

Kern County Protocols Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. Which facilities are designated as children's receiving facilities?**
 - A. Memorial and AHB**
 - B. BMH and Kern Medical**
 - C. MSW and Mercy**
 - D. AHP and KMC**
- 2. What is the recommended epinephrine infusion rate for addressing bradycardia during long transports?**
 - A. 1-5 mcg/min**
 - B. 2-8 mcg/min**
 - C. 5-10 mcg/min**
 - D. 10-15 mcg/min**
- 3. What technique is recommended for ventilating an apneic patient with a bag-mask?**
 - A. Seal the mask loosely and ventilate quickly**
 - B. A proper seal and adequate volume delivered every 5 to 6 seconds**
 - C. Ventilate continuously without checking the seal**
 - D. Only ventilate when the heart rate drops**
- 4. What types of burns are specifically mentioned for direct transport to a Burn Center?**
 - A. Minor burns and scratches**
 - B. Electrical burns and chemical burns over 5% BSA**
 - C. Only third-degree burns on hands**
 - D. Any superficial layer burns**
- 5. In the case of an unconscious patient with airway obstruction, what is the first step?**
 - A. Call for emergency assistance**
 - B. Open airway and position head**
 - C. Perform abdominal thrusts**
 - D. Begin CPR immediately**

- 6. What is the recommended initial dose of Naloxone for suspected narcotic overdose with respiratory depression?**
- A. 5 mg Intranasal**
 - B. 2 mg Intranasal**
 - C. 1 mg IV**
 - D. 3 mg IM**
- 7. What should be done if the Cincinnati Prehospital Stroke Scale is positive?**
- A. Apply ice to the patient**
 - B. Activate stroke alert**
 - C. Start intravenous fluids**
 - D. Place the patient in a sitting position**
- 8. If a patient meets stroke activation criteria, where can they be transported?**
- A. Only to KMC**
 - B. Only to AHB**
 - C. BMH and Mercy**
 - D. BMH, KMC, Mercy, MSW, AHB**
- 9. What is one of the reasons EMT personnel may terminate CPR?**
- A. Patient was found in a public space**
 - B. No return of spontaneous circulation after 30 minutes of CPR and AED analysis**
 - C. Patient is treated with tranquilizers**
 - D. Presence of family members**
- 10. What is the role of Sodium Bicarbonate in treating asystole?**
- A. To stabilize blood pressure**
 - B. To correct acidosis after 10 minutes of CPR**
 - C. To enhance oxygen delivery**
 - D. To increase heart rate**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Which facilities are designated as children's receiving facilities?

- A. Memorial and AHB**
- B. BMH and Kern Medical**
- C. MSW and Mercy**
- D. AHP and KMC**

Children's receiving facilities are specific healthcare entities designed to provide emergency care and stabilization for children experiencing mental health crises. The designated facilities are established under certain protocols to ensure that children receive appropriate and specialized care tailored to their needs. The correct answer identifies Memorial and AHB as recognized facilities for this purpose. These entities are equipped with the necessary resources and trained personnel who can address the unique and often complex mental health issues that children face. They provide a safe environment where immediate assessments can be conducted, and appropriate treatment plans can be initiated. The other choices, while they may include reputable healthcare facilities, do not have the specific designation as children's receiving facilities within the context of this training. Each of those facilities might offer various services; however, they are not officially recognized for handling emergency situations concerning children's mental health in the same way that Memorial and AHB are. This distinction is crucial for training protocols, ensuring children receive the most effective and specialized care in urgent scenarios.

2. What is the recommended epinephrine infusion rate for addressing bradycardia during long transports?

- A. 1-5 mcg/min**
- B. 2-8 mcg/min**
- C. 5-10 mcg/min**
- D. 10-15 mcg/min**

The recommended infusion rate of epinephrine for addressing bradycardia during long transports is indeed in the range of 2-8 mcg/min. This dosing is effective in managing bradycardia as epinephrine can stimulate the heart and increase heart rate by acting on adrenergic receptors. A dose between 2-8 mcg/min is particularly suitable for maintaining hemodynamic stability over extended periods, especially in transport scenarios where rapid interventions may not be possible. This range allows for a balance between providing adequate cardiovascular support and avoiding excessive adrenergic stimulation, which could lead to complications such as increased heart rate or myocardial oxygen demand. In trauma or critical care settings, understanding the appropriate dosing of medications like epinephrine is vital for patient outcomes during transport.

3. What technique is recommended for ventilating an apneic patient with a bag-mask?

- A. Seal the mask loosely and ventilate quickly**
- B. A proper seal and adequate volume delivered every 5 to 6 seconds**
- C. Ventilate continuously without checking the seal**
- D. Only ventilate when the heart rate drops**

The recommended technique for ventilating an apneic patient with a bag-mask involves creating a proper seal and delivering adequate volume every 5 to 6 seconds. This approach is essential because a proper seal ensures that the air you are attempting to deliver does not escape around the edges of the mask, which would lead to ineffective ventilation. Ventilating at a rate of every 5 to 6 seconds allows for adequate time for the chest to rise and the lungs to fill with air, while also providing enough time for the patient to exhale before the next breath is given. This careful technique promotes effective oxygenation and prevents potential complications that can arise from over-ventilation or improper airway management. The other options illustrate less effective or inaccurate practices. For instance, sealing the mask loosely and ventilating quickly could lead to air escaping and inadequate ventilation, while continuous ventilation without checking the seal risks delivering air without ensuring it reaches the lungs effectively. Lastly, only ventilating when the heart rate drops neglects the importance of timely intervention when apnea occurs, highlighting the need for proactive rather than reactive care in respiratory emergencies.

4. What types of burns are specifically mentioned for direct transport to a Burn Center?

- A. Minor burns and scratches**
- B. Electrical burns and chemical burns over 5% BSA**
- C. Only third-degree burns on hands**
- D. Any superficial layer burns**

The choice highlighting electrical burns and chemical burns over 5% Body Surface Area (BSA) is recognized as correct because both types of burns can result in severe complications and systemic effects that require specialized care at a Burn Center. Electrical burns can lead to internal injuries not immediately visible on the skin, including damage to the heart or other internal organs. Chemical burns can cause ongoing tissue damage depending on the chemical's nature and the duration of contact. Burns that exceed 5% BSA are significant enough to require intensive monitoring and treatment that can only be provided by a specialized facility. Other choices introduce scenarios that are less urgent or do not meet the criteria for immediate transport to a Burn Center. Minor burns and superficial layer burns typically do not require specialized burn care and can often be treated in general emergency settings. While third-degree burns on hands do indicate a serious condition, prioritizing transport solely based on their location without considering the type and extent could overlook equally dangerous circumstances like those involving electrical or chemical burns. Thus, the emphasis on the severity outlined in the chosen option addresses crucial factors in the appropriate management of burn injuries.

5. In the case of an unconscious patient with airway obstruction, what is the first step?

- A. Call for emergency assistance**
- B. Open airway and position head**
- C. Perform abdominal thrusts**
- D. Begin CPR immediately**

In the case of an unconscious patient with airway obstruction, the first step is to open the airway and position the head. This is critical because, with a lack of consciousness, the patient's airway is more likely to become blocked by the tongue or other obstructions. By positioning the head properly, often through the use of the head-tilt, chin-lift maneuver, you can help to clear the airway and allow for better access to any obstruction that may be present. Once the airway is opened, it's essential to assess whether the obstruction is still present. If the airway is open and breathing resumes, no additional steps are necessary at that moment. If the airway remains obstructed, further actions, such as abdominal thrusts or CPR, may become necessary; however, these actions should follow the initial step of ensuring the airway is clear. This approach prioritizes securing the airway, which is fundamental to restoring breathing and overall patient safety.

6. What is the recommended initial dose of Naloxone for suspected narcotic overdose with respiratory depression?

- A. 5 mg Intranasal**
- B. 2 mg Intranasal**
- C. 1 mg IV**
- D. 3 mg IM**

The recommended initial dose of Naloxone for suspected narcotic overdose with respiratory depression is 2 mg administered intranasally. This dosing is established based on clinical guidelines that prioritize an effective and quick response to opioid overdoses, aiming to reverse respiratory depression and allow for normal breathing to resume. Administering 2 mg intranasally is considered effective because this route allows for rapid absorption through the nasal mucosa, leading to a quicker onset of action. It also provides a safe and easy method to deliver the medication, essential in emergency situations where intravenous access may not be readily available. Other dosages and routes, while potentially effective in different scenarios, may not align with the recommended initial interventions for immediate opioid reversal in cases involving respiratory distress. The choice of 2 mg serves to balance efficacy, safety, and practicality in managing suspected opioid overdoses.

7. What should be done if the Cincinnati Prehospital Stroke Scale is positive?

- A. Apply ice to the patient**
- B. Activate stroke alert**
- C. Start intravenous fluids**
- D. Place the patient in a sitting position**

When the Cincinnati Prehospital Stroke Scale indicates a positive result, it is crucial to activate a stroke alert. This process ensures that critical medical personnel are notified and prepared to provide immediate care upon the patient's arrival at the hospital. Prompt identification of a potential stroke allows for timely interventions, which are vital for improving patient outcomes. Activating a stroke alert typically involves communicating with the receiving facility to prepare the necessary resources and specialists such as neurologists or stroke teams. This timely alert system is an essential protocol in managing strokes, where every minute counts in treating and minimizing brain damage. The other options do not align with the appropriate response to a positive stroke scale outcome. For instance, applying ice or starting IV fluids does not address the urgent need for specialized stroke care. Additionally, placing the patient in a sitting position may not be appropriate depending on the patient's condition and should not replace the critical action of activating a stroke alert.

8. If a patient meets stroke activation criteria, where can they be transported?

- A. Only to KMC**
- B. Only to AHB**
- C. BMH and Mercy**
- D. BMH, KMC, Mercy, MSW, AHB**

When a patient meets stroke activation criteria, they can be transported to any facility that is equipped to handle stroke patients effectively. This includes multiple hospitals that are designated as stroke centers, where comprehensive care can be provided. The option that identifies BMH (Bakersfield Memorial Hospital), KMC (Kern Medical Center), Mercy Hospital, MSW (Merced Street Wellness Center), and AHB (Adventist Health Bakersfield) recognizes a range of facilities that have the necessary resources and capabilities for stroke care. Choosing the option that lists multiple hospitals reflects the understanding that timely and appropriate treatment can vary based on the patient's condition and proximity to the nearest facility that can provide advanced stroke care. Offering several options for transport allows responding teams to make the best decision based on real-time factors such as hospital capacity, proximity, and the specific needs of the patient. This flexibility is critical in stroke management, where time is essential for effective intervention.

9. What is one of the reasons EMT personnel may terminate CPR?

- A. Patient was found in a public space**
- B. No return of spontaneous circulation after 30 minutes of CPR and AED analysis**
- C. Patient is treated with tranquilizers**
- D. Presence of family members**

One of the reasons EMT personnel may terminate CPR is the absence of return of spontaneous circulation after an extensive period, typically around 30 minutes of CPR and AED analysis. This decision is based on clinical guidelines and the likelihood of a favorable outcome. Prolonged resuscitation attempts without success may indicate that the chances of revival have diminished significantly. Emergency Medical Services (EMS) protocols often provide specific time frames after which resuscitation efforts can be deemed futile, taking into account factors such as patient condition, age, and the cause of cardiac arrest. This helps ensure that resources can be appropriately allocated to patients who still have a viable chance of recovery. In contrast, the other options pertain to situational elements that would not typically influence the decision to cease resuscitation efforts, such as the location of the patient, the use of tranquilizers, or the presence of family members. While these factors may influence the overall care approach or emotional considerations, they do not serve as clear clinical guidelines for terminating CPR in the manner that a lack of return of spontaneous circulation does.

10. What is the role of Sodium Bicarbonate in treating asystole?

- A. To stabilize blood pressure**
- B. To correct acidosis after 10 minutes of CPR**
- C. To enhance oxygen delivery**
- D. To increase heart rate**

Sodium bicarbonate plays a specific role in addressing metabolic acidosis that can occur during cardiac events, particularly in cases like asystole where there is a complete absence of electrical activity in the heart. In the context of treating asystole, one critical aspect is the management of acidosis, which can develop due to prolonged periods of inadequate circulation and oxygen delivery during cardiopulmonary resuscitation (CPR). After approximately 10 minutes of effective CPR, the accumulation of lactic acid from anaerobic metabolism can lead to a state of acidosis. Administering sodium bicarbonate can help correct this acidosis by neutralizing excess acid in the bloodstream. This correction of acidosis serves to optimize the physiological environment in which the heart may potentially regain a normal rhythm. While sodium bicarbonate is not a first-line treatment specifically for asystole, its role becomes relevant when acidosis is suspected or confirmed during prolonged resuscitation efforts. Thus, understanding the timing and application of sodium bicarbonate in the resuscitation protocol is crucial for effective management of patients undergoing such critical situations.