CARDIAC HEALTHSTREAM TELEMETRY 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

1. What information should you document when a telemetry alarm occurs?

A. Time and alarm type

B. Time and patient name

C. Time, patient, lead(s) involved, rhythm, symptoms, actions taken, clinician notified, and resolution status

D. Time, room number, and nurse on duty

2. How do Mobitz I and Mobitz II differ on telemetry?

A. Mobitz I (Wenckebach) shows progressive PR prolongation with eventual dropped beats; Mobitz II shows dropped beats without PR prolongation and a fixed PR interval.

B. Mobitz I shows dropped beats with PR prolongation; Mobitz II shows no dropped beats.

C. Mobitz I is associated with wide QRS; Mobitz II with narrow QRS.

D. Mobitz I is always symptomatic; Mobitz II always asymptomatic.

3. What is the typical heart rate range for the AV node when acting as pacemaker?

A. 60-100 bpm

B. 40-60 bpm

C. 20-40 bpm

D. 80-120 bpm

4. What does line noise artifact look like and how can you mitigate it in telemetry monitoring?

A. High-frequency noise with an irregular pattern; fix by reattaching leads, avoiding electrical interference, and ensuring good contact.

B. Low-amplitude, regular baseline drift that does not affect rhythm interpretation.

C. Slow, rhythmic baseline wander due to respiration.

D. A flat line with no variation during patient movement.

5. Which statement BEST defines Second Degree AV Block Type II?

A. PRI lengthens until a QRS is dropped

B. P waves and QRS dissociate completely

C. Dropped QRS with no PRI prolongation

D. QRS is narrow with regular rhythm

6. Which condition indicates the need for synchronized cardioversion in SVT?

A. Unstable patient with SVT.

B. Stable patient with mild symptoms.

C. Stable patient with chest pain but adequate perfusion.

D. Any SVT with normal vital signs.

7. In a standard telemetry setup, where are the precordial leads placed?

A. Precordial leads V1-V6 in standard positions; limb leads placed on shoulders/trunk to approximate limb lead placement

B. Precordial leads V1-V6 on the abdomen

C. Only limb leads used

D. V1-V6 on the chest but without limb leads

8. In tele strip paper, what is the duration represented by a single small box and by a large 5x5 box?

A. Small box = 0.04 sec; Large box = 0.20 sec

B. Small box = 0.02 sec; Large box = 0.12 sec

C. Small box = 0.04 sec; Large box = 0.10 sec

D. Small box = 0.01 sec; Large box = 0.05 sec

9. How can hypoxia appear on ECG telemetry?

A. Sinus tachycardia or ST changes; correlate with oxygen saturation and symptoms.

B. Atrial fibrillation with rapid ventricular response exclusively due to hypoxia.

C. Ventricular tachycardia as the initial sign.

D. Normal ECG with no changes.

10. In Normal Sinus Rhythm, the P wave duration is within which range?

A. 0.08-0.12 seconds

B. 0.28-0.36 seconds

C. 0.12-0.20 seconds

D. 0.20-0.28 seconds

Answers

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

Explanations

1. What information should you document when a telemetry alarm occurs?

A. Time and alarm type

B. Time and patient name

C. Time, patient, lead(s) involved, rhythm, symptoms, actions taken, clinician notified, and resolution status

D. Time, room number, and nurse on duty

Thorough documentation of telemetry alarms is essential for patient safety, clinical decision-making, and accountability. Recording the exact time of the alarm anchors the event in the patient's care timeline, and noting what type of alarm it was helps distinguish between a rhythm abnormality, a lead/disconnection issue, or a device fault. The patient's identity ensures the information is linked to the correct chart. Documenting leads involved and the rhythm observed provides the clinical context needed to interpret the alarm correctly and to determine whether the abnormality is likely real or artifact from a loose or misplaced lead. Including symptoms the patient experienced, actions taken by staff, and who was notified (clinician) shows how the alarm was addressed and who took responsibility for escalation, which is vital for continuity of care and accountability. Finally, the resolution status confirms whether the issue was resolved, ongoing, or reoccurring, aiding in discharge planning and quality assurance. This comprehensive set of details supports safe patient care, enables accurate charting, and helps identify patterns for device or lead issues. If an option were missing elements like the patient's identity, rhythm, or actions taken, the documentation would be less useful for clinical decision-making and audit purposes.

2. How do Mobitz I and Mobitz II differ on telemetry?

A. Mobitz I (Wenckebach) shows progressive PR prolongation with eventual dropped beats; Mobitz II shows dropped beats without PR prolongation and a fixed PR interval.

B. Mobitz I shows dropped beats with PR prolongation; Mobitz II shows no dropped beats.

C. Mobitz I is associated with wide QRS; Mobitz II with narrow QRS.

D. Mobitz I is always symptomatic; Mobitz II always asymptomatic.

The key idea is how these second degree AV blocks look on telemetry, specifically the behavior of the PR interval and when a beat is dropped. In Mobitz I (Wenckebach), you observe a progressive prolongation of the PR interval with each beat until a P wave is not followed by a QRS—the dropped beat after a lengthened PR. In Mobitz II, you see dropped beats without any preceding PR prolongation—the PR interval before the drop stays the same, and the block is typically below the AV node. Sometimes Mobitz II can have a wide QRS if the block is infranodal, whereas Mobitz I usually has a narrow QRS. This makes the pattern described in the correct choice the best match: progressive PR prolongation with eventual dropped beats for Mobitz I, and dropped beats without PR prolongation with a fixed PR interval for Mobitz II. The other options mix up these features or rely on symptoms, which aren't reliable on telemetry.

3. What is the typical heart rate range for the AV node when acting as pacemaker?

A. 60-100 bpm

B. 40-60 bpm

C. 20-40 bpm

D. 80-120 bpm

The main concept is that the AV node can act as a backup pacemaker, and its intrinsic rhythm is slower than the SA node. When the SA node isn't driving the heart or there's a block preventing atrial conduction, the AV node can take over with a slower escape rhythm of about 40–60 beats per minute. This slower rate reflects its automaticity and its role as a secondary pacing focus, still maintaining enough cardiac output in many cases. The numbers in other ranges correspond to other pacing sites: the SA node normally paces about 60–100 bpm, and the ventricular escape rhythm is even slower, around 20–40 bpm. An 80–120 bpm rate would not be the typical AV nodal pacing rate.

4. What does line noise artifact look like and how can you mitigate it in telemetry monitoring?

A. High-frequency noise with an irregular pattern; fix by reattaching leads, avoiding electrical interference, and ensuring good contact.

B. Low-amplitude, regular baseline drift that does not affect rhythm interpretation.

C. Slow, rhythmic baseline wander due to respiration.

D. A flat line with no variation during patient movement.

Line noise artifact shows up as rapid, high-frequency spikes or jagged activity that ride on the ECG baseline in an irregular pattern. It's a type of electromagnetic interference that distorts the tracing rather than reflecting the heart's electrical activity. The best way to mitigate it is to ensure the leads are firmly and properly attached, with good skin contact. This means reapplying or re-securing the leads after skin preparation and verifying that impedance is acceptable. Also minimize electrical interference by keeping the patient away from nearby devices that emit EMI, turning off nonessential equipment when possible, and ensuring the monitor and its power source are properly grounded. Inspect and replace any damaged leads, use shielded cables if available, and keep lead wires tidy and well separated to reduce cross-talk. For contrast, slow, rhythmic baseline wander from respiration is not line noise, and a flat line during movement suggests a lead disconnection, not line noise.

5. Which statement BEST defines Second Degree AV Block Type II?

A. PRI lengthens until a QRS is dropped

B. P waves and QRS dissociate completely

C. Dropped QRS with no PRI prolongation

D. QRS is narrow with regular rhythm

Mobitz II shows intermittent non-conducted P waves with dropped QRS complexes, but the PR interval on the beats that do conduct stays constant and does not progressively lengthen before a drop. This pattern points to a block below the AV node (often in the His-Purkinje system). The key feature is the sudden loss of QRS without prior PR prolongation, which distinguishes it from Mobitz I (where the PR interval lengthens before a drop). The QRS duration can be normal or widened depending on additional conduction disease, but the defining clue is the dropped QRS without a preceding change in PR. The other descriptions don't fit Mobitz II: progressive PR prolongation before a drop describes Mobitz I; complete dissociation of P waves and QRS describes third-degree block; and simply noting a narrow QRS with regular rhythm doesn't capture the characteristic intermittent dropped beats.

6. Which condition indicates the need for synchronized cardioversion in SVT?

A. Unstable patient with SVT.

B. Stable patient with mild symptoms.

C. Stable patient with chest pain but adequate perfusion.

D. Any SVT with normal vital signs.

When SVT causes hemodynamic instability, synchronized cardioversion is indicated. Instability means the rhythm is compromising perfusion—evidence includes low blood pressure, altered mental status, chest pain with signs of poor perfusion, or other shock symptoms. In this scenario, a rapid, definitive rhythm restoration is necessary, and delivering a synchronized shock (timed to the R wave) minimizes the risk of causing ventricular fibrillation. Stable SVT, even with mild symptoms or chest pain but adequate perfusion, is typically approached with nonemergent measures such as vagal maneuvers or adenosine and rate-control medications. A patient with normal vital signs generally does not require immediate synchronized cardioversion. Hence, instability is the condition that dictates synchronized cardioversion.

7. In a standard telemetry setup, where are the precordial leads placed?

A. Precordial leads V1-V6 in standard positions; limb leads placed on shoulders/trunk to approximate limb lead placement

B. Precordial leads V1-V6 on the abdomen

C. Only limb leads used

D. V1-V6 on the chest but without limb leads

In telemetry, the six precordial leads are placed on the chest in their standard V1 through V6 positions, while the limb leads are placed on the shoulders or trunk to approximate the limb-lead placement when the arms and legs aren't accessible. This arrangement preserves the chest-wall views these leads provide and keeps the overall limb-lead vectors in line with normal ECG interpretation. Placing V1–V6 on the abdomen would not give the correct chest views, using only limb leads misses the chest information, and putting V1–V6 on the chest without any limb leads would not yield a complete 12-lead view.

8. In tele strip paper, what is the duration represented by a single small box and by a large 5x5 box?

A. Small box = 0.04 sec; Large box = 0.20 sec

B. Small box = 0.02 sec; Large box = 0.12 sec

C. Small box = 0.04 sec; Large box = 0.10 sec

D. Small box = 0.01 sec; Large box = 0.05 sec

Timing on tele strip paper is set by the paper speed. At the standard 25 mm per second, each small box (1 mm) represents 0.04 seconds. A large 5x5 box spans five small boxes in time, so it equals 5 × 0.04 s = 0.20 seconds. So a single small box is 0.04 seconds, and a large 5x5 box is 0.20 seconds. (If the speed were 50 mm/s, these values would be halved.)

9. How can hypoxia appear on ECG telemetry?

A. Sinus tachycardia or ST changes; correlate with oxygen saturation and symptoms.

B. Atrial fibrillation with rapid ventricular response exclusively due to hypoxia.

C. Ventricular tachycardia as the initial sign.

D. Normal ECG with no changes.

When oxygen delivery is insufficient, the heart often responds with a faster rhythm and possible ischemic-type changes on the ECG. Sinus tachycardia is a very common telemetry finding in hypoxia because the body tries to maintain cardiac output by increasing heart rate. In addition, reduced oxygen supply can cause subendocardial ischemia, which may show up as ST-segment deviations on the tracing. Because these ECG findings are not specific to hypoxia alone, it's essential to interpret them with the patient's oxygen saturation and clinical symptoms (such as dyspnea or chest discomfort). While hypoxia can predispose to arrhythmias like atrial fibrillation with rapid ventricular response or ventricular tachycardia, these are not the generic or initial patterns you'd rely on to identify hypoxia. Likewise, a normal ECG does not rule out hypoxia, especially in milder or early cases. So the typical telemetry presentation of hypoxia centers on sinus tachycardia and potential ST changes, interpreted in the context of oxygen saturation and symptoms.

10. In Normal Sinus Rhythm, the P wave duration is within which range?

A. 0.08-0.12 seconds

B. 0.28-0.36 seconds

C. 0.12-0.20 seconds

D. 0.20-0.28 seconds

P wave duration reflects how long atrial depolarization takes. In a normal sinus rhythm, this interval is short because atrial activation is quick and efficient. The typical upper limit you'll see in most references is about 0.12 seconds (roughly three small boxes on the ECG). If the P wave lasts significantly longer than that, it can indicate slowed atrial conduction or atrial enlargement. In the context of the answer you've got, remember that the time from the start of the P wave to the start of the QRS complex (the PR interval) is normally 0.12 to 0.20 seconds. This is a common source of confusion because the PR interval and the P wave duration are different measurements. The key point for P wave duration is that it should be brief—typically up to 0.12 seconds—and longer durations point to atrial conduction issues.

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://cardiachealthstreamtelemetry.examzify.com

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