

ACLS PROMED PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

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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. Which statement concerning PCI is true?

- A. PCI is preferred in patients with contraindications to fibrinolytics and only if it can be performed within 90 minutes of first medical contact by a skilled provider.
- B. PCI should be used in all acute coronary syndrome patients regardless of time window.
- C. PCI is never recommended if fibrinolytics can be given.
- D. PCI is preferred only for non-ST elevation ACS.

2. How should you manage a non-shockable rhythm (asystole or PEA) in cardiac arrest?

- A. High-quality CPR, identify and treat reversible causes (Hs and Ts), and give epinephrine 1 mg IV/IO every 3-5 minutes
- B. Deliver shock immediately
- C. Start CPR but do not give epinephrine
- D. Wait for ROSC

3. Why is minimizing hyperventilation important during CPR?

- A. Hyperventilation reduces venous return and coronary perfusion, decreasing ROSC.
- B. Hyperventilation increases cerebral perfusion and ROSC.
- C. Ventilation rate has no impact on ROSC.
- D. Hyperventilation improves defibrillation success.

4. In ACLS, ECMO is considered in which scenario?

- A. A routine first-line intervention in all arrests.
- B. Not part of ACLS protocols.
- C. Consideration in refractory cardiac arrest or cardiogenic shock when conventional therapies fail and resources are available.
- D. Only used if conventional therapies fail.

5. How often is epinephrine given during CPR for a non-shockable rhythm?

- A. Every 1-2 minutes
- B. Every 2-4 minutes
- C. Every 3-5 minutes
- D. Every 5-7 minutes

- 6. After ROSC, how should antiseizure therapy be considered?**
- A. Evaluate ongoing antiseizure therapy as indicated
 - B. Start antibiotic therapy
 - C. Start diuretics
 - D. Do nothing
- 7. The BLS assessment emphasizes which of the following early actions?**
- A. Oxygen Therapy
 - B. Medication Administration
 - C. CPR and Defibrillation
 - D. Advanced Airway Placement
- 8. Name three Hs in the ACLS Hs and Ts mnemonic.**
- A. Hypovolemia, Hypoxia, Hydrogen ion (acidosis)
 - B. Hypovolemia, Hypoxia, Hypothermia
 - C. Hydrogen ion, Hypothermia, Hyperkalemia
 - D. Hypovolemia, Hypoxia, Hyperkalemia
- 9. What is the recommended 'no-flow' time principle in ACLS?**
- A. Minimize time from recognition to start CPR; avoid delays; rapid defibrillation when indicated.
 - B. Delay CPR to verify rhythm with multiple devices.
 - C. Focus on IV line placement before starting CPR.
 - D. No-flow time is not a concern in modern ACLS.
- 10. Endovascular therapy for ischemic stroke is considered within what timeframe?**
- A. Only after CT shows occlusion on CTA
 - B. Within appropriate time windows
 - C. In all patients regardless of time
 - D. Not used in ischemic stroke

Answers

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

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Explanations

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1. Which statement concerning PCI is true?

- A. PCI is preferred in patients with contraindications to fibrinolytics and only if it can be performed within 90 minutes of first medical contact by a skilled provider.
- B. PCI should be used in all acute coronary syndrome patients regardless of time window.
- C. PCI is never recommended if fibrinolytics can be given.
- D. PCI is preferred only for non-ST elevation ACS.

In STEMI care, restoring blood flow quickly is the priority. If fibrinolytics are contraindicated, primary PCI is the preferred reperfusion method, provided it can be done promptly—ideally within about 90 minutes of first medical contact and by a skilled interventional team at an experienced facility. This approach offers mechanical revascularization with higher success rates and tends to have better outcomes, including lower mortality and fewer bleeding complications, compared with thrombolysis when the procedure can be completed in time. If PCI cannot be performed within that window, fibrinolysis may be considered if there are no contraindications, but the emphasis remains on achieving rapid reperfusion via PCI when feasible.

2. How should you manage a non-shockable rhythm (asystole or PEA) in cardiac arrest?

- A. High-quality CPR, identify and treat reversible causes (Hs and Ts), and give epinephrine 1 mg IV/IO every 3-5 minutes
- B. Deliver shock immediately
- C. Start CPR but do not give epinephrine
- D. Wait for ROSC

In non-shockable cardiac arrest rhythms, the priority is to restore and maintain perfusion while addressing treatable underlying problems. High-quality CPR with minimal interruptions keeps blood flowing to the brain and heart, while actively identifying and treating reversible causes (the Hs and Ts) such as hypoxia, hypovolemia, electrolyte disturbances, acidosis, toxins, tamponade, tension pneumothorax, and thrombosis. Epinephrine 1 mg IV/IO every 3-5 minutes is given to improve perfusion pressures during CPR and increase the chance of ROSC. Defibrillation isn't effective for asystole or pulseless electrical activity, so delivering a shock would not help and delays ongoing CPR and cause treatment gaps. Waiting for ROSC without continuing CPR and addressing reversible causes also reduces survival chances.

3. Why is minimizing hyperventilation important during CPR?

- A. Hyperventilation reduces venous return and coronary perfusion, decreasing ROSC.
- B. Hyperventilation increases cerebral perfusion and ROSC.
- C. Ventilation rate has no impact on ROSC.
- D. Hyperventilation improves defibrillation success.

During CPR, how you ventilate matters because each rapid breath increases intrathoracic pressure and reduces the amount of blood returning to the heart. This drop in venous return lowers preload and, more importantly, decreases coronary perfusion pressure—the pressure driving blood to the heart muscle between compressions. When coronary perfusion pressure falls, the chance of returning to a sustainable heartbeat (ROSC) goes down. That's why minimizing hyperventilation is important: you want enough ventilation to oxygenate without pushing in air so forcefully or so rapidly that it impedes blood flow to the heart and brain. Hyperventilation can also cause hypocapnia and cerebral vasoconstriction, further reducing brain perfusion. The other statements aren't correct because overly rapid ventilation doesn't improve perfusion or ROSC, and it doesn't inherently boost defibrillation success.

4. In ACLS, ECMO is considered in which scenario?

- A. A routine first-line intervention in all arrests.
- B. Not part of ACLS protocols.
- C. Consideration in refractory cardiac arrest or cardiogenic shock when conventional therapies fail and resources are available.
- D. Only used if conventional therapies fail.

ECMO is used as a rescue therapy in ACLS when the heart and lungs cannot be supported adequately by standard resuscitation, buying time to treat the reversible problem and stabilize the patient. This approach, sometimes called ECPR, provides both circulatory support and oxygenation, effectively bridging to recovery or to definitive treatment. It is not a routine first-line step in every arrest, and it is not absent from ACLS protocols; rather, it is a specialized option reserved for cases where conventional therapies have failed to restore circulation or stabilize cardiogenic shock, and only if a capable center with the necessary resources, expertise, and rapid access is available. It is more than simply "used after failure"; it requires a demonstrated reversible cause, favorable timing, and a facility equipped to deploy ECMO quickly and safely.

5. How often is epinephrine given during CPR for a non-shockable rhythm?

- A. Every 1-2 minutes
- B. Every 2-4 minutes
- C. Every 3-5 minutes
- D. Every 5-7 minutes

During CPR for a non-shockable rhythm, the goal is to maintain perfusion to the heart and brain while continuing high-quality chest compressions. Epinephrine is given to boost coronary and cerebral perfusion pressure, and the standard practice is to administer 1 mg IV/IO every 3 to 5 minutes and repeat as CPR continues. This 3–5 minute interval fits with the typical CPR cycle, usually about two minutes of compressions before reassessment. Shorter intervals (like every 1–2 minutes) would be too frequent and longer gaps (like every 5–7 minutes) could miss opportunities to improve perfusion. Therefore, the best interval is every 3–5 minutes.

6. After ROSC, how should antiseizure therapy be considered?

A. Evaluate ongoing antiseizure therapy as indicated

B. Start antibiotic therapy

C. Start diuretics

D. Do nothing

Seizure risk is a consideration after resuscitation, but routine prophylaxis with antiseizure drugs isn't routinely recommended. The key is to review what the patient was already on and tailor decisions to what's actually happening neurologically. If there are clinical seizures or EEG findings of seizures, continue or adjust antiseizure therapy accordingly. If there are no seizures and no electrographic seizures, there's no need to start prophylaxis. This approach balances potential benefits with the risks and side effects of antiseizure medications, and it often involves EEG monitoring to detect nonconvulsive seizures that would need treatment.

7. The BLS assessment emphasizes which of the following early actions?

A. Oxygen Therapy

B. Medication Administration

C. CPR and Defibrillation

D. Advanced Airway Placement

Early actions in BLS focus on restoring circulation and rhythm. Starting high-quality chest compressions right away keeps blood flowing to the brain and other vital organs when the heart isn't pumping effectively, which is critical for survival. If an AED is available, using it as soon as possible to deliver a shock addresses the most common treatable cause of cardiac arrest—a shockable rhythm like ventricular fibrillation or pulseless VT—and the sooner the first shock occurs, the better the chance of recovery. Oxygen therapy, while important in overall care, does not restore circulation as quickly as compressions and defibrillation, so it isn't the immediate priority in the initial response. Medications and advanced airway placement are beyond basic life support and come into play with more advanced providers, after the initial CPR and defibrillation efforts have been started.

8. Name three Hs in the ACLS Hs and Ts mnemonic.

A. Hypovolemia, Hypoxia, Hydrogen ion (acidosis)

B. Hypovolemia, Hypoxia, Hypothermia

C. Hydrogen ion, Hypothermia, Hyperkalemia

D. Hypovolemia, Hypoxia, Hyperkalemia

In ACLS, focusing on reversible causes during resuscitation helps guide what to fix to improve outcomes. Among the Hs, three classic ones are hypovolemia, hypoxia, and hydrogen ion (acidosis). Hypovolemia means there isn't enough circulating volume from bleeding or fluid loss, so restoring fluids or blood and stopping the source of loss can improve preload and circulation. Hypoxia indicates insufficient oxygen delivery, so securing the airway and providing adequate oxygen (with airway support as needed) is essential to restore oxygenation and help ROSC. Hydrogen ion refers to acidosis, which impairs heart function and the heart's response to medications; correcting ventilation to remove CO₂ and addressing the underlying cause helps improve the heart's ability to respond during resuscitation. Other Hs can be recognized in various guidelines, such as hypothermia or electrolyte disturbances, but the trio of hypovolemia, hypoxia, and acidosis is a core, high-yield set often highlighted in questions like this.

9. What is the recommended 'no-flow' time principle in ACLS?

- A. Minimize time from recognition to start CPR; avoid delays; rapid defibrillation when indicated.**
- B. Delay CPR to verify rhythm with multiple devices.
- C. Focus on IV line placement before starting CPR.
- D. No-flow time is not a concern in modern ACLS.

The main concept here is reducing no-flow time—the period after collapse when chest compressions are not being delivered. In ACLS, every second without perfusion lowers the chances of return of spontaneous circulation and survival, so the guideline emphasizes starting CPR immediately when cardiac arrest is recognized and avoiding delays for other tasks. Starting high-quality chest compressions right away preserves blood flow to the heart and brain. Delaying CPR to verify rhythm with multiple devices would create pauses that reduce this flow, and delaying CPR to place an IV line similarly interrupts perfusion. If a shockable rhythm is identified, delivering a defibrillating shock as soon as possible helps restore effective circulation with minimal extra delay. In contrast, no-flow time is a real concern in modern ACLS; minimizing it is a core principle of resuscitation. So the best answer is the one that emphasizes starting CPR quickly and defibrillating promptly when indicated, to minimize no-flow time and maximize survival chances.

10. Endovascular therapy for ischemic stroke is considered within what timeframe?

- A. Only after CT shows occlusion on CTA
- B. Within appropriate time windows**
- C. In all patients regardless of time
- D. Not used in ischemic stroke

Endovascular therapy is a time-dependent treatment, and the key is offering it within established time windows from when symptoms started (or from the last known well time). Rapid imaging is used to confirm the presence of a proximal occlusion and salvageable brain tissue, but the main decision driver is timing. That's why the best answer is: within appropriate time windows. It's not limited to confirming an occlusion on CTA before considering treatment, it's not given to all patients regardless of time, and it is definitely used in eligible cases of ischemic stroke.

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:

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

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