Plantation Fire Rescue EMS Protocols Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Questions

1. What should be done if an automatic blood pressure cuff reading is abnormal?

- **A. Document the reading without further action**
- **B. A manual blood pressure should be taken to confirm the reading**
- **C. Ignore the reading and proceed with treatment**
- **D. Notify a physician immediately without reassessment**

2. What is the ideal dose for administration via MAD?

- **A. 1.0mL to 1.5mL per nostril**
- **B. 0.5mL to 1mL per nostril**
- **C. 0.3mL to 0.5mL per nostril**
- **D. 1.5mL to 2mL per nostril**

3. What vital signs must be assessed during a public assist incident?

- **A. Temperature, Heart Rate, Blood Sugar**
- **B. Weight, Blood Pressure, Pulse Rate**
- **C. Blood Pressure, Pulse Rate, Respiratory Rate**
- **D. Respiratory Rate, Blood Oxygen Level, Heart Rate**

4. How often should vital signs be reassessed in an unstable patient?

- **A. Every 15 minutes**
- **B. Every 30 minutes**
- **C. As needed based on patient condition**
- **D. Only at the end of the incident**

5. How is Left Ventricular Hypertrophy (LVH) assessed?

- **A. By measuring blood pressure changes**
- **B. By counting deflections from the isoelectric line in specific leads**
- **C. By evaluating heart rhythm**
- **D. By checking for murmur sounds**

6. What should be prioritized when treating a patient with a suspected airway obstruction?

- **A. Stabilizing spine injuries**
- **B. Clearing the airway**
- **C. Administering medication**
- **D. Monitoring vital signs**

7. What is a key factor in assessing the effectiveness of transcutaneous pacing?

- **A. Heart rhythm monitoring**
- **B. Blood pressure stabilization**
- **C. Electrolyte levels**
- **D. Patient's age**

8. What is the contraindication for administering Adenosine in adults?

- **A. It is contraindicated in patients with known AFIB or A-Flutter.**
- **B. It should not be given to patients with a BMI over 30.**
- **C. It is contraindicated for patients with a history of seizures.**
- **D. Adenosine cannot be administered to patients over 65 years old.**

9. What is the dosage of Albuterol for nebulization in adults?

- **A. 2.5 mg via nebulizer**
- **B. 10 mg via nebulizer**
- **C. 5 mg via nebulizer**
- **D. 15 mg via nebulizer**

10. What is the dosage of Magnesium Sulfate for pediatric patients?

- **A. 20 mg/kg**
- **B. 30 mg/kg**
- **C. 40 mg/kg**
- **D. 50 mg/kg**

Answers

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

Explanations

1. What should be done if an automatic blood pressure cuff reading is abnormal?

A. Document the reading without further action

B. A manual blood pressure should be taken to confirm the reading

C. Ignore the reading and proceed with treatment

D. Notify a physician immediately without reassessment

When an automatic blood pressure cuff reading is abnormal, taking a manual blood pressure reading is essential to confirm or refute the accuracy of the initial reading. Automatic devices can be affected by various factors, such as patient movement, improper cuff placement, or the patient's physiological state, leading to possibly erroneous results. By assessing blood pressure manually, practitioners can ensure that they have an accurate measurement before making any treatment decisions. Confirming the automatic reading allows for a more reliable evaluation of the patient's condition. If the manual reading aligns with the abnormal automatic reading, it will indicate the need for urgent intervention or treatment modifications. Conversely, if the manual reading is within normal limits, it could suggest the potential for a false alarm from the automatic device. This two-step verification process is crucial as it ensures accurate information drives clinical decisions, ultimately leading to better patient care and outcomes.

2. What is the ideal dose for administration via MAD?

A. 1.0mL to 1.5mL per nostril

B. 0.5mL to 1mL per nostril

C. 0.3mL to 0.5mL per nostril

D. 1.5mL to 2mL per nostril

The ideal dose for administration via a mucosal atomization device (MAD) is typically in the range of 0.3mL to 0.5mL per nostril. This dosage is optimal because it balances effective delivery of the medication while minimizing waste and ensuring proper absorption through the mucosal membranes in the nasal cavity. Administering too high a volume could lead to problems such as overflow or difficulty in absorption, where the medication may not be adequately retained in the nasal passages. In contrast, doses lower than this range might not provide sufficient therapeutic effect. This rationale is grounded in the pharmacokinetics of intranasal medications, where the goal is to achieve a rapid onset of action through the rich blood supply in the nasal mucosa, making the 0.3mL to 0.5mL range the most effective for achieving these therapeutic outcomes.

3. What vital signs must be assessed during a public assist incident?

A. Temperature, Heart Rate, Blood Sugar

B. Weight, Blood Pressure, Pulse Rate

C. Blood Pressure, Pulse Rate, Respiratory Rate

D. Respiratory Rate, Blood Oxygen Level, Heart Rate

The assessment of vital signs during a public assist incident focuses on monitoring the essential physiological parameters that can indicate a person's health status. The correct answer emphasizes Blood Pressure, Pulse Rate, and Respiratory Rate, which are critical components in evaluating the overall condition of a patient. Blood Pressure provides insight into cardiovascular health and helps identify whether a person is experiencing shock or other circulatory issues. The Pulse Rate offers valuable information about heart function and can indicate stress on the heart or other issues such as arrhythmias. Similarly, the Respiratory Rate is crucial for assessing how effectively a person is breathing and can signal respiratory distress or failure. By monitoring these specific vital signs, responders can obtain a clear picture of the individual's well-being, allowing for appropriate interventions or referrals as necessary. In contrast, other combinations of vital signs listed do not cover the fundamental aspects of physiological monitoring typically needed in such situations, focusing instead on factors that may not be as critical in non-emergency situations or do not provide the same immediate insights into patient stability.

4. How often should vital signs be reassessed in an unstable patient?

A. Every 15 minutes

B. Every 30 minutes

C. As needed based on patient condition

D. Only at the end of the incident

Reassessing vital signs in an unstable patient is critical for monitoring their condition and determining if any changes in treatment are necessary. The guideline indicates that the frequency of reassessment should be based on the patient's condition and clinical judgement rather than a fixed interval. This means that if a patient is unstable or showing signs of deterioration, vital signs should be checked more frequently to quickly identify any changes that may require immediate intervention. In contrast, a patient who may be stable may require less frequent monitoring. The emphasis on assessing vital signs as needed allows for flexibility and responsiveness in patient care, prioritizing the patient's immediate health status and ensuring that any deterioration is promptly noted and addressed. This approach aligns with best practices in emergency medical service protocols where patient safety and timely interventions are paramount.

5. How is Left Ventricular Hypertrophy (LVH) assessed?

A. By measuring blood pressure changes

B. By counting deflections from the isoelectric line in specific leads

C. By evaluating heart rhythm

D. By checking for murmur sounds

Left Ventricular Hypertrophy (LVH) is primarily assessed through an electrocardiogram (ECG or EKG), which provides valuable information about the electrical activity of the heart. The correct method involves counting deflections from the isoelectric line in specific leads because LVH is characterized by changes in the size and the shape of the electrical signals generated by the hypertrophied left ventricle. When assessing for LVH on an ECG, clinicians typically look for certain criteria, such as increased amplitude of the QRS complexes in specific leads, or changes in the ST segment and T wave morphology. These changes reflect the thicker muscle mass of the left ventricle and its impact on the heart's electrical conduction system. Other methods mentioned, such as measuring blood pressure, evaluating heart rhythm, or checking for murmur sounds, may provide useful information about cardiac health but do not specifically assess for LVH. Blood pressure changes might indicate hypertension, which can lead to LVH, but they do not directly measure the structural changes in the heart. Similarly, heart rhythm evaluation can highlight arrhythmias but does not assess for ventricular hypertrophy. Finally, checking for murmur sounds is more insightful for valvular heart disease rather than directly indicating

6. What should be prioritized when treating a patient with a suspected airway obstruction?

A. Stabilizing spine injuries

B. Clearing the airway

C. Administering medication

D. Monitoring vital signs

When treating a patient with a suspected airway obstruction, clearing the airway is the most critical step because an obstructed airway can lead to lack of oxygen, respiratory failure, and potentially death if not addressed swiftly. An unobstructed airway is vital for the patient to breathe and maintain adequate oxygenation. Therefore, immediate action focused on clearing any blockage is essential to restore airflow, allowing the patient to breathe effectively. Other priorities, while important in a broader assessment of a patient's condition, become secondary in the context of an immediate airway obstruction. Stabilizing spine injuries is vital in trauma cases but does not take precedence over resolving the airway issue. Administering medication may be necessary later in the treatment process but will not be effective if the patient cannot breathe. Monitoring vital signs is crucial for ongoing assessment, but without a clear airway, there may be little to monitor effectively, as the patient could decompensate rapidly. Thus, prioritizing the clearing of the airway is fundamental in this emergency scenario.

7. What is a key factor in assessing the effectiveness of transcutaneous pacing?

A. Heart rhythm monitoring

B. Blood pressure stabilization

C. Electrolyte levels

D. Patient's age

Blood pressure stabilization is crucial in assessing the effectiveness of transcutaneous pacing because it indicates how well the pacing is supporting the heart's function and maintaining adequate circulation. When transcutaneous pacing is initiated, the goal is to restore a normal heart rhythm and improve hemodynamics. Effective pacing should lead to an increase in cardiac output, which is reflected in the blood pressure readings. A rise in blood pressure following pacing indicates that the heart is responding appropriately to the pacing stimulus and that blood flow to vital organs is being maintained. While monitoring heart rhythm is important in pacing to ensure that the electrical impulses are effective, it does not directly assess the patient's overall hemodynamic status. Electrolyte levels, while relevant to cardiac function, are not an immediate indicator of pacing effectiveness. The patient's age can influence treatment approaches and prognosis but does not specifically relate to the assessment of pacing efficacy in the moment. Thus, the emphasis on blood pressure stabilization is key in evaluating how well transcutaneous pacing is working in a clinical setting.

8. What is the contraindication for administering Adenosine in adults?

A. It is contraindicated in patients with known AFIB or A-Flutter.

B. It should not be given to patients with a BMI over 30.

C. It is contraindicated for patients with a history of seizures.

D. Adenosine cannot be administered to patients over 65 years old.

The contraindication for administering Adenosine in adults primarily relates to its effects on cardiac rhythm. Adenosine is particularly effective in treating certain types of supraventricular tachycardia (SVT) by temporarily blocking conduction through the atrioventricular (AV) node. However, in patients with known atrial fibrillation (AFIB) or atrial flutter, Adenosine may not only be ineffective but also potentially harmful. This is because the use of Adenosine in the presence of these conditions can lead to rapid ventricular response due to the irregular atrial activity, increasing the risk for more severe complications, such as hemodynamic instability or worsening of the arrhythmia. In contrast, other options presented do not reflect direct contraindications based on the pharmacological action of Adenosine. Factors such as body mass index, historical medical issues like seizures, or age-related concerns are not established contraindications for the administration of Adenosine, making the first option the most accurate choice in the context of proper clinical guidelines.

9. What is the dosage of Albuterol for nebulization in adults?

A. 2.5 mg via nebulizer

B. 10 mg via nebulizer

C. 5 mg via nebulizer

D. 15 mg via nebulizer

The appropriate dosage of Albuterol for nebulization in adults is 2.5 mg via nebulizer. This dosage is widely accepted in medical practice for the treatment of conditions such as bronchospasm associated with asthma and chronic obstructive pulmonary disease (COPD). Using 2.5 mg allows for effective bronchodilation, providing relief from wheezing, shortness of breath, and chest tightness. Albuterol acts quickly and is generally well-tolerated, making it a staple in emergency situations involving respiratory distress. The higher dosages presented in the other choices are not typically used due to the increased risk of side effects without providing significant additional therapeutic benefit. Therefore, 2.5 mg is the standard and recommended dosage for adult patients receiving nebulized Albuterol treatment.

10. What is the dosage of Magnesium Sulfate for pediatric patients?

A. 20 mg/kg

B. 30 mg/kg

C. 40 mg/kg

D. 50 mg/kg

In pediatric patients, Magnesium Sulfate is commonly used in situations such as severe asthma exacerbations and certain types of cardiac arrhythmias. The recommended dosage for Magnesium Sulfate in these cases is typically around 40 mg/kg, with a maximum limit often set at 2 grams depending on the specific condition being treated and the protocols in place at the EMS department. The dosage of 40 mg/kg allows for adequate therapeutic effects while minimizing the risk of potential side effects associated with higher doses. It is important to follow established protocols and guidelines, as proper dosing is critical for safety and efficacy in pediatric patients. Additionally, medical providers need to adjust dosages based on the patient's weight and clinical condition to ensure optimal care. This correct dosage ensures that the administration of Magnesium Sulfate will provide the necessary therapeutic benefits while adhering to safety standards for pediatric patients.