Clostridium *difficile* Post Test

1) The following are considered risk factors for development of Clostridium difficile infection (CDI)?
   a) Resident of a skilled nursing facility
   b) Recent antibiotic exposure
   c) Recent hospital stay
   d) Advanced age
   e) Previous history of CDI
   f) All of the above

2) Clostridium *difficile* bacteria are part of the normal intestinal flora
   a) True
   b) False

3) The two major reservoirs for C. *difficile* in the healthcare setting are:
   a) The patient's room and direct patient care providers
   b) The environment and the nurse's stethoscope
   c) The infected patient and the doctor's lab coat
   d) The environment and the infected patient

4) What percent of room surfaces become contaminated with C. *difficile* spores when the patient has active CDI?
   a) 7% to 29%
   b) 3 % to 8%
   c) 20% to 50%
   d) 35% to 48%

5) A 79 year old patient has been in your hospital for 3 days receiving treatment for urosepsis. Two weeks prior to admission, the patient was discharged to home from a skilled nursing facility after recovering from a stroke.
Which of following are considered patient risk factors for CDI:
   a) Recent hospital stay
   b) Recent skilled nursing stay
   c) History of stroke
   d) Advanced age
   e) A and C
   f) B and D

6) The same 79 year old patient has been in your hospital for 3 days receiving treatment for urosepsis. Two weeks prior to admission, the patient was discharged to home from a skilled nursing facility after recovering from a stroke.
Which of following should prompt the nurse to send a stool specimen for C. *difficile* testing:
   a) Four dark, foul smelling formed stools in 12 hours (type 3 on Bristol Stool Chart)
   b) One large, liquid stool in 24 hours (type 7)
   c) Three small, soft stools in 6 hours (type 4) followed by two formed stools in 6 hours (type 2)
   d) Three small and two medium loose, mushy stools in 14 hours (type 6)

7) The patient in the previous scenario developed frequent loose, mushy stools and is now complaining of abdominal pain. Based on his assessment of risk factors and symptoms, the off-going nurse sent a stool for C. *difficile* testing. What are the next actions the nurse should take while awaiting test results:

a) Contact the attending physician
b) Wait for test results to finalize before taking any kind of action
c) Place the patient into Contact Precautions, document the isolation in the EMR and provide the patient with education

8) Referring to the patient in the previous scenario with frequent, mushy stools and abdominal pain, the on-coming nurse is notified by the lab that the result of the C. difficile test is positive. What are the next actions the nurse should take:

a) Notify physician of results
b) Maintain Contact Precautions
c) Verify that patient education was provided and documented
d) All of the above

9) Early detection of a symptomatic patient at risk for CDI results in:

a. Prompt patient treatment
b. Reduced transmission of disease
c. Prompt placement of patients into precautions
d. Reduced environmental contamination
e. All of the above

10) Which of the following patient care activities increase risk of transmitting C. difficile to the patient's?

a. Assisting with oral care or feeding a patient
b. Washing a patient's face or hands
c. Ambulating with a patient or transferring the patient to the commode