

ACCS RESPIRATORY PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the definitive test for confirming brain death?**
 - A. Cerebral Perfusion Scan
 - B. EEG
 - C. CT head
 - D. Transcranial Doppler
- 2. Which class of medication is considered first-line therapy for gastroesophageal reflux disease (GERD)?**
 - A. Antacids
 - B. H2 receptor antagonists
 - C. Proton pump inhibitors
 - D. Prokinetic agents
- 3. Which of the following is a common disadvantage of noninvasive ventilation?**
 - A. Mask leak is the most common problem
 - B. Preserves speech
 - C. Reduces ICU length of stay
 - D. Reduces pharmacologic needs
- 4. Which of the following is NOT an absolute contraindication to noninvasive ventilation?**
 - A. Cardiac or respiratory arrest
 - B. Upper airway obstruction
 - C. Nasal/pharyngeal abnormalities
 - D. Facial/head trauma
- 5. Tachycardia is defined as a heart rate exceeding which threshold?**
 - A. >100 bpm
 - B. <60 bpm
 - C. 60-100 bpm
 - D. 40-50 bpm

- 6. In myocardial injury, the ECG finding is**
- A. ST segment elevation from baseline
 - B. ST segment depression
 - C. T wave inversion without elevation
 - D. Q wave alone
- 7. Which combination represents a corticosteroid plus a long-acting beta agonist (LABA)?**
- A. Ipratropium + Albuterol
 - B. Fluticasone + Salmeterol
 - C. Budesonide + Ipratropium
 - D. Theophylline + Albuterol
- 8. In HFOV, which parameter is the primary control of oxygenation (PaO₂)?**
- A. Mean Airway Pressure (Paw) is primary control of PaO₂
 - B. Amplitude is primary control of PaO₂
 - C. FiO₂ is primary control of PaO₂
 - D. Frequency is primary control of PaO₂
- 9. Is the work of breathing measurable during mechanical ventilation?**
- A. WOB can be measured during mechanical ventilation
 - B. WOB is not susceptible to measurement during ventilation
 - C. Cannot be measured during mechanical ventilation
 - D. WOB is always equal to the resistance
- 10. What is the formula for Respiratory Quotient?**
- A. VO_2/VC_{O_2}
 - B. $VO_2 \cdot VC_{O_2}$
 - C. VC_{O_2}/VO_2
 - D. $(VC_{O_2} + VO_2)/2$

Answers

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1. A
2. C
3. A
4. C
5. A
6. A
7. B
8. A
9. C
10. C

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Explanations

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1. What is the definitive test for confirming brain death?

A. Cerebral Perfusion Scan

B. EEG

C. CT head

D. Transcranial Doppler

Determining brain death hinges on proving there is no cerebral blood flow. The most definitive way to demonstrate this is with cerebral perfusion imaging, which uses radioactive tracers to show whether the brain is receiving blood. If the scan shows no uptake in the brain tissue, it confirms that cerebral perfusion is absent, aligning with the defining criterion of brain death. Electrical activity tests like EEG can be suppressed by sedation, metabolic disturbances, or other factors, so they aren't reliably definitive on their own. CT head reveals anatomy and possible causes but does not prove whether brain tissue is being perfused. Transcranial Doppler looks at blood flow in large vessels but can be inconclusive or affected by technical factors. Therefore, cerebral perfusion imaging provides the most direct confirmation of the absence of brain perfusion and is considered the definitive ancillary test in many protocols.

2. Which class of medication is considered first-line therapy for gastroesophageal reflux disease (GERD)?

A. Antacids

B. H2 receptor antagonists

C. Proton pump inhibitors

D. Prokinetic agents

Proton pump inhibitors are the go-to initial therapy because they provide strong, sustained suppression of gastric acid by blocking the final step of acid production in the stomach. This level of acid control leads to higher rates of symptom relief and healing of esophageal irritation, which is why they are preferred as first-line treatment for GERD. Antacids offer quick, short-lived relief but don't promote healing. H2 receptor antagonists reduce acid but are less potent and can lose effectiveness over time. Prokinetic agents can help with motility and some symptoms, but they don't match the efficacy and tolerability of PPIs for most GERD patients, making them a less favored first option.

3. Which of the following is a common disadvantage of noninvasive ventilation?

A. Mask leak is the most common problem

B. Preserves speech

C. Reduces ICU length of stay

D. Reduces pharmacologic needs

Mask leaks are the most common drawback of noninvasive ventilation. The seal between the mask and the facial contours is hard to maintain in everyone, so air escapes during both inhalation and exhalation. This leakage means the ventilator may deliver less than the intended pressure or tidal volume, reducing the effectiveness of ventilation. It can cause patient-ventilator asynchrony, where the patient's own breathing pattern doesn't match the machine's support, leading to discomfort and the need for frequent mask readjustments. Leaks also irritate the skin, eyes, or mucosa, and can set off alarms or require more clinician attention, which can hinder tolerance and continuation of therapy. Proper mask fitting, skin protection, and humidification help mitigate leaks, but they remain the most frequent disadvantage of this therapy. By contrast, preserving speech, shortening ICU stays, and reducing pharmacologic needs are generally considered benefits of noninvasive ventilation rather than disadvantages.

4. Which of the following is NOT an absolute contraindication to noninvasive ventilation?

- A. Cardiac or respiratory arrest
- B. Upper airway obstruction
- C. Nasal/pharyngeal abnormalities**
- D. Facial/head trauma

Noninvasive ventilation works best when the patient can breathe spontaneously, protect their airway, and a good seal can be achieved with a mask. When any factor makes these conditions unsafe or impossible, NIV is not appropriate. Cardiac or respiratory arrest means there's no effective spontaneous breathing to support gas exchange, so NIV won't meet the patient's needs and invasive ventilation is required. An upper airway obstruction prevents airflow despite the applied pressures, so NIV cannot relieve the obstruction. Facial or head trauma often prevents a reliable mask seal and can increase the risk of further injury or aspiration, making NIV unsafe in many cases. Nasal or pharyngeal abnormalities, however, do not automatically rule out NIV. With the right interface and setup—such as an alternative mask that accommodates the anatomy—NIV can still be used safely and effectively.

5. Tachycardia is defined as a heart rate exceeding which threshold?

- A. >100 bpm**
- B. <60 bpm
- C. 60-100 bpm
- D. 40-50 bpm

The key idea is how tachycardia is defined by resting heart-rate thresholds. In adults, a normal resting heart rate ranges from about 60 to 100 beats per minute. Tachycardia is defined as the heart rate exceeding 100 beats per minute. That's why the option describing a heart rate greater than 100 bpm is the correct one. The other values correspond to bradycardia (<60 bpm) or a normal range (60–100 bpm) and do not describe tachycardia. Keep in mind tachycardia can occur with exercise or fever, but clinically it's defined by resting rate above 100 bpm.

6. In myocardial injury, the ECG finding is

- A. ST segment elevation from baseline**
- B. ST segment depression
- C. T wave inversion without elevation
- D. Q wave alone

ST-segment elevation from baseline reflects acute myocardial injury due to transmural ischemia. The injured heart muscle generates a current of injury that shifts the baseline of the resting ECG, causing ST segments to rise in the leads facing the affected area. This is the classic early sign of acute myocardial injury and tends to be focal and in contiguous leads corresponding to the involved region. ST depression generally points to subendocardial ischemia rather than full-thickness injury. T wave inversion without elevation can occur with evolving ischemia or reperfusion but is not as specific for acute injury. Q waves indicate established necrosis from a prior infarction, not current injury.

7. Which combination represents a corticosteroid plus a long-acting beta agonist (LABA)?

- A. Ipratropium + Albuterol
- B. Fluticasone + Salmeterol**
- C. Budesonide + Ipratropium
- D. Theophylline + Albuterol

A corticosteroid plus a long-acting beta agonist combines anti-inflammatory control with sustained bronchodilation. Fluticasone is an inhaled corticosteroid that reduces airway inflammation, while Salmeterol is a long-acting beta agonist that keeps the airways dilated for up to about 12 hours. Using them together provides both mechanisms needed for effective long-term control of asthma or COPD symptoms, and this ICS-LABA pair is a standard, widely used combination therapy. The other options either lack a corticosteroid with a LABA (they include short-acting agents or non-LABA bronchodilators) or pair an anti-inflammatory with a different class of bronchodilator. So the combination that explicitly includes both a corticosteroid and a LABA is the correct choice.

8. In HFOV, which parameter is the primary control of oxygenation (PaO₂)?

- A. Mean Airway Pressure (Paw) is primary control of PaO₂**
- B. Amplitude is primary control of PaO₂
- C. FiO₂ is primary control of PaO₂
- D. Frequency is primary control of PaO₂

In HFOV, keeping the lungs open and well recruited is what drives oxygenation. The mean airway pressure sets the baseline lung volume throughout the breath cycle, so higher Paw maintains higher end-expiratory lung volume, expands the surface area for gas exchange, and improves diffusion of oxygen into the blood. FiO₂ supplies the oxygen content of the inspired gas, but it doesn't modulate the amount of recruited lung or the diffusion surface the way Paw does, so Paw is the primary lever for PaO₂. Amplitude and frequency mainly influence CO₂ removal rather than oxygenation: amplitude changes the tidal swings and ventilation, while frequency affects how quickly oscillations occur. As a result, adjusting Paw is the key way to control PaO₂ in HFOV, with caution to avoid overdistension or hemodynamic effects.

9. Is the work of breathing measurable during mechanical ventilation?

- A. WOB can be measured during mechanical ventilation
- B. WOB is not susceptible to measurement during ventilation
- C. Cannot be measured during mechanical ventilation**
- D. WOB is always equal to the resistance

Work of breathing is the energy the respiratory muscles spend to move air, overcoming airway resistance and lung elastic recoil. When a patient is on a ventilator, the machine contributes much of that energy, and the patient's own effort is blended with the ventilator's work in the airway pressure and flow you observe. Without specialized monitoring to separate the ventilator's contribution from the patient's, there isn't a single simple bedside measurement that directly gives the patient's WOB. You can approximate it with invasive techniques that estimate inspiratory muscle pressure or diaphragm activity, but these require extra equipment and interpretation. Therefore, in routine practice, WOB cannot be reliably measured during mechanical ventilation. The idea that WOB is simply equal to resistance is inaccurate, since elastic recoil and ventilator support also influence the overall effort.

10. What is the formula for Respiratory Quotient?

- A. VO_2/VCO_2
- B. $\text{VO}_2 \times \text{VCO}_2$
- C. VCO_2/VO_2
- D. $(\text{VCO}_2 + \text{VO}_2)/2$

The main concept being tested is the respiratory quotient, which is the ratio of carbon dioxide produced to oxygen consumed during metabolism. It is defined as VCO_2 divided by VO_2 , the rate of CO_2 output over the rate of O_2 uptake. This reflects which substrate is being oxidized: around 1.0 for carbohydrate, about 0.7 for fat, and roughly 0.8 for protein, and it is determined by indirect calorimetry. The other formulations don't match how the body's gas exchange is quantified: taking the inverse would misrepresent the relationship, multiplying would have no physiological meaning, and averaging the two gases isn't how the ratio is defined.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://accsrespiratory.examzify.com>

We wish you the very best on your exam journey. You've got this!

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