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CBIC Certified Infection Control

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Question: 1

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**Explanation:**

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., ,]

Question: 2

The annual report for Infection Prevention shows a dramatic decrease in urinary catheter days, a decrease in the catheter utilization ratio, and a slight decrease in the number of catheter-associated urinary tract infections (CAUTIs). The report does not show an increase in the overall rate of CAUTI. How would the infection preventionist explain this to the administration?

- A. The rate is incorrect and needs to be recalculated.
- B. The rate may be higher if the denominator is very small.
- C. The rate is not affected by the number of catheter days.
- D. Decreasing catheter days will not have an effect on decreasing CAUTI.

Answer: B

Explanation:

The correct answer is B, "The rate may be higher if the denominator is very small," as this provides the most plausible explanation for the observed data in the annual report. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the CAUTI rate is calculated as the number of CAUTIs per 1,000 catheter days, where catheter days serve as the denominator. The report indicates a dramatic decrease in urinary catheter days and a slight decrease in the number of CAUTIs, yet the overall CAUTI rate has not increased. This discrepancy can occur if the denominator (catheter days) becomes very small, which can inflate or destabilize the rate, potentially masking an actual increase in the infection risk per catheter day (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.2 - Analyze surveillance data). A smaller denominator amplifies the impact of even a slight change in the number of infections, suggesting that the rate may be higher than expected or less reliable, necessitating further investigation.

Option A (the rate is incorrect and needs to be recalculated) assumes an error in the calculation without evidence, which is less specific than the denominator effect explanation. Option C (the rate is not affected

of catheter days as the denominator; a decrease in catheter days should typically lower the rate if infections decrease proportionally, but the lack of an increase here suggests a calculation or interpretation issue. Option D (decreasing catheter days will not have an effect on decreasing CAUTI) contradicts evidence-based practice, as reducing catheter days is a proven strategy to lower CAUTI incidence, though the rate's stability here indicates a potential statistical artifact.

The explanation focusing on the denominator aligns with CBIC's emphasis on accurate surveillance and data analysis to guide infection prevention strategies, allowing the infection preventionist to advise administration on the need to review data trends or adjust monitoring methods (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.5 - Use data to guide infection prevention and control strategies). This insight can prompt a deeper analysis to ensure the CAUTI rate reflects true infection risk.

[References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competencies 2.2 - Analyze surveillance data, 2.5 - Use data to guide infection prevention and control strategies., , ,]

Question: 3

Hand-hygiene audits in a long-term care facility have demonstrated consistently low levels of staff compliance. An infection preventionist is planning an education program to try to improve hand-hygiene rates. Regarding assessment of the effectiveness of the education program, which of the following is true?

- A. A summative evaluation will accurately reflect the extent to which participants will change their hand-hygiene practices.
- B. Repeated observations of staff will be required in order to demonstrate that the program has been effective.
- C. A change between pre- and post-test scores correlates well with the expected change in hand-hygiene compliance.
- D. An evaluation of the program is not required if the program is mandatory.

Answer: B

Explanation:

The correct answer is B, "Repeated observations of staff will be required in order to demonstrate that the program has been effective," as this statement is true regarding the assessment of the effectiveness of the education program. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, evaluating the impact of an education program on hand-hygiene compliance in a long-term care facility requires ongoing monitoring to assess sustained behavior change. Repeated observations provide direct evidence of staff adherence to hand-hygiene protocols over time, allowing the infection preventionist (IP) to measure the program's effectiveness beyond initial training (CBIC Practice Analysis, 2022, Domain IV: Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs). This method aligns with the World Health Organization (WHO) and CDC recommendations for hand-hygiene improvement, which emphasize continuous auditing to ensure lasting improvements in compliance rates.

Option A (a summative evaluation will accurately reflect the extent to which participants will change

of a program, assesses overall outcomes but does not predict future behavior changes or account for long-term compliance, which is critical in this context. Option C (a change between pre- and post-test scores correlates well with the expected change in hand-hygiene compliance) is misleading; while pre- and post-tests can measure knowledge gain, they do not reliably correlate with actual practice changes, as knowledge does not always translate to behavior without observation. Option D (an evaluation of the program is not required if the program is mandatory) is false, as mandatory programs still require evaluation to verify effectiveness, especially when addressing low compliance, per CBIC and quality improvement standards.

The focus on repeated observations aligns with CBIC's emphasis on data-driven assessment to improve infection prevention practices, ensuring that the education program leads to sustained hand-hygiene improvements and reduces healthcare-associated infections (CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.4 - Evaluate the effectiveness of infection prevention and control interventions).

[References: CBIC Practice Analysis, 2022, Domain II: Surveillance and Epidemiologic Investigation, Competency 2.4 - Evaluate the effectiveness of infection prevention and control interventions; Domain IV: Education and Research, Competency 4.2 - Evaluate the effectiveness of educational programs. WHO Guidelines on Hand Hygiene in Health Care, 2009. CDC Hand Hygiene in Healthcare Settings, 2019., , ,]

Question: 4

Which of the following processes is MOST important for the infection preventionist (IP) to review when evaluating a third-party reprocessor for single-use devices?

- A. Observe all steps for reprocessing.
- B. Review the facility's blueprints and policies.
- C. Ensure air and water cultures are performed regularly.
- D. Obtain feedback from other IPs who use the reprocessor.

Answer: A

Explanation:

The correct answer is A, "Observe all steps for reprocessing," as this is the most important process for the infection preventionist (IP) to review when evaluating a third-party reprocessor for single-use devices. According to the Certification Board of Infection Control and Epidemiology (CBIC) guidelines, the reprocessing of single-use devices (SUDs) by third-party entities must adhere to stringent infection control standards to ensure they are safe for reuse and do not contribute to healthcare-associated infections (HAIs). Observing all steps—such as cleaning, disinfection, sterilization, packaging, and quality control—allows the IP to directly assess compliance with manufacturer instructions, regulatory requirements (e.g., FDA guidelines), and best practices (e.g., AAMI ST91) (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.3 - Ensure safe reprocessing of medical equipment). This hands-on evaluation is critical because any deviation in the reprocessing chain can compromise device sterility and patient safety.

Option B (review the facility's blueprints and policies) provides context about the physical layout and procedural framework, but it is a preliminary step that does not directly verify the reprocessing process's effectiveness. Option C (ensure air and water cultures are performed regularly) is important for

supportive measure rather than the primary focus of evaluating the reprocessor's core activities. Option D (obtain feedback from other IPs who use the reprocessor) offers valuable peer insights, but it is subjective and secondary to direct observation, which provides firsthand evidence of compliance and performance. The priority on observing reprocessing steps aligns with CBIC's emphasis on ensuring the safety and efficacy of reprocessed medical devices, a key responsibility for IPs when outsourcing to third-party reproducers (CBIC Practice Analysis, 2022, Domain III: Infection Prevention and Control, Competency 3.5 - Evaluate the environment for infection risks). This process enables the IP to identify specific weaknesses, validate adherence to standards, and make informed decisions about the reprocessor's suitability.

[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 ST91:2015, Flexible and semi-rigid endoscope processing in health care facilities., , ,]

Question: 5

At a facility with 10,000 employees. 5,000 are at risk for bloodborne pathogen exposure. Over the past five years, 100 of the 250 needlestick injuries involved exposure to bloodborne pathogens, and 2% of exposed employees seroconverted. How many employees became infected?

- A. 1
- B. 2
- C. 5
- D. 10

Answer: B

Explanation:

To determine the number of employees who seroconverted (became infected) after a needlestick exposure, we use the given data:

Total Needlestick Injuries: 250

Needlestick Injuries Involving Bloodborne Pathogens: 100

Seroconversion Rate: 2%

Calculation:

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Why Other Options Are Incorrect:

- A. 1: Incorrect calculation; 2% of 100 is 2, not 1.
- C. 5: Overestimates the actual number of infections.
- D. 10: Exceeds the calculated value based on given data.

CBIC Infection Control References:

APIC Text, "Occupational Exposure and Seroconversion Risks"?

APIC Text, "Bloodborne Pathogens and Needlestick Injury Prevention"?

Question: 6

Which of the following pathogens is associated with the highest risk of seroconversion after percutaneous

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