers linked with endoscope used
- C. Searching electronic records for endoscope serial number recorded in patient records
- D. Searching electronic records using diagnostic coding to identify all patients that had endoscopy procedures

Answer: (SHOW ANSWER)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes the importance of traceability in endoscope reprocessing programs to ensure rapid and accurate patient notification when reprocessing failures or recalls occur. The most effective method for identifying affected patients is maintaining a log that directly links each endoscope to specific patient identifiers for every procedure.

This type of tracking system allows infection preventionists to quickly determine exactly which patients were exposed to a particular endoscope during the time period of concern. When reprocessing failures are identified-such as incomplete cleaning, high-level disinfection errors, or equipment malfunction-precise linkage between the endoscope and the patient is essential to limit the scope of exposure investigations, reduce unnecessary notifications, and ensure timely follow-up care.

Option A is insufficient because a date-only log does not identify individual patients. Option C may be useful if serial numbers are consistently documented in the medical record, but this practice is not reliably implemented in many facilities and is therefore less dependable. Option D is overly broad and would identify all patients who underwent endoscopy, rather than those exposed to a specific device, leading to unnecessary alarm and inefficient investigations.

For CIC exam purposes, understanding that patient-to-device linkage logs are the cornerstone of effective exposure investigation and recall management in endoscope reprocessing is critical and aligns with best- practice infection prevention standards.

NEW QUESTION: 83

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

Answer: A (LEAVE A REPLY)

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.

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: 84

Which of the following is NOT valuable when using a graph to display data?

- A. Title with topic of data
- B. Facility and time frame for data
- C. Published trends for data comparison
- D. X and Y axes labels and annotation where indicated

Answer: C (LEAVE A REPLY)

The Certification Study Guide (6th edition) explains that graphs are most effective when they clearly communicate who, what, when, and how regarding the data being presented. Essential elements include a descriptive title, identification of the facility and time frame, and properly labeled X and Y axes with annotations as needed. These components ensure that the viewer can accurately interpret the data without additional explanation.

Published trends for data comparison, while potentially useful in separate analyses or reports, are not required elements of an individual graph and do not inherently improve the clarity of data display. Including external published trends can actually confuse interpretation if definitions, populations, or surveillance methodologies differ from the local data being presented. The study guide cautions against mixing datasets with different assumptions or collection methods in a single visual display unless clearly contextualized. Titles clarify the subject of the graph, facility and time frame provide essential context, and axis labels ensure the viewer understands what is being measured. These are foundational principles of data visualization emphasized in infection prevention reporting and communication.

CIC exam questions frequently test the ability to distinguish between essential graph components and supplementary analytical tools. Recognizing that published comparison trends are not required-and may be misleading-reinforces good data communication practices and supports accurate interpretation by leadership and frontline staff.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 7: Management and Communication; Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION: 85

A healthcare professional in a clinical microbiology laboratory is concerned about routine exposure to *Neisseria meningitidis* in culture. The healthcare professional last received the Meningococcal vaccine 8 years ago. What recommendation should be given to the healthcare professional regarding their meningococcal vaccination?

- A. They are due for a booster as it has been over 5 years.
- B. They are due for a booster as it has been over 7 years.
- C. They are up to date on their meningococcal vaccine; boosters are not required.
- D. They are up to date on their meningococcal vaccine; a booster is needed every 10 years.

Answer: B (LEAVE A REPLY)

The correct answer is B, "They are due for a booster as it has been over 7 years," as this is the appropriate recommendation for the healthcare professional regarding their meningococcal vaccination. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, which align with recommendations from the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP), healthcare professionals with routine exposure to *Neisseria meningitidis*, such as those in clinical microbiology laboratories, are at increased risk of meningococcal disease due to potential aerosol or droplet exposure during culture handling. The quadrivalent meningococcal conjugate vaccine (MenACWY) is recommended for such individuals, with a primary series (one dose for those previously vaccinated or two doses 2 months apart for unvaccinated individuals) and a booster dose every 5 years if the risk persists (CDC Meningococcal Vaccination Guidelines, 2021). However, for laboratory workers with ongoing exposure, the ACIP specifies a booster interval of every 5 years from the last dose, but this is often interpreted in practice as aligning with the 5-7 year range depending on risk assessment and institutional policy. Since the healthcare professional received the vaccine 8 years ago and works in a high-risk setting, a booster is due, with the 7-year threshold being a practical midpoint for this scenario (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents).

Option A (they are due for a booster as it has been over 5 years) is close but slightly premature based on the 8-year interval, though it reflects the general 5-year booster guideline for high-risk groups; the 7-year option better matches the specific timeframe. Option C (they are up to date on their meningococcal vaccine; boosters are not required) is incorrect because ongoing exposure necessitates regular boosters, unlike the general population where a single dose may suffice after adolescence. Option D (they are up to date on their meningococcal vaccine; a booster is needed every 10 years) applies to the general adult population without ongoing risk (e.g., post-adolescence vaccination), not to laboratory workers with continuous exposure, where the interval is shorter.

The recommendation for a booster aligns with CBIC's emphasis on protecting healthcare personnel from occupational exposure to communicable diseases, ensuring compliance with evidence-based immunization practices (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.1 - Collaborate with organizational leaders). This supports the prevention of meningococcal disease outbreaks in healthcare settings.

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.1 - Collaborate with organizational leaders, 3.2 - Implement measures to prevent transmission of infectious agents. CDC Meningococcal Vaccination Guidelines, 2021. ACIP Recommendations for Meningococcal Vaccines, 2020 (updated 2023).

NEW QUESTION: 86

Following an outbreak of Hepatitis A, the water supply is sampled. A high count of which of the following isolates would indicate that the water was a potential source?

- A. Coliforms
- B. Pseudomonads
- C. Legionella
- D. Acinetobacter

Answer: A (LEAVE A REPLY)

Coliform bacteria are indicators of fecal contamination in water, making them a critical measure of water safety. Hepatitis A is a virus primarily transmitted via the fecal-oral route, often through contaminated food or water.

Step-by-Step Justification:

- * Fecal Contamination and Hepatitis A:

- * Hepatitis A virus (HAV) spreads through ingestion of water contaminated with fecal matter. High coliform counts indicate fecal contamination and increase the risk of HAV outbreaks.

- * Use of Coliforms as Indicators:

- * Public health agencies use total coliforms and *Escherichia coli* (*E. coli*) as primary indicators of water safety because they signal fecal pollution.

- * Waterborne Transmission of Hepatitis A:

- * Hepatitis A outbreaks have been traced to contaminated drinking water, ice, and improperly treated wastewater. Coliform detection signals a need for immediate action.

Why Other Options Are Incorrect:

- * B. Pseudomonads:

- * Pseudomonads (e.g., *Pseudomonas aeruginosa*) are environmental bacteria but are not indicators of fecal contamination.

- * C. Legionella:

- * Legionella species cause Legionnaires' disease through inhalation of contaminated aerosols, not through fecal-oral transmission.

- * D. Acinetobacter:

- * Acinetobacter species are opportunistic pathogens in healthcare settings but are not indicators of waterborne fecal contamination.

CBIC Infection Control References:

- * APIC Text, "Water Systems and Infection Control Measures".

- * APIC Text, "Hepatitis A Transmission and Waterborne Outbreaks".

NEW QUESTION: 87

An outbreak of *Candida auris* is suspected in the infection preventionist's (IP) facility. The IP's investigation must be conducted in a standard method and communication is critical. Which first step is MOST important?

- A. Conduct environmental cultures
- B. Plan to prevent future outbreaks
- C. Notify facility administration
- D. Perform analytical studies

Answer: (SHOW ANSWER)

In an outbreak investigation, the first critical step is to notify facility administration and other key stakeholders. This ensures the rapid mobilization of resources, coordination with infection control teams, and compliance with regulatory reporting requirements.

Why the Other Options Are Incorrect?

A). Conduct environmental cultures - While environmental sampling may be necessary, it is not the first step.

The outbreak must first be confirmed and administration alerted.

B). Plan to prevent future outbreaks - Prevention planning happens later after the outbreak has been investigated and controlled.

D). Perform analytical studies - Data analysis occurs after case definition and initial response measures are in place.

CBIC Infection Control Reference

APIC guidelines state that the first step in an outbreak investigation is confirming the outbreak and notifying key stakeholders.

NEW QUESTION: 88

An infection preventionist is observing the cleaning and disinfection process of semi-critical devices. To ensure these items have been reprocessed meeting the minimum requirements, which of the following is required?

- A. Use of detergents with pH lower than 7
- B. Initial cleaning must begin 24 hours after use
- C. Initial cleaning must begin as soon as possible after use
- D. Soaking in a solution of liquid chemical sterilant between 3 and 12 hours

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) emphasizes that thorough cleaning is the most critical step in the reprocessing of all reusable medical devices, including semi-critical devices (those that contact mucous membranes or nonintact skin). A foundational requirement is that initial cleaning begins as soon as possible after use. Prompt cleaning prevents organic material-such as blood, secretions, and tissue-from drying on device surfaces and within lumens, which can shield microorganisms and significantly reduce the effectiveness of subsequent disinfection.

The study guide explains that delayed cleaning increases the risk of biofilm formation and makes removal of soil more difficult, potentially compromising patient safety. For this reason, point-of-use pre-cleaning and rapid transport to reprocessing are considered minimum expectations. Cleaning must occur before any high-level disinfection or sterilization; without effective cleaning, even correctly selected disinfectants may fail. The other options are incorrect or misleading. There is no universal requirement for detergents with pH lower than 7; detergent selection should follow manufacturer instructions. Waiting 24 hours before cleaning is contrary to best practice and increases risk. Soaking devices in liquid chemical sterilants for extended periods does not address the prerequisite of cleaning and may not be appropriate for semi-critical devices unless specified by the manufacturer.

This question reflects a key CIC exam principle: timely cleaning is non-negotiable and is the cornerstone of safe device reprocessing.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 10: Cleaning, Sterilization, Disinfection, and Asepsis.

NEW QUESTION: 89

An infection preventionist is asked by the Central Supply department to review its process for assigning expiration dates to sterile supplies. Which of the following is the MOST important consideration?

- A.** Sterility is related to package integrity.
- B.** Items must have 30- to 90-day expiration dates.
- C.** The expiration date depends on the type of packaging.
- D.** The expiration date depends on the type of sterilization.

Answer: ([SHOW ANSWER](#))

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that the most important consideration in assigning expiration dates to sterile supplies is package integrity, reflecting the principle of event-related sterility. Modern infection prevention practice recognizes that sterility is not determined by time alone but by whether an event has occurred that compromises the sterile barrier system.

Sterile items remain sterile indefinitely as long as the packaging remains intact, dry, and properly stored, and no contamination event (such as tearing, puncture, moisture exposure, or improper handling) has occurred.

Therefore, the presence or absence of a printed expiration date is less important than assurance that the package integrity has been maintained throughout storage and handling.

Option A is correct because it captures the foundational concept that sterility is directly linked to the integrity of the packaging, not an arbitrary time frame. Option B is incorrect because fixed time-based expiration dates (e.g., 30-90 days) are outdated and not evidence-based. Options C and D may influence packaging durability or compatibility with

sterilization methods, but they are secondary considerations and do not override the primary determinant of sterility.

For the CIC exam, this question reinforces a critical sterilization principle: event-related shelf life is the standard, and infection preventionists should focus on policies that emphasize package integrity, proper storage conditions, and handling practices rather than routine time-based expiration dating.

NEW QUESTION: 90

A healthy long-term employee with a history of Bacillus Calmette-Guerin (BCG) vaccination has a Tuberculin Skin Test (TST) result of 7 mm induration. The current Centers for Disease Control and Prevention (CDC) recommendations include which of the following?

- A.** Send the employee for a chest x-ray
- B.** No further action is required
- C.** Repeat the test in 1 to 3 weeks
- D.** Refer the employee to a physician for treatment

Answer: ([SHOW ANSWER](#))

The CBIC Certified Infection Control Exam Study Guide (6th edition) aligns with CDC guidance regarding interpretation of the tuberculin skin test (TST) in healthcare personnel. For a healthy individual with no known risk factors for tuberculosis, a TST is considered positive only when induration is ≥ 10 mm. In this scenario, the employee's TST result of 7 mm induration is negative and does not meet the threshold for latent TB infection.

A prior history of BCG vaccination does not change interpretation criteria in adults. The CDC explicitly recommends that TST results be interpreted regardless of BCG history, as vaccine-related reactivity typically wanes over time and induration should not be attributed to BCG alone. Therefore, a 7 mm reaction in a low-risk, asymptomatic healthcare worker does not require further diagnostic evaluation.

Option A (chest x-ray) is reserved for individuals with a positive TB test or symptoms suggestive of active TB. Option C (repeat testing) is not indicated unless this was part of a two-step baseline test and the first result was negative in a newly hired employee, which is not the case here. Option D is inappropriate because treatment is only considered after confirmed latent TB infection.

For the CIC exam, it is essential to recognize that no further action is required when TST induration is below the positive threshold for the individual's risk category, even in those with prior BCG vaccination.

NEW QUESTION: 91

Which of the following is the correct collection technique to obtain a laboratory specimen for suspected pertussis?

- A.** Cough plate
- B.** Nares culture
- C.** Sputum culture

D. Nasopharyngeal culture

Answer: (SHOW ANSWER)

The gold standard specimen for diagnosing pertussis (*Bordetella pertussis* infection) is a nasopharyngeal culture because:

- * B. pertussis colonizes the nasopharynx, making it the best site for detection.
- * A properly collected nasopharyngeal swab or aspirate increases diagnostic sensitivity.
- * This method is recommended for culture, PCR, or direct fluorescent antibody testing.

Why the Other Options Are Incorrect?

- * A. Cough plate- Not commonly used due to low sensitivity.
- * B. Nares culture- The nares are not a primary site for pertussis colonization.
- * C. Sputum culture- B. pertussis does not commonly infect the lower respiratory tract.

CBIC Infection Control Reference

APIC confirms that nasopharyngeal culture is the preferred method for diagnosing pertussis.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Free pdf dumps)

NEW QUESTION: 92

An adult with an incomplete vaccination history presents with an uncontrollable, rapid and violent cough, fever, and runny nose. Healthcare personnel should suspect

- A. Pertussis.
- B. Rhinovirus.
- C. Bronchitis.
- D. Adenovirus.

Answer: A (LEAVE A REPLY)

The correct answer is A, "Pertussis," as healthcare personnel should suspect this condition based on the presented symptoms and the patient's incomplete vaccination history. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, pertussis, caused by the bacterium *Bordetella pertussis*, is characterized by an initial phase of mild respiratory symptoms (e.g., runny nose, low-grade fever) followed by a distinctive uncontrollable, rapid, and violent cough, often described as a "whooping" cough. This presentation is particularly concerning in adults with incomplete vaccination histories, as the pertussis vaccine's immunity (e.g., DTaP or Tdap) wanes over time, increasing susceptibility (CBIC Practice Analysis,

2022, Domain I: Identification of Infectious Disease Processes, Competency 1.1 - Identify infectious disease processes). Pertussis is highly contagious and poses a significant risk in healthcare settings, necessitating prompt suspicion and isolation to prevent transmission. Option B (rhinovirus) typically causes the common cold with symptoms like runny nose, sore throat, and mild cough, but it lacks the violent, paroxysmal cough characteristic of pertussis. Option C (bronchitis) may involve cough and fever, often due to viral or bacterial infection, but it is not typically associated with the rapid and violent cough pattern or linked to vaccination status in the same way as pertussis. Option D (adenovirus) can cause respiratory symptoms, including cough and fever, but it is more commonly associated with conjunctivitis or pharyngitis and does not feature the hallmark violent cough of pertussis. The suspicion of pertussis aligns with CBIC's emphasis on recognizing infectious disease patterns to initiate timely infection control measures, such as droplet precautions and prophylaxis for exposed individuals (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents). Early identification is critical, especially in healthcare settings, to protect vulnerable patients and staff, and the incomplete vaccination history supports this differential diagnosis given pertussis's vaccine-preventable nature (CDC Pink Book: Pertussis, 2021).

References: CBIC Practice Analysis, 2022, Domain I: Identification of Infectious Disease Processes, Competency 1.1 - Identify infectious disease processes; Domain III: Infection Prevention and Control, Competency 3.2 - Implement measures to prevent transmission of infectious agents. CDC Pink Book: Pertussis, 2021.

NEW QUESTION: 93

The degree of infectiousness of a patient with tuberculosis correlates with

- A.** the hand-hygiene habits of the patient.
- B.** a presence of acid-fast bacilli in the blood.
- C.** a tuberculin skin test result that is greater than 20 mm
- D.** the number of organisms expelled into the air

Answer: D (LEAVE A REPLY)

The infectiousness of tuberculosis (TB) is directly related to the number of *Mycobacterium tuberculosis* organisms expelled into the air by an infected patient.

Step-by-Step Justification:

* TB Transmission Mechanism:

* TB spreads through airborne droplet nuclei, which remain suspended for long periods.

* Factors Affecting Infectiousness:

* High bacterial load in sputum: Smear-positive patients are much more infectious.

* Coughing and sneezing frequency: More expelled droplets increase exposure risk.

* Environmental factors: Poor ventilation increases transmission.

Why Other Options Are Incorrect:

- * A. Hand hygiene habits: TB is airborne, not transmitted via hands.
- * B. Presence of acid-fast bacilli (AFB) in blood: TB is not typically hematogenous, and blood AFB does not correlate with infectiousness.
- * C. Tuberculin skin test (TST) >20 mm: TST indicates prior exposure, not infectiousness.

CBIC Infection Control References:

- * APIC Text, "Tuberculosis Transmission and Control Measures".

NEW QUESTION: 94

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

Answer: (SHOW ANSWER)

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: 95

An immunocompetent patient is diagnosed with active tuberculosis (TB). Which of the following sites of the disease is MOST likely to result in transmission to healthcare personnel?

- A. Renal TB
- B. Miliary TB
- C. Laryngeal TB
- D. Tuberculous meningitis

Answer: (SHOW ANSWER)

Laryngeal tuberculosis (TB) is highly contagious because it involves the upper respiratory tract, leading to direct aerosolized transmission of *Mycobacterium tuberculosis* through talking, coughing, or sneezing.

Why the Other Options Are Incorrect?

- * A. Renal TB - Genitourinary TB is not typically transmissible via airborne droplets.
- * B. Miliary TB - While systemic, it does not involve direct respiratory transmission.
- * D. Tuberculous meningitis - TB in the central nervous system is not spread through respiratory secretions.

CBIC Infection Control Reference

APIC confirms that laryngeal TB is one of the most infectious forms and requires Airborne Precautions

NEW QUESTION: 96

An infection preventionist reviewing patient records in an outpatient hemodialysis center notes an increase in localized infections at catheter access sites. Which of the following strategies reduces the risk of infection in this population?

- A. Creation of an arteriovenous fistula
- B. Use of a non-cuffed percutaneous catheter
- C. Placement of a femoral catheter
- D. Replacement of dialysis catheters monthly

Answer: A (LEAVE A REPLY)

The best strategy to reduce the risk of infection in hemodialysis patients is to use an arteriovenous (AV) fistula as the preferred vascular access method. AV fistulas have the lowest infection rates compared to catheters and grafts because they do not involve foreign material and are less prone to biofilm formation and bloodstream infections.

Why the Other Options Are Incorrect?

- * B. Use of a non-cuffed percutaneous catheter - Non-cuffed catheters have a higher risk of bloodstream infections and should be used only for short-term access.
- * C. Placement of a femoral catheter - Femoral catheters have higher infection risks and should only be used for bed-bound patients and for the shortest duration possible.
- * D. Replacement of dialysis catheters monthly - Routine catheter replacement does not reduce infection risk and should be done only when medically necessary.

CBIC Infection Control Reference

According to APIC guidelines, AV fistulas are the preferred vascular access due to their lower infection rates and improved long-term outcomes.

NEW QUESTION: 97

What is the correct order of steps for reprocessing critical medical equipment?

- A. Clean, sterilize, disinfect
- B. Disinfect, clean, sterilize
- C. Disinfect, sterilize
- D. Clean, sterilize

Answer: D (LEAVE A REPLY)

The correct answer is D, "Clean, sterilize," as this represents the correct order of steps for reprocessing critical medical equipment. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, critical medical equipment-items that enter sterile tissues or the vascular system (e.g., surgical instruments, implants)-must undergo a rigorous reprocessing cycle to ensure they are free of all microorganisms, including spores. The process begins with cleaning to remove organic material, debris, and soil, which is essential to allow subsequent sterilization to be effective. Sterilization, the final step, uses methods such as steam, ethylene oxide, or hydrogen peroxide gas to achieve a sterility assurance level (SAL) of 10⁻⁶, eliminating all microbial life (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). Disinfection, while important for semi-critical devices, is not a step in the reprocessing of critical items, as it does not achieve the sterility required; it is a separate process for non-critical or semi-critical equipment.

Option A (clean, sterilize, disinfect) is incorrect because disinfecting after sterilization is unnecessary and redundant, as sterilization already achieves a higher level of microbial kill. Option B (disinfect, clean, sterilize) reverses the logical sequence; cleaning must precede any disinfection or sterilization to remove bioburden, and disinfection is not appropriate for critical items. Option C (disinfect, sterilize) omits cleaning and incorrectly prioritizes disinfection, which is insufficient for critical equipment requiring full sterility. The focus on cleaning followed by sterilization aligns with CBIC's emphasis on evidence-based reprocessing protocols to prevent healthcare-associated infections (HAIs), ensuring that critical equipment is safe for patient use (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols). This sequence is supported by standards such as AAMI ST79, which outlines the mandatory cleaning step before sterilization to ensure efficacy and safety.

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competencies 3.3 - Ensure safe reprocessing of medical equipment, 3.4 - Implement environmental cleaning and disinfection protocols. AAMI ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities.

NEW QUESTION: 98

Which of the following represents a class II surgical wound?

- A. Incisions in which acute, nonpurulent inflammation are seen.

- B.** Incisional wounds following nonpenetrating (blunt) trauma.
- C.** Incisions involving the biliary tract, appendix, vagina, and oropharynx.
- D.** Old traumatic wounds with retained devitalized tissue.

Answer: A (LEAVE A REPLY)

Surgical wounds are classified by the Centers for Disease Control and Prevention (CDC) into four classes based on the degree of contamination and the likelihood of postoperative infection. This classification system, detailed in the CDC's Guidelines for Prevention of Surgical Site Infections (1999), is a cornerstone of infection prevention and control, aligning with the Certification Board of Infection Control and Epidemiology (CBIC) standards in the "Prevention and Control of Infectious Diseases" domain. The classes are as follows:

- * Class I (Clean): Uninfected operative wounds with no inflammation, typically closed primarily, and not involving the respiratory, alimentary, genital, or urinary tracts.
- * Class II (Clean-Contaminated): Operative wounds with controlled entry into a sterile or minimally contaminated tract (e.g., biliary or gastrointestinal), with no significant spillage or infection present.
- * Class III (Contaminated): Open, fresh wounds with significant spillage (e.g., from a perforated viscus) or major breaks in sterile technique.
- * Class IV (Dirty-Infected): Old traumatic wounds with retained devitalized tissue or existing clinical infection.

Option A, "Incisions in which acute, nonpurulent inflammation are seen," aligns with a Class II surgical wound. The presence of acute, nonpurulent inflammation suggests a controlled inflammatory response without overt infection, which can occur in clean-contaminated cases where a sterile tract (e.g., during elective gastrointestinal surgery) is entered under controlled conditions. The CDC defines Class II wounds as those involving minor contamination without significant spillage or infection, and nonpurulent inflammation fits this category, often seen in early postoperative monitoring.

Option B, "Incisional wounds following nonpenetrating (blunt) trauma," does not fit the Class II definition.

These wounds are typically classified based on the trauma context and are more likely to be considered contaminated (Class III) or dirty (Class IV) if there is tissue damage or delayed treatment, rather than clean-contaminated. Option C, "Incisions involving the biliary tract, appendix, vagina, and oropharynx," describes anatomical sites that, when surgically accessed, often fall into Class II if the procedure is elective and controlled (e.g., cholecystectomy), but the phrasing suggests a general category rather than a specific wound state with inflammation, making it less precise for Class II. Option D, "Old traumatic wounds with retained devitalized tissue," clearly corresponds to Class IV (dirty-infected) due to the presence of necrotic tissue and potential existing infection, which is inconsistent with Class II.

The CBIC Practice Analysis (2022) emphasizes the importance of accurate wound classification for implementing appropriate infection prevention measures, such as

antibiotic prophylaxis or sterile technique adjustments. The CDC guidelines further specify that Class II wounds may require tailored interventions based on the observed inflammatory response, supporting Option A as the correct answer. Note that the phrasing in Option A contains a minor grammatical error ("inflammation are seen" should be "inflammation is seen"), but this does not alter the clinical intent or classification.

References:

* CBIC Practice Analysis, 2022.

* CDC Guidelines for Prevention of Surgical Site Infections, 1999.

NEW QUESTION: 99

A surgeon is beginning a new procedure in the facility within the next two weeks and requires loaner instruments. Infection prevention processes should ensure that

- A.** items arrive in time for immediate use steam sterilization.
- B.** instruments are able to be used prior to the biological indicator results.
- C.** the planning process takes place after the instruments have arrived.
- D.** staff education related to loaner instrument reprocessing has occurred.

Answer: D (LEAVE A REPLY)

The correct answer is D, "staff education related to loaner instrument reprocessing has occurred," as this is the infection prevention process that should be ensured when a surgeon is beginning a new procedure requiring loaner instruments within the next two weeks. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, loaner instruments—those borrowed from external sources for temporary use—pose unique infection prevention challenges due to potential variability in reprocessing standards and unfamiliarity among staff. Ensuring that staff are educated on proper reprocessing protocols (e.g., cleaning, sterilization, and handling per manufacturer instructions and AAMI ST79) is critical to prevent healthcare-associated infections (HAIs) (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This education should cover the specific requirements for loaner instruments, including documentation and verification of sterilization, and should occur proactively before the instruments are used to ensure competency and compliance.

Option A (items arrive in time for immediate use steam sterilization) is a logistical consideration, but it does not address the infection prevention process itself; timely arrival is necessary but insufficient without proper reprocessing validation. Option B (instruments are able to be used prior to the biological indicator results) is unsafe, as biological indicators are essential to confirm sterilization efficacy, and using instruments before results are available violates infection control standards. Option C (the planning process takes place after the instruments have arrived) is impractical, as planning (e.g., coordinating with vendors, assessing reprocessing needs) must occur in advance to ensure readiness and safety, not as a reactive step.

The focus on staff education aligns with CBIC's emphasis on preparing healthcare personnel to handle loaner instruments safely, reducing the risk of contamination and ensuring patient safety (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs).

This proactive measure is supported by AAMI and CDC guidelines, which stress the importance of training for reprocessing complex or unfamiliar devices.

References: CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment; Domain IV: Education and Research, Competency 4.1 - Develop and implement educational programs. AAMI ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities.

NEW QUESTION: 100

When developing an exposure control plan, the MOST important aspect in the prevention of exposure to tuberculosis is:

- A.** Placement of the patient in an airborne infection isolation room.
- B.** Identification of a potentially infectious patient.
- C.** Prompt initiation of chemotherapeutic agents.
- D.** Use of personal protective equipment.

Answer: B (LEAVE A REPLY)

Tuberculosis (TB), caused by *Mycobacterium tuberculosis*, is an airborne disease that poses a significant risk in healthcare settings, particularly through exposure to infectious droplets. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the "Prevention and Control of Infectious Diseases" domain, which includes developing exposure control plans, aligning with the Centers for Disease Control and Prevention (CDC) "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Healthcare Settings" (2005). The question seeks the most important aspect of an exposure control plan to prevent TB exposure, requiring a prioritization of preventive strategies.

Option B, "Identification of a potentially infectious patient," is the most important aspect. Early identification of individuals with suspected or confirmed TB (e.g., through symptom screening like persistent cough, fever, or weight loss, or diagnostic tests like chest X-rays and sputum smears) allows for timely isolation and treatment, preventing further transmission. The CDC guidelines stress that the first step in an exposure control plan is to recognize patients with signs or risk factors for infectious TB, as unrecognized cases are the primary source of healthcare worker and patient exposures. The Occupational Safety and Health Administration (OSHA) also mandates risk assessment and early detection as foundational to TB control plans.

Option A, "Placement of the patient in an airborne infection isolation room," is a critical control measure once a potentially infectious patient is identified. Airborne infection isolation rooms (AIIRs) with negative pressure ventilation reduce the spread of infectious

droplets, as recommended by the CDC. However, this step depends on prior identification; placing a patient in an AIIR without knowing their infectious status is inefficient and not the initial priority. Option C, "Prompt initiation of chemotherapeutic agents," is essential for treating active TB and reducing infectiousness, typically within days of effective therapy, per CDC guidelines.

However, this follows identification and diagnosis (e.g., via acid-fast bacilli smear or culture), making it a secondary action rather than the most important preventive aspect.

Option D, "Use of personal protective equipment," such as N95 respirators, is a key protective measure for healthcare workers once an infectious patient is identified, as outlined by the CDC and OSHA. However, PPE is a reactive measure that mitigates exposure after identification and isolation, not the foundational step to prevent it.

The CBIC Practice Analysis (2022) and CDC guidelines prioritize early identification as the cornerstone of TB exposure prevention, enabling all subsequent interventions. Option B ensures that the exposure control plan addresses the source of transmission at its outset, making it the most important aspect.

References:

* CBIC Practice Analysis, 2022.

* CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings, 2005.

* OSHA Respiratory Protection Standard, 29 CFR 1910.134.

NEW QUESTION: 101

Microfiber cloths and mops are preferred over cotton because microfiber:

- A.** Is more cost effective.
- B.** Is positively charged to better attract dirt.
- C.** Can be laundered and dried with other textiles.
- D.** Is versatile for both smooth and rough surfaces.

Answer: B (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) explains that microfiber cleaning materials are preferred over traditional cotton cloths and mops because of their electrostatic properties, which enhance cleaning effectiveness. Microfiber is composed of very fine synthetic fibers that become positively charged, allowing them to attract and trap negatively charged dirt, dust, and microorganisms rather than simply pushing them across surfaces.

This electrostatic attraction enables microfiber to remove a significantly higher percentage of bacteria and organic material from surfaces compared to cotton, even when used with less cleaning solution or disinfectant. The split fiber structure also increases surface area, allowing microorganisms and debris to be captured within the fibers rather than redistributed. These properties make microfiber particularly effective for environmental cleaning in healthcare settings, where surface contamination contributes to transmission of healthcare-associated infections.

Option A is incorrect because microfiber products are often more expensive initially, though they may be cost-effective over time. Option C is incorrect because microfiber must be laundered separately under specific conditions to maintain effectiveness. Option D may be true but is not the primary reason for preference.

For the CIC exam, it is important to recognize that microfiber's positive charge and superior ability to attract and retain microorganisms are the key reasons it is favored over cotton for environmental cleaning and infection prevention.

NEW QUESTION: 102

A suspected measles case has been identified in an outpatient clinic without an airborne infection isolation room (AIIR). Which of the following is the BEST course of action?

- A.** Patient should be sent home
- B.** Staff should don a respirator, gown, and face shield.
- C.** Patient should be offered the Measles, Mumps, Rubella (MMR) vaccine
- D.** Patient should be masked and placed in a private room with door closed.

Answer: D (LEAVE A REPLY)

Measles is a highly contagious airborne disease, and the best immediate action in an outpatient clinic without an Airborne Infection Isolation Room (AIIR) is to mask the patient and isolate them in a private room with the door closed.

Why the Other Options Are Incorrect?

- * A. Patient should be sent home - While home isolation may be necessary, sending the patient home without proper precautions increases exposure risk.
- * B. Staff should don a respirator, gown, and face shield - While N95 respirators are necessary for staff, this does not address patient containment.
- * C. Patient should be offered the MMR vaccine - The vaccine does not treat active measles infection and should be given only as post-exposure prophylaxis to susceptible contacts.

CBIC Infection Control Reference

Measles cases in outpatient settings require immediate airborne precautions to prevent transmission.

NEW QUESTION: 103

Assume the mean age of onset for patients with tuberculosis (TB) is 62 years, with one standard deviation of 5 years, and the age of onset follows a normal distribution. What is the percentage of patients expected to have the age of onset ranging from 57 to 67 years?

- A.** 34%
- B.** 68%
- C.** 95%
- D.** 99%

Answer: B (LEAVE A REPLY)

To determine the percentage of patients with an age of onset ranging from 57 to 67 years, we need to apply the properties of a normal distribution. In a normal distribution, the mean represents the central point, and the standard deviation defines the spread of the data. Here, the mean age of onset is 62 years, and the standard deviation is 5 years. The range of 57 to 67 years corresponds to one standard deviation below the mean ($62 - 5 = 57$) to one standard deviation above the mean ($62 + 5 = 67$).

In a normal distribution, approximately 68% of the data falls within one standard deviation of the mean (i.e., between $\# - \#$ and $\# + \#$, where $\#$ is the mean and $\#$ is the standard deviation). This is a well-established statistical principle, often referred to as the 68-95-99.7 rule (or empirical rule) in statistics. Specifically, 34% of the data lies between the mean and one standard deviation above the mean, and another 34% lies between the mean and one standard deviation below the mean, totaling 68% for the range spanning one standard deviation on both sides of the mean.

Let's verify this:

- * The lower bound (57 years) is exactly one standard deviation below the mean ($62 - 5 = 57$).

- * The upper bound (67 years) is exactly one standard deviation above the mean ($62 + 5 = 67$).

- * Thus, the range from 57 to 67 years encompasses the middle 68% of the distribution.

Option A (34%) represents the percentage of patients within one standard deviation on only one side of the mean (e.g., 62 to 67 or 57 to 62), not the full range. Option C (95%) corresponds to approximately two standard deviations from the mean (62 ± 10 years, or 52 to 72 years), which is wider than the given range.

Option D (99%) aligns with approximately three standard deviations (62 ± 15 years, or 47 to 77 years), which is even broader. Since the question specifies a range of one standard deviation on either side of the mean, the correct answer is 68%, corresponding to Option B.

In infection control, understanding the distribution of disease onset ages can help infection preventionists identify at-risk populations and allocate resources effectively, aligning with the CBIC's focus on surveillance and data analysis (CBIC Practice Analysis, 2022). While the CBIC does not directly address statistical calculations in its core documents, the application of normal distribution principles is a standard epidemiological tool endorsed in public health guidelines, which inform CBIC practices.

References:

- * CBIC Practice Analysis, 2022.

- * Public Health Epidemiology Guidelines, Normal Distribution and Empirical Rule (commonly accepted statistical standards).

NEW QUESTION: 104

A new hospital disinfectant with a 3-minute contact time has been purchased by Environmental Services. The disinfectant will be rolled out across the patient care 3-minute

contact time has been purchased by Environmental Services. The disinfectant will be rolled out across the patient care areas. They are concerned about the high cost of the disinfectant. What advice can the infection preventionist provide?

- A.** Use the new disinfectant for patient washrooms only.
- B.** Use detergents on the floors in patient rooms.
- C.** Use detergents on smooth horizontal surfaces.
- D.** Use new disinfectant for all surfaces in the patient room.

Answer: (SHOW ANSWER)

The scenario involves the introduction of a new hospital disinfectant with a 3-minute contact time, intended for use across patient care areas, but with concerns raised by Environmental Services about its high cost. The infection preventionist's advice must balance infection control efficacy with cost management, adhering to principles outlined by the Certification Board of Infection Control and Epidemiology (CBIC) and evidence-based practices. The goal is to optimize the disinfectant's use while ensuring a safe environment. Let's evaluate each option:

A). Use the new disinfectant for patient washrooms only: Limiting the disinfectant to patient washrooms focuses its use on high-touch, high-risk areas where pathogens (e.g., *Clostridioides difficile*, norovirus) may be prevalent. However, this approach restricts the disinfectant's application to a specific area, potentially leaving other patient care surfaces (e.g., bed rails, tables) vulnerable to contamination. While cost-saving, it does not address the broad infection control needs across all patient care areas, making it an incomplete strategy.

B). Use detergents on the floors in patient rooms: Detergents are cleaning agents that remove dirt and organic material but lack the antimicrobial properties of disinfectants. Floors in patient rooms can harbor pathogens, but they are generally considered lower-risk surfaces compared to high-touch areas (e.g., bed rails, doorknobs). Using detergents instead of the new disinfectant on floors could reduce costs but compromises infection control, as floors may still contribute to environmental transmission (e.g., via shoes or equipment).

This option is not optimal given the availability of an effective disinfectant.

C). Use detergents on smooth horizontal surfaces: Smooth horizontal surfaces (e.g., tables, counters, overbed tables) are common sites for pathogen accumulation and transmission in patient rooms. Using detergents to clean these surfaces removes organic material, which is a critical first step before disinfection. If the 3-minute contact time disinfectant is reserved for high-touch or high-risk surfaces (e.g., bed rails, call buttons) where disinfection is most critical, this approach maximizes the disinfectant's efficacy while reducing its overall use and cost. This strategy aligns with CBIC guidelines, which emphasize a two-step process (cleaning followed by disinfection) and targeted use of resources, making it a practical and cost-effective recommendation.

D). Use new disinfectant for all surfaces in the patient room: Using the disinfectant on all surfaces ensures comprehensive pathogen reduction but increases consumption and cost,

which is a concern for Environmental Services. While the 3-minute contact time suggests efficiency, overusing the disinfectant on low-risk surfaces (e.g., floors, walls) may not provide proportional infection control benefits and could strain the budget. This approach does not address the cost concern and is less strategic than targeting high-risk areas. The best advice is C, using detergents on smooth horizontal surfaces to handle routine cleaning, while reserving the new disinfectant for high-touch or high-risk areas where its antimicrobial action is most needed.

This optimizes infection prevention, aligns with CBIC's emphasis on evidence-based environmental cleaning, and addresses the cost concern by reducing unnecessary disinfectant use. The infection preventionist should also recommend a risk assessment to identify priority surfaces for disinfectant application.

CBIC Infection Prevention and Control (IPC) Core Competency Model (updated 2023), Domain IV:

Environment of Care, which advocates for targeted cleaning and disinfection based on risk.

CBIC Examination Content Outline, Domain III: Prevention and Control of Infectious Diseases, which includes cost-effective use of disinfectants.

CDC Guidelines for Environmental Infection Control in Healthcare Facilities (2022), which recommend cleaning with detergents followed by targeted disinfection.

NEW QUESTION: 105

Immediate use steam sterilization is NOT recommended for implantable items requiring immediate use because

- A.** the high temperature may damage the items.
- B.** chemical indicators may not be accurate at high temperatures.
- C.** results of biologic indicators are unavailable prior to use of the item.
- D.** the length of time is inadequate for the steam to penetrate the pack.

Answer: C (LEAVE A REPLY)

The correct answer is C, "results of biologic indicators are unavailable prior to use of the item," as this is the primary reason immediate use steam sterilization (IUSS) is not recommended for implantable items requiring immediate use. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, IUSS is a process used for sterilizing items needed urgently when no other sterile options are available, typically involving a shortened cycle (e.g., flash sterilization). However, for implantable items- such as orthopedic hardware or prosthetic devices-ensuring absolute sterility is critical due to the risk of deep infection. Biologic indicators (BIs), which contain highly resistant spores to verify sterilization efficacy, require incubation (typically 24-48 hours) to confirm the kill, but IUSS does not allow time for BI results to be available before the item is used (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This lack of immediate verification poses a significant infection risk, making IUSS inappropriate for implants, as per AAMI ST79 standards.

Option A (the high temperature may damage the items) is a consideration for some heat-sensitive materials, but modern IUSS cycles are designed to minimize damage, and this is not the primary reason for the restriction on implants. Option B (chemical indicators may not be accurate at high temperatures) is incorrect, as chemical indicators (e.g., color-changing strips) are reliable at high temperatures and serve as an immediate check, though they are not a substitute for BIs. Option D (the length of time is inadequate for the steam to penetrate the pack) is not the main issue, as IUSS cycles are optimized for penetration, though the shortened time may be a secondary concern; the unavailability of BI results remains the decisive factor.

The focus on biologic indicator results aligns with CBIC's emphasis on ensuring the safety and sterility of reprocessed medical devices, particularly for high-risk implantable items (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This recommendation is supported by AAMI and CDC guidelines, which prioritize BI confirmation for implants to prevent healthcare-associated infections (AAMI ST79:2017, CDC Sterilization Guidelines, 2019).
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. AAMI ST79:2017, Comprehensive guide to steam sterilization and sterility assurance in health care facilities. CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2019.

NEW QUESTION: 106

An infection preventionist has been informed that a patient admitted 2 days ago has been diagnosed with chickenpox. Ten employees have had contact with this patient. Those employees with significant exposure may be furloughed after exposure. "Significant exposure" is considered

- A.** greater than one hour of direct patient contact occurring within 24 hours prior to the appearance of lesions.
- B.** sharing the same air space for any duration of time after the patient has developed skin lesions.
- C.** unprotected contact with respiratory secretions or skin lesions occurring after 12 hours of the appearance of lesions.
- D.** irrelevant unless the employee has a negative varicella antibody titer.

Answer: (SHOW ANSWER)

Chickenpox (varicella) is primarily spread through airborne transmission, and exposure is defined by being in the same airspace with a contagious person (from 1-2 days before rash onset until lesions are crusted), even if briefly.

The APIC Text states:

"Significant exposure is defined as being in the same room or airspace during the period of infectivity, regardless of duration".

This reflects airborne precaution definitions and CDC exposure management guidelines for varicella.

References:

APIC Text, 4th Edition, Chapter 105 - Immunization of Healthcare Personnel

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!
Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 107

Which of the following BEST describes the content of an interpretive surveillance report?

- A. Outlines the organization's mission for patient quality and safety
- B. Cites the frequency of the evaluation of the monitoring program
- C. Highlights the steps of the facility's quality improvement activities
- D. Provides findings in a manner designed for the intended audience

Answer: D (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) explains that an interpretive surveillance report goes beyond simply presenting raw data. Its primary purpose is to translate surveillance findings into meaningful, actionable information that can be understood and used by the intended audience, such as frontline staff, clinical leaders, executive leadership, or quality committees.

Interpretive reports contextualize infection data by explaining trends, comparisons, implications, and recommended actions. This may include highlighting increases or decreases in infection rates, identifying areas of concern, interpreting statistical significance, and linking findings to prevention strategies. The format, level of detail, and language are tailored to the audience's role and decision-making responsibilities. For example, senior leadership may need high-level summaries and risk implications, while unit-level staff benefit from detailed, practice-focused feedback.

Option A describes a mission statement, not a surveillance report. Option B refers to program evaluation logistics rather than interpretation of findings. Option C outlines quality improvement processes but does not describe how surveillance data are communicated. For the CIC exam, it is essential to recognize that interpretive surveillance reporting focuses on meaningful communication, not just data display. Providing findings in a manner designed for the intended audience ensures surveillance data drive prevention actions, accountability, and performance improvement-making option D the best answer.

NEW QUESTION: 108

A change in the disinfection protocol is indicated for which of the following scenarios?

- A. A high-level disinfectant being used for diaphragm fitting rings
- B. Sodium hypochlorite being used for blood pressure cuffs
- C. An enzymatic solution being used for rectal probes
- D. 2% glutaraldehyde being used for cryosurgical probes

Answer: C (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes the importance of applying Spaulding's classification to determine appropriate cleaning, disinfection, and sterilization levels for medical devices based on their intended use.

According to this framework, rectal probes are classified as semi-critical devices because they come into contact with mucous membranes. Semi-critical devices require at least high-level disinfection after thorough cleaning.

An enzymatic solution, as listed in option C, is not a disinfectant. Enzymatic detergents are designed solely for cleaning, meaning they help remove organic material such as blood, mucus, and feces, but they do not kill microorganisms. Using an enzymatic solution alone for rectal probes is therefore inadequate and represents an improper disinfection practice, making this the scenario that clearly requires a protocol change.

Option A is acceptable because diaphragm fitting rings are noncritical devices that contact intact skin and may be safely processed using high-level disinfection. Option B is appropriate because blood pressure cuffs are noncritical items and can be disinfected using low- to intermediate-level disinfectants such as sodium hypochlorite. Option D is also appropriate, as cryosurgical probes are semi-critical devices and 2% glutaraldehyde is an accepted high-level disinfectant.

Recognizing the distinction between cleaning versus disinfection and applying the correct level of processing is a core competency for infection preventionists and a frequently tested concept on the CIC exam.

NEW QUESTION: 109

The infection preventionist and Occupational Health discuss the 65% influenza vaccination rate for healthcare personnel. Which is MOST effective method to increase compliance?

- A. Pre-schedule healthcare personnel for vaccine administration
- B. Require annual vaccine as a condition of employment
- C. Educate staff about risks of not receiving vaccine
- D. Offer the vaccine year round to increase compliance

Answer: (SHOW ANSWER)

Requiring influenza vaccination as a condition of employment has consistently been shown to be the most effective method to increase compliance among healthcare personnel.

The APIC/JCR Workbook recommends this as a gold standard:

"Some organizations have adopted policies requiring annual vaccination as a condition of employment unless medically contraindicated".

CDC and APIC also support this method for maximizing coverage and protecting vulnerable populations.

References:

APIC/JCR Workbook, 4th Edition, Chapter 10 - Occupational Health Issues
APIC Position Paper: Influenza Vaccination Should Be a Condition of Employment for Healthcare Personnel

NEW QUESTION: 110

Passive immunity results from the use of:

- A.** Tetanus antitoxin
- B.** Hepatitis B vaccine
- C.** Influenza vaccine
- D.** Human diploid cell rabies vaccine

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) defines passive immunity as protection that results from the administration of preformed antibodies, rather than stimulation of the individual's own immune system.

Passive immunity provides immediate but temporary protection, because the recipient does not produce antibodies and therefore does not develop immunologic memory.

Tetanus antitoxin is a classic example of passive immunity. It contains antibodies that neutralize tetanus toxin directly and is used in situations where immediate protection is needed, such as after certain wounds in individuals with unknown or inadequate vaccination history. The study guide emphasizes that passive immunization is particularly important in post-exposure management when waiting for an active immune response would be too slow to prevent disease.

The other options represent active immunization, not passive immunity. Vaccines such as hepatitis B vaccine, influenza vaccine, and human diploid cell rabies vaccine stimulate the recipient's immune system to produce its own antibodies and immune memory. While rabies immune globulin provides passive immunity, the rabies vaccine itself is an active immunizing agent.

This distinction between active and passive immunity is a frequently tested CIC exam concept, especially in the context of occupational health, post-exposure prophylaxis, and immunization programs. Recognizing that passive immunity involves antibody products (antitoxins or immune globulins) rather than vaccines is essential for accurate infection prevention decision-making.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 6: Employee

/Occupational Health; Chapter 3: Identification of Infectious Disease Processes.

NEW QUESTION: 111

Which of the following microorganisms does NOT cause gastroenteritis in humans?

- A. Norovirus
- B. Rhinovirus
- C. Rotavirus
- D. Coxsackievirus

Answer: B (LEAVE A REPLY)

Gastroenteritis, characterized by inflammation of the stomach and intestines, typically presents with symptoms such as diarrhea, vomiting, and abdominal pain. The Certification Board of Infection Control and Epidemiology (CBIC) emphasizes the identification of infectious agents in the "Identification of Infectious Disease Processes" domain, aligning with the Centers for Disease Control and Prevention (CDC) guidelines on foodborne and enteric diseases. The question requires identifying the microorganism among the options that does not cause gastroenteritis, necessitating an evaluation of each pathogen's clinical associations.

Option B, "Rhinovirus," is the correct answer as it does not cause gastroenteritis.

Rhinoviruses are the primary cause of the common cold, affecting the upper respiratory tract and leading to symptoms like runny nose, sore throat, and cough. The CDC and WHO classify rhinoviruses as picornaviruses that replicate in the nasopharynx, with no significant evidence linking them to gastrointestinal illness in humans. Their transmission is primarily through respiratory droplets, not the fecal-oral route associated with gastroenteritis.

Option A, "Norovirus," is a well-known cause of gastroenteritis, often responsible for outbreaks of acute vomiting and diarrhea, particularly in closed settings like cruise ships or nursing homes. The CDC identifies norovirus as the leading cause of foodborne illness in the U.S., transmitted via the fecal-oral route. Option C,

"Rotavirus," is a major cause of severe diarrheal disease in infants and young children worldwide, also transmitted fecal-orally, with the CDC noting its significance before widespread vaccination reduced its impact. Option D, "Coxsackievirus," a member of the enterovirus genus, can cause gastroenteritis, particularly in children, alongside other syndromes like hand-foot-mouth disease. The CDC and clinical literature (e.g., Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases) document its gastrointestinal involvement, though it is less common than norovirus or rotavirus.

The CBIC Practice Analysis (2022) and CDC guidelines on enteric pathogens underscore the importance of distinguishing between respiratory and gastrointestinal pathogens for effective infection control. Rhinovirus's exclusive association with respiratory illness makes Option B the microorganism that does not cause gastroenteritis.

References:

- * CBIC Practice Analysis, 2022.
- * CDC Norovirus Fact Sheet, 2021.
- * CDC Rotavirus Vaccination Information, 2020.
- * Mandell, Douglas, and Bennett's Principles and Practice of Infectious Diseases, 9th Edition, 2019.

NEW QUESTION: 112

During the last week in June, an emergency department log reveals numerous cases of profuse watery diarrhea in individuals 74 years of age and older. During the same time period, four immunocompromised patients were admitted with possible *Cryptosporidium*. Which of the following actions should the infection preventionist take FIRST?

- A. Characterize the outbreak by person, place, and time
- B. Increase surveillance facility wide for additional cases
- C. Contact the laboratory to confirm stool identification results
- D. Form a tentative hypothesis about the potential reservoir for this outbreak

Answer: (SHOW ANSWER)

When an outbreak of infectious disease is suspected, the first step is to conduct an epidemiologic investigation. This begins with characterizing the outbreak by person, place, and time to establish patterns and trends. This approach, known as descriptive epidemiology, provides critical insights into potential sources and transmission patterns.

Step-by-Step Justification:

Identify Cases and Patterns:

The infection preventionist should analyze patient demographics (person), locations of cases (place), and onset of symptoms (time). This helps in defining the outbreak scope and potential exposure sources.

Create an Epidemic Curve:

An epidemic curve helps determine whether the outbreak is a point-source or propagated event. This can indicate whether the infection is spreading person-to-person or originating from a common source.

Compare with Baseline Data:

Reviewing historical data ensures that the observed cases exceed the expected norm, confirming an outbreak.

Guide Further Investigation:

Establishing basic epidemiologic patterns guides subsequent actions, such as laboratory testing, environmental sampling, and surveillance.

Why Other Options Are Incorrect:

B). Increase surveillance facility-wide for additional cases:

While enhanced surveillance is important, it should follow the initial characterization of the outbreak.

Surveillance without a defined case profile may lead to misclassification and misinterpretation.

C). Contact the laboratory to confirm stool identification results:

Confirming lab results is essential but comes after defining the outbreak's characteristics. Without an epidemiologic link, testing may yield results that are difficult to interpret.

D). Form a tentative hypothesis about the potential reservoir for this outbreak:

Hypothesis generation occurs after sufficient epidemiologic data have been collected. Jumping to conclusions without characterization may result in incorrect assumptions and ineffective control measures.

CBIC Infection Control References:

APIC Text, "Outbreak Investigations," Epidemiology, Surveillance, Performance, and Patient Safety Measures.

APIC/JCR Infection Prevention and Control Workbook, Chapter 4, Surveillance Program.

APIC Text, "Investigating Infectious Disease Outbreaks," Guidelines for Epidemic Curve Analysis.

NEW QUESTION: 113

An outbreak of carbapenem-resistant *Klebsiella pneumoniae* is linked to duodenoscopes. What is the infection preventionist's **PRIORITY** intervention?

- A.** Perform targeted patient screening for *Klebsiella pneumoniae*.
- B.** Implement immediate enhanced reprocessing procedures and audit compliance.
- C.** Discontinue the use of duodenoscopes until further notice.
- D.** Conduct whole-genome sequencing of outbreak isolates.

Answer: B (LEAVE A REPLY)

* The CDC and FDA have identified duodenoscopes as high-risk devices due to inadequate reprocessing, leading to MDRO transmission.

* The first priority is enhancing reprocessing protocols and ensuring strict compliance with manufacturer instructions.

CBIC Infection Control References:

* APIC Text, "Endoscope Reprocessing and Infection Risk," Chapter 10.

NEW QUESTION: 114

The Sterile Processing Department alerts an infection preventionist that a load of surgical Instruments sterilized with high temperature steam:moist heat needs to be recalled. Which of the following is the **MOST** likely reason for the recall?

- A.** Failure of the biological Indicator *Bacillus subtilis*
- B.** Failure of the biological Indicator *Geobacillus stearothermophilus*
- C.** Placement of the biological Indicator on the bottom shelf over the drain
- D.** Incorrect placement of the instruments in the tray

Answer: B (LEAVE A REPLY)

The most likely reason for the recall of a steam-sterilized load is the failure of the biological indicator (BI), specifically *Geobacillus stearothermophilus*, which is used to monitor high-temperature steam (moist heat) sterilization processes. This organism is the biological indicator of choice because it has high resistance to moist heat and thus serves as a reliable marker for sterilization efficacy.

The APIC Text and AAMI ST79 guidelines confirm that *Geobacillus stearothermophilus* is used for steam sterilization and that a failed BI indicates a failure in the sterilization

process, which requires immediate action, including recalling all items sterilized since the last negative BI and reprocessing them. This is a crucial aspect of ensuring patient safety and preventing the use of potentially non-sterile surgical instruments.

According to the APIC Text:

"BIs are the only process indicators that directly monitor the lethality of a given sterilization process. [...] *Geobacillus stearothermophilus* spores are used to monitor steam sterilization..." The CIC Study Guide (6th ed.) also specifies that:

"Evidence of sterilization failures (e.g., positive biological indicators) is the most common reason for a recall." Additionally, it is noted:

"With steam sterilization, the instrument load does not need to be recalled for a single positive biological indicator test, with the exception of implantable objects." However, multiple positive BIs or BI failure confirmation does require a recall.

The incorrect options explained:

A). *Bacillus subtilis* - This is not used in steam sterilization but rather in dry heat or EO processes.

C). Placement of the biological indicator on the bottom shelf over the drain - While incorrect placement can lead to test failure, the recall is prompted by BI failure, not just placement.

D). Incorrect placement of instruments - This can cause sterilization failure but is not the direct trigger for a recall unless it leads to a failed BI.

References:

CIC Study Guide, 6th Edition, Chapter 10 - Cleaning, Sterilization, Disinfection, Asepsis, Pages 211, 236 APIC Text, 4th Edition, Chapter 106 - Sterile Processing ANSI/AAMI ST79:2017, cited throughout APIC Text and APIC 4 for sterilization monitoring protocols.

NEW QUESTION: 115

An infection preventionist is writing a policy about prevention of intravascular device infection. Which of the following is important for healthcare personnel to know as part of central line insertion and maintenance procedures?

- A. Change the central line every seven days.
- B. Use maximum sterile barrier precautions for the line insertion.
- C. The femoral site is the preferred site of insertion in an adult patient.
- D. Use 70% isopropyl alcohol for skin preparation before line insertion.

Answer: B (LEAVE A REPLY)

The Certification Study Guide (6th edition) identifies the use of maximum sterile barrier (MSB) precautions during central line insertion as a cornerstone practice for preventing intravascular device-associated infections, including central line-associated bloodstream infections (CLABSIs). MSB precautions include wearing a cap, mask, sterile gown, and sterile gloves, and using a large sterile drape to fully cover the patient during line insertion. These measures significantly reduce the risk of introducing skin flora and environmental microorganisms into the bloodstream at the time of catheter placement.

The study guide emphasizes that the highest risk for contamination occurs during insertion, making strict aseptic technique essential. MSB precautions are a required element of evidence-based central line insertion bundles and are consistently associated with reduced CLABSI rates when reliably implemented.

The other options reflect outdated or incorrect practices. Routine scheduled replacement of central lines every seven days is not recommended and does not reduce infection risk. The femoral vein is not the preferred insertion site in adults due to higher infection risk compared to subclavian or internal jugular sites. While alcohol is used during hub disinfection, chlorhexidine-based antisepsis (preferably chlorhexidine with alcohol) is recommended for skin preparation-not alcohol alone.

This question highlights a core CIC exam concept: standardized insertion practices using maximum sterile barriers are among the most effective strategies for preventing intravascular device infections.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 5: Preventing

/Controlling the Transmission of Infectious Agents; Chapter 10: Cleaning, Sterilization, Disinfection, and Asepsis.

NEW QUESTION: 116

Infection Prevention and Control identified a cluster of *Aspergillus fumigatus* infections in the transplant unit.

The infection preventionist (IP) meets with the unit director and Environmental Services director to begin investigation. What information does the IP need from the Environmental Services director?

- A.** Date of last terminal clean of the infected patient rooms
- B.** Hospital grade disinfectant used on the transplant unit
- C.** Use of dust mitigating strategies during floor care
- D.** Date of the last cleaning of the fish tank in the waiting room

Answer: ([SHOW ANSWER](#))

The correct answer is A, "Date of last terminal clean of the infected patient rooms," as this is the most critical information the infection preventionist (IP) needs from the Environmental Services director to begin the investigation of a cluster of *Aspergillus fumigatus* infections in the transplant unit. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, *Aspergillus fumigatus* is an environmental fungus that thrives in areas with poor ventilation, construction dust, or inadequate cleaning, posing a significant risk to immunocompromised patients, such as those in transplant units. A terminal clean- thorough disinfection and cleaning of a patient room after discharge or transfer-is a key infection control measure to eliminate fungal spores and other pathogens (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols).

Determining the date of the last terminal clean helps the IP assess whether lapses in cleaning schedules or procedures could have contributed to the cluster, guiding further environmental sampling or process improvements.

Option B (hospital grade disinfectant used on the transplant unit) is relevant to the investigation but is secondary; the IP would need to know the cleaning schedule first to contextualize the disinfectant's effectiveness. Option C (use of dust mitigating strategies during floor care) is important, as *Aspergillus* spores can be aerosolized during floor maintenance, but this is a specific procedural detail that follows the initial focus on cleaning history. Option D (date of the last cleaning of the fish tank in the waiting room) is unlikely to be a priority unless evidence suggests a direct link to the transplant unit, which is not indicated here; *Aspergillus* is more commonly associated with air quality and room cleaning rather than fish tanks.

The focus on the date of the last terminal clean aligns with CBIC's emphasis on investigating environmental factors in healthcare-associated infection (HAI) clusters, enabling the IP to collaborate with Environmental Services to pinpoint potential sources and implement corrective actions (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.2 - Analyze surveillance data). This step is foundational to controlling the outbreak and protecting vulnerable patients.

References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.2 - Analyze surveillance data; Domain III: Infection Prevention and Control, Competency 3.4 - Implement environmental cleaning and disinfection protocols.

NEW QUESTION: 117

After reviewing quarterly surveillance data, the infection preventionist (IP) identifies an upward trend in needlestick injuries occurring during bedside blood draws. What is the MOST appropriate collaborative action for the IP to take with the Occupational Health Department?

- A.** Wait for the next regulatory survey to address the issue more formally with hospital leadership.
- B.** Complete a device review and determine if faulty equipment has been the cause or if the manufacturer has issued a recall.
- C.** Convene a multidisciplinary safety team to evaluate workflows, review device usage, and recommend practice changes.
- D.** Discuss trends at the quarterly quality assurance and performance improvement meeting with the multidisciplinary safety team.

Answer: C (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that when surveillance identifies an increasing trend in occupational exposures, such as needlestick injuries, the infection preventionist must take prompt, proactive, and collaborative action. The most appropriate response is to convene a multidisciplinary

safety team in partnership with Occupational Health to perform a focused evaluation of the problem.

A multidisciplinary approach allows for comprehensive assessment of workflows, staffing practices, device selection, training, and compliance with standard precautions. Team members may include nursing leadership, frontline staff, occupational health, infection prevention, materials management, and safety officers. This collaboration supports root cause analysis to identify contributing factors-such as improper technique, workflow inefficiencies, inadequate training, or suboptimal safety-engineered devices-and to implement targeted interventions.

Option A is inappropriate because delaying action increases risk to healthcare personnel. Option B may be part of the evaluation but is too narrow and should not occur in isolation. Option D is insufficient because discussing trends alone does not result in immediate corrective action.

The Study Guide highlights that timely, interdisciplinary performance improvement efforts are essential to reduce occupational exposures and comply with regulatory and safety standards. Convening a multidisciplinary safety team enables rapid intervention, staff engagement, and sustainable injury reduction- making option C the best answer and a high-yield CIC exam concept.

NEW QUESTION: 118

A team was created to determine what has contributed to the recent increase in catheter associated urinary tract infections (CAUTIs). What quality tool should the team use?

- A.** Gap analysis
- B.** Fishbone diagram
- C.** Plan, do, study, act (PDSA)
- D.** Failure mode and effect analysis (FMEA)

Answer: ([SHOW ANSWER](#))

The correct answer is B, "Fishbone diagram," as this is the most appropriate quality tool for the team to use when determining what has contributed to the recent increase in catheter-associated urinary tract infections (CAUTIs). According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the fishbone diagram, also known as an Ishikawa or cause-and-effect diagram, is a structured tool used to identify and categorize potential causes of a problem. In this case, the team needs to explore the root causes of the CAUTI increase, which could include factors such as improper catheter insertion techniques, inadequate maintenance, staff training gaps, or environmental issues (CBIC Practice Analysis, 2022, Domain II:

Surveillance and Epidemiologic Investigation, Competency 2.2 - Analyze surveillance data). The fishbone diagram organizes these causes into categories (e.g., people, process, equipment, environment), facilitating a comprehensive analysis and guiding further investigation or intervention.

Option A (gap analysis) is useful for comparing current performance against a desired standard or benchmark, but it is more suited for identifying deficiencies in existing processes rather than uncovering the specific causes of a recent increase. Option C (plan, do, study, act [PDSA]) is a cyclical quality improvement methodology for testing and implementing changes, which would be relevant after identifying causes and designing interventions, not as the initial tool for root cause analysis. Option D (failure mode and effect analysis [FMEA]) is a proactive risk assessment tool used to predict and mitigate potential failures in a process before they occur, making it less applicable to analyzing an existing increase in CAUTIs.

The use of a fishbone diagram aligns with CBIC's emphasis on using data-driven tools to investigate and address healthcare-associated infections (HAIs) like CAUTIs, supporting the team's goal of pinpointing contributory factors (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.3 - Identify risk factors for healthcare-associated infections). This tool's visual and collaborative nature also fosters team engagement, which is essential for effective problem-solving in infection prevention. References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competencies 2.2 - Analyze surveillance data, 2.3 - Identify risk factors for healthcare-associated infections.

NEW QUESTION: 119

Which of the following process performance indicators should result in improvement in central line- associated bloodstream infections (CLABSI)?

- A.** All patients with a central line are on total parenteral nutrition (TPN).
- B.** 100% compliance with the insertion bundle.
- C.** Povidone-iodine antiseptic ointment placed at the insertion site of a peripherally inserted central catheter line.
- D.** Routinely changing the central line over a guidewire every seven days.

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) emphasizes that process performance indicators directly linked to evidence-based practices are the most effective measures for reducing healthcare-associated infections such as CLABSI. Among the options listed, 100% compliance with the central line insertion bundle is the only indicator consistently demonstrated to reduce CLABSI rates.

Insertion bundles are standardized sets of practices that include proper hand hygiene, maximal sterile barrier precautions, use of appropriate skin antisepsis (preferably chlorhexidine), optimal catheter site selection, and daily review of line necessity. The study guide explains that reliable execution of these bundled practices addresses the most common routes of microbial entry at the time of line placement, which is a critical risk period for bloodstream infection.

The other options do not represent valid improvement indicators. Total parenteral nutrition is a known risk factor for CLABSI, not a prevention strategy. Use of povidone-iodine

ointment at insertion sites is not recommended and may increase infection risk. Routine guidewire exchanges are discouraged because they do not reduce infection risk and may increase contamination.

Therefore, measuring and achieving full compliance with the insertion bundle is a meaningful, actionable performance indicator that aligns with CBIC exam expectations and infection prevention best practices.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 5: Preventing

/Controlling the Transmission of Infectious Agents; Chapter 4: Surveillance and Epidemiologic Investigation.

\

NEW QUESTION: 120

An infection preventionist (IP) receives a phone call from a local health department alerting the hospital of the occurrence of a sewer main break. Contamination of the city water supply is a possibility. Which of the following actions should the IP perform FIRST?

- A.** Notify the Emergency and Admissions departments to report diarrhea cases to infection control.
- B.** Review microbiology laboratory reports for enteric organisms in the past week.
- C.** Contact the Employee Health department and ask for collaboration in case-finding.
- D.** Review the emergency preparedness plan with engineering for sources of potable water.

Answer: (SHOW ANSWER)

The correct answer is B, "Review microbiology laboratory reports for enteric organisms in the past week," as this is the first action the infection preventionist (IP) should perform following the alert of a sewer main break and potential contamination of the city water supply. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, a rapid assessment of existing data is a critical initial step in investigating a potential waterborne outbreak. Reviewing microbiology laboratory reports for enteric organisms (e.g., *Escherichia coli*, *Salmonella*, or *Shigella*) helps the IP identify any recent spikes in infections that could indicate water supply contamination, providing an evidence-based starting point for the investigation (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.2 - Analyze surveillance data). This step leverages available hospital data to assess the scope and urgency of the situation before initiating broader actions.

Option A (notify the Emergency and Admissions departments to report diarrhea cases to infection control) is an important subsequent step to enhance surveillance, but it relies on proactive reporting and does not provide immediate evidence of an ongoing issue. Option C (contact the Employee Health department and ask for collaboration in case-finding) is valuable for involving additional resources, but it should follow the initial data review to prioritize case-finding efforts based on identified trends. Option D (review the emergency

preparedness plan with engineering for sources of potable water) is a critical preparedness action, but it is more relevant once contamination is confirmed or as a preventive measure, not as the first step in assessing the current situation.

The focus on reviewing laboratory reports aligns with CBIC's emphasis on using surveillance data to guide infection prevention responses, enabling the IP to quickly determine if the sewer main break has already impacted patient health and to escalate actions accordingly (CBIC Practice Analysis, 2022, Domain II:

Surveillance and Epidemiologic Investigation, Competency 2.1 - Conduct surveillance for healthcare-associated infections and epidemiologically significant organisms). This approach is consistent with CDC guidelines for responding to waterborne outbreak alerts (CDC Environmental Public Health Guidelines, 2020).

References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competencies 2.1 - Conduct surveillance for healthcare-associated infections and epidemiologically significant organisms, 2.2 - Analyze surveillance data. CDC Environmental Public Health Guidelines, 2020.

NEW QUESTION: 121

While completing compliance rounds in the Central Supply department, the infection preventionist notes items that have completed the sterilization process are showing evidence of moisture on the inside of the sterilization package. The FIRST step that the IP should take is to

- A.** re-educate the employee on the sterilization process.
- B.** instruct central supply staff to recall all items in the affected load and reprocess.
- C.** monitor employee's compliance with facility policy regarding the sterilization process.
- D.** do nothing as it is normal to have some condensation on the inside of the sterilization package.

Answer: B (LEAVE A REPLY)

Any evidence of moisture inside a sterilization package indicates a compromised sterilization process. The immediate action is to recall and reprocess the entire affected load.

* According to ANSI/AAMI ST79 and cited in the APIC Text:

"Any items with packaging that appears to be wet should not be used." These items must be reprocessed to ensure sterility is not compromised.

* This is not a matter for education or monitoring-it requires direct corrective action to protect patient safety.

References:

APIC Text, 4th Edition, Chapter 108 - Sterile Processing

exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:
https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**
Special Discount: Freepdfdumps)

NEW QUESTION: 122

An infection preventionist (IP) is asked to participate on a team to decrease ventilator-associated pneumonia (VAP) rates in a 20-bed ICU. The IP provides the following information. What is the first quarter ventilator utilization ratio?

	<u>Jan</u>	<u>Feb</u>	<u>Mar</u>	<u>Total</u>
1. # ventilator days	300	220	280	800
2. # patient days	449	350	401	1200
3. # pneumonias in ventilated patients	3	2	5	10
4. # total pneumonias in the ICU	11	2	7	20

Data Provided (First Quarter):

Ventilator days (Jan-Mar total): 800

Patient days (Jan-Mar total): 1200

- A. 0.13
- B. 0.67
- C. 1.50
- D. 1.67

Answer: (SHOW ANSWER)

The Certification Study Guide (6th edition) defines the ventilator utilization ratio (VUR) as a device utilization measure used in surveillance to describe the proportion of patient time during which a specific medical device—in this case, mechanical ventilation—is in use. It is calculated by dividing the total number of ventilator days by the total number of patient days for the same location and time period.

Using the first-quarter data provided, the calculation is as follows:

Ventilator Utilization Ratio = Ventilator Days ÷ Patient Days

Ventilator Utilization Ratio = $800 \div 1200 = 0.67$

This means that ventilators were in use for 67% of all patient days in the ICU during the first quarter. The study guide emphasizes that device utilization ratios are essential for interpreting device-associated infection data, such as VAP rates, because they reflect the level of patient exposure to the device. Higher utilization increases the population at risk and can influence infection rates independently of prevention practices.

The other answer options are incorrect because they do not reflect the correct calculation.

A ratio greater than

1.0 (options C and D) would imply more device days than patient days, which is not possible in this context.

Option A underestimates utilization and does not match the provided data.

Understanding and correctly calculating utilization ratios is a core CIC exam competency, as these metrics support accurate surveillance, benchmarking, and performance improvement efforts.

Reference: Certification Study Guide (CBIC/CIC Exam Study Guide), 6th edition, Chapter 4: Surveillance and Epidemiologic Investigation.

NEW QUESTION: 123

During an outbreak investigation of *Pseudomonas aeruginosa* in a medical intensive care unit (ICU), what is a critical INITIAL step the infection preventionist (IP) should take to better understand an investigation process and this organism?

- A.** Notify public health officials to alert them of the outbreak.
- B.** Consult with other IPs in their region to find out what others have seen.
- C.** Conduct a literature search that summarizes similar outbreak investigations.
- D.** Contact the Centers for Disease Control and Prevention to determine if anyone in their area has experienced similar situations.

Answer: C (LEAVE A REPLY)

The CBIC Certified Infection Control Exam Study Guide (6th edition) emphasizes that a critical initial step in any outbreak investigation is for the infection preventionist to develop a strong understanding of the organism involved, its epidemiology, reservoirs, modes of transmission, and previously reported outbreak sources.

Conducting a literature search of similar outbreak investigations provides this foundational knowledge and helps guide a structured, evidence-based investigation.

Pseudomonas aeruginosa is an opportunistic, water-associated pathogen frequently implicated in healthcare-associated outbreaks, particularly in ICUs. Prior outbreak investigations described in the literature commonly identify sources such as sink drains, faucets, respiratory equipment, humidifiers, contaminated medications, and inadequate reprocessing of medical devices. Reviewing published investigations allows the IP to anticipate likely sources, identify high-yield environmental sampling locations, and avoid unnecessary or unfocused interventions.

Options A and D may become appropriate later, depending on outbreak magnitude and reporting requirements, but they are not the initial step. Option B can be helpful but relies on anecdotal experience rather than systematic evidence. The Study Guide stresses that outbreak investigations should begin with background research and hypothesis generation, followed by targeted data collection and analysis.

For the CIC exam, this question reinforces that effective outbreak management starts with understanding what is already known, making a literature review the most appropriate initial action.

Valid CIC Dumps shared by Actual4test.com for Helping Passing CIC Exam!

Actual4test.com now offer the **newest CIC exam dumps**, the Actual4test.com CIC exam **questions have been updated** and **answers have been corrected** get the **newest** Actual4test.com CIC dumps with Test Engine here:

https://www.actual4test.com/CIC_examcollection.html (302 Q&As Dumps, **30%OFF**

Special Discount: Freepdfdumps)