ACLS ProMed Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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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

1. **How long should post-cardiac arrest targeted temperature management be maintained?**

   A. 6 hours

   B. 24 hours

   C. 48 hours

   D. 72 hours

2. **What is the device-dependent initial energy for synchronized cardioversion of unstable tachyarrhythmia with wide QRS?**

   A. 50 J

   B. 200 J

   C. 360 J

   D. 100 J (device-dependent; follow manufacturer)

3. **Which condition is an indication for fibrinolytic therapy in ACS management?**

   A. STEMI

   B. NSTEMI

   C. Unstable Angina

   D. Variant Angina

4. **Which of the following is not used to treat acute stroke?**

   A. Tissue plasminogen activator

   B. Aspirin

   C. Clopidogrel

   D. Naloxone

5. **Which of the following is part of the team leader's role?**

   A. All of the above

   B. Be clear about role assignments

   C. Monitor individual performance of team members

   D. Train and coach

6. Which rhythm is considered shockable for immediate defibrillation?

A. Asystole

B. Pulseless electrical activity

C. Sinus bradycardia with pulse

D. Ventricular fibrillation

7. Which pair of rhythms correctly represents the two rhythm-based pathways of the ACLS cardiac arrest algorithm?

A. VF/pVT and PEA/Asystole

B. VF/pVT and AF

C. PEA/Asystole and SVT

D. VT and SVT

8. In acute coronary syndrome, NSAIDs are associated with which outcomes?

A. Decreased mortality

B. Decreased reinfarction

C. Increased risk of mortality and reinfarction

D. No effect on outcomes

9. In post-arrest care, maintaining adequate perfusion pressure is intended to minimize which injury?

A. Secondary brain injury

B. Myocardial injury

C. Renal injury

D. Cerebral edema

10. Which statement about atropine use in ACLS is true?

A. It has a maximum dose of 3 mg when patient has symptomatic bradycardia.

B. It has detrimental effects during asystolic arrests.

C. Administration should be followed by 5 cycles of CPR in PEA.

D. All of the above.

Answers

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

Explanations

1. How long should post-cardiac arrest targeted temperature management be maintained?

A. 6 hours

B. 24 hours

C. 48 hours

D. 72 hours

Targeted temperature management after cardiac arrest is used to protect the brain during the vulnerable reperfusion period. The standard approach is to keep the patient at a controlled temperature for about 24 hours (typically 32–36°C). This duration provides meaningful neuroprotection without adding the risks seen with longer cooling, such as infections or electrolyte and hemodynamic disturbances. Extending cooling to 48–72 hours hasn't shown additional benefit in major studies, and rapid or prolonged cooling can complicate recovery. After the 24-hour window, rewarming is started gradually to avoid instability.

2. What is the device-dependent initial energy for synchronized cardioversion of unstable tachyarrhythmia with wide QRS?

A. 50 J

B. 200 J

C. 360 J

D. 100 J (device-dependent; follow manufacturer)

The main idea is that the initial energy for synchronized cardioversion is determined by the defibrillator you're using. Different devices have different capacitor and waveform characteristics, so there isn't one universal number. For unstable tachyarrhythmia with wide QRS, you deliver a synchronized shock to terminate the rhythm, and you start with the energy recommended by the device's manufacturer. In many modern biphasic units, that starting dose is commonly 100 J; some older or monophasic machines use higher initial energies (such as 200 J). The key point is to follow the manufacturer's guidance for the initial synchronized energy, then escalate if necessary. That's why the correct guidance is to treat the initial energy as device-dependent. If a device's manual specifies a different starting dose, use that instead. The other numbers are not as universally appropriate: a very low dose like 50 J is unlikely to cardiovert, and a high dose like 360 J is typically reserved for defibrillation (unsynchronized) rather than synchronized cardioversion.

3. Which condition is an indication for fibrinolytic therapy in ACS management?

A. STEMI

B. NSTEMI

C. Unstable Angina

D. Variant Angina

In fibrinolytic therapy for ACS, the key indication is an acute ST-elevation myocardial infarction. That ECG pattern means a complete occlusion of a coronary artery with ongoing transmural ischemia, where dissolving the clot can promptly restore blood flow and limit heart muscle damage. Fibrinolytics are most beneficial when given as early as possible after symptoms begin, ideally within the first few hours. If a patient can have primary PCI quickly, that approach is usually preferred because it more reliably reopens the artery and carries a lower bleeding risk compared with fibrinolysis. For non-ST elevation ACS—NSTEMI and unstable angina—the problem is not a persistent ST-segment elevation from a complete occlusion, so fibrinolysis does not provide a benefit and is avoided to prevent unnecessary bleeding. Variant angina is due to coronary vasospasm rather than a thrombotic occlusion, so vasodilator therapy is the approach and fibrinolysis isn't indicated.

4. Which of the following is not used to treat acute stroke?

A. Tissue plasminogen activator

B. Aspirin

C. Clopidogrel

D. Naloxone

In acute stroke, the focus is on restoring blood flow or preventing further clotting to minimize brain injury. Tissue plasminogen activator is used for eligible patients with acute ischemic stroke within a defined time window to dissolve the clot and reopen the blocked vessel. Antiplatelet agents like aspirin are given early to reduce the risk of early recurrence and additional events, and clopidogrel serves as another antiplatelet option in certain stroke scenarios or after initial therapy depending on guidelines. Naloxone, on the other hand, is an opioid receptor antagonist used to reverse opioid overdose and has no role in treating stroke or improving cerebral perfusion, so it is not used in acute stroke management.

5. Which of the following is part of the team leader's role?

A. All of the above

B. Be clear about role assignments

C. Monitor individual performance of team members

D. Train and coach

The team leader's job centers on coordinating and guiding the resuscitation effort. Being clear about who does what ensures everyone knows their assignment, avoids duplication, and speeds up decision-making in a high-stress moment. Monitoring how each team member performs matters because the quality of critical actions—like chest compressions, airway management, and medication administration—depends on ongoing assessment and real-time adjustments. Training and coaching are essential to keep skills sharp, provide timely feedback, and raise overall performance. When you put these pieces together, they all belong to the leader's responsibilities, so the option that includes all of these aspects is the best fit.

6. Which rhythm is considered shockable for immediate defibrillation?

A. Asystole

B. Pulseless electrical activity

C. Sinus bradycardia with pulse

D. Ventricular fibrillation

Shockable rhythms are those where the heart's electrical activity is chaotic enough that a rapid energy input can reset the rhythm. Ventricular fibrillation fits this: the ventricles quiver with no organized contraction, so there's no effective pumping and no pulse. A defibrillation shock briefly depolarizes a critical mass of heart muscle, allowing the heart's natural pacemaker to reestablish a perfusing rhythm. The other options aren't treated with immediate defibrillation. Asystole is a flatline with no electrical activity, and pulseless electrical activity shows electrical activity but no effective heartbeat—both require CPR and other interventions, not shock. Sinus bradycardia with a pulse isn't in cardiac arrest and isn't treated with shocks; it's managed by rhythm control and addressing underlying causes.

7. Which pair of rhythms correctly represents the two rhythm-based pathways of the ACLS cardiac arrest algorithm?

A. VF/pVT and PEA/Asystole

B. VF/pVT and AF

C. PEA/Asystole and SVT

D. VT and SVT

The ACLS cardiac arrest algorithm separates rhythms into two pathways: shockable rhythms and non-shockable rhythms. Shockable rhythms include ventricular fibrillation and pulseless ventricular tachycardia, for which defibrillation is the priority. Non-shockable rhythms include pulseless electrical activity and asystole, where CPR with appropriate medications is the main course. Other rhythms like atrial fibrillation or SVT aren't the two rhythm-based arrest pathways, and VT with a pulse isn't part of the non-shockable path. So pairing VF/pVT with PEA/Asystole correctly reflects the two rhythm-based pathways.

8. In acute coronary syndrome, NSAIDs are associated with which outcomes?

A. Decreased mortality

B. Decreased reinfarction

C. Increased risk of mortality and reinfarction

D. No effect on outcomes

In acute coronary syndrome, NSAIDs are linked to worse cardiovascular outcomes because they can blunt the beneficial antiplatelet effect of aspirin and promote prothrombotic conditions. Aspirin works by irreversibly inhibiting platelet COX-1, reducing thromboxane A2 and platelet aggregation, which lowers mortality and the risk of recurrent events. NSAIDs, especially nonselective ones, can temporarily occupy COX-1 and interfere with aspirin's ability to suppress platelets when given together, diminishing this protective effect. They can also cause fluid retention, increased blood pressure, and kidney strain, all of which can worsen outcomes in ACS. Taken together, these factors translate to an increased risk of mortality and reinfarction, making that option the best choice.

9. In post-arrest care, maintaining adequate perfusion pressure is intended to minimize which injury?

A. Secondary brain injury

B. Myocardial injury

C. Renal injury

D. Cerebral edema

Maintaining adequate perfusion pressure is about preserving cerebral perfusion after cardiac arrest. The brain endures a period of global ischemia during arrest, and after return of circulation, ongoing low blood flow can worsen injury through hypoxia, inflammation, and edema. By keeping mean arterial pressure at a level that maintains cerebral perfusion pressure, you ensure the brain continues to receive enough blood flow to meet metabolic needs, reducing the extent of neuronal damage from the ischemia–reperfusion process. In practice, this approach aims to minimize secondary brain injury. While other organs are affected by perfusion, the primary reason for this focus in post-arrest care is protecting the brain from additional injury due to inadequate blood flow.

10. Which statement about atropine use in ACLS is true?

A. It has a maximum dose of 3 mg when patient has symptomatic bradycardia.

B. It has detrimental effects during asystolic arrests.

C. Administration should be followed by 5 cycles of CPR in PEA.

D. All of the above.

In ACLS, atropine is used for symptomatic bradycardia to increase the heart rate by blocking parasympathetic (vagal) influence on the heart. The dosing is 0.5 mg IV every 3–5 minutes, with a total maximum dose of 3 mg. This makes the statement about a 3 mg maximum the correct one. For asystole or PEA, atropine is not routinely recommended because it does not improve outcomes in non-perfusing rhythms, so the idea that it has detrimental effects in arrest scenarios isn't a standard ACLS assertion. Also, during a cardiac arrest the protocol emphasizes high-quality CPR and epinephrine every 3–5 minutes rather than a fixed sequence of CPR cycles after atropine. Therefore, the only true statement is the maximum dose for symptomatic bradycardia.

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://aclspromed.examzify.com

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