QIC Acadian Ambulance 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. Under standing orders for analgesia, the increments are:

A. Morphine 10 mg; Fentanyl 100 mcg

B. Morphine 5 mg; Fentanyl 50 mcg

C. Morphine 15 mg; Fentanyl 75 mcg

D. Morphine 20 mg; Fentanyl 200 mcg

2. In neonatal resuscitation, when should CPR be started?

A. Immediately start chest compressions

B. After establishing a pulse oximeter reading

C. CPR should be started if heart rate remains below threshold

D. CPR should be started immediately on all non-breathing newborns

3. If indicated, within how many minutes should 12-lead ECGs be obtained?

A. 5 minutes

B. 10 minutes

C. 15 minutes

D. 20 minutes

4. How many acceptable reasons for diversion of a status 1 or 2 patient are listed?

A. 4

B. 5

C. 7

D. 6

5. What is the first-line medication for pediatric bronchospasm?

A. Epinephrine via injection

B. Ipratropium bromide inhalation

C. Theophylline oral

D. Albuterol via inhalation

6. A Glasgow Coma Scale score of 8 typically indicates which of the following?

A. Mild confusion

B. Severe disturbance of consciousness; airway protection and likely intubation

C. Awake and oriented

D. Localized pain

7. How many proximal long bone fractures qualify as a trauma positive finding in the secondary assessment?

A. One

B. Two

C. Three

D. Four

8. Which of the following is a trauma secondary finding (status 2)?

A. Laceration to scalp

B. Contusion to thigh

C. Pelvic fracture

D. Fracture of the clavicle with no neuro compromise

9. In a patient with suspected ectopic pregnancy, what is a critical action during transport?

A. Rapid transport

B. Delay for ultrasound

C. Administer analgesia only

D. On-scene surgery

10. How should pediatric drug dosing be determined in the field?

A. Use weight-based dosing tools (Broselow tape or pediatric dose charts) and verify dose with protocols

B. Use age-based dosing

C. Fixed adult doses

D. Guess dose

Answers

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

Explanations

1. Under standing orders for analgesia, the increments are:

A. Morphine 10 mg; Fentanyl 100 mcg

B. Morphine 5 mg; Fentanyl 50 mcg

C. Morphine 15 mg; Fentanyl 75 mcg

D. Morphine 20 mg; Fentanyl 200 mcg

In standing orders for analgesia, doses are given in fixed, equianalgesic increments to titrate pain effectively while staying safe. For morphine and fentanyl, an approximate equianalgesic relationship is 1 mg morphine ≈ 10 mcg fentanyl, so one standard dose increment is about 10 mg morphine or 100 mcg fentanyl. The best choice uses that standard increment: morphine 10 mg with fentanyl 100 mcg. This pairing reflects the defined dose step you'd give per administration to achieve a consistent, predictable effect. The other options either use nonstandard increments (for example, a 15 mg/75 mcg pairing isn't an equivalent increment) or a smaller increment (5 mg/50 mcg) that isn't the defined step, or a larger amount that effectively doubles the standard increment (20 mg/200 mcg would be two increments at once).

2. In neonatal resuscitation, when should CPR be started?

A. Immediately start chest compressions

B. After establishing a pulse oximeter reading

C. CPR should be started if heart rate remains below threshold

D. CPR should be started immediately on all non-breathing newborns

In neonatal resuscitation, you first establish effective ventilation and monitor the heart rate. Start chest compressions when the heart rate remains below 60 beats per minute despite adequate ventilation. This threshold signals poor perfusion and the need for circulatory support. If the heart rate is above 60, you continue to optimize ventilation and monitoring rather than starting compressions. Pulse oximetry helps assess oxygenation but isn't the trigger for initiating CPR. Non-breathing newborns aren't automatically started on CPR; the decision hinges on the heart rate in relation to the ventilation being provided.

3. If indicated, within how many minutes should 12-lead ECGs be obtained?

A. 5 minutes

B. 10 minutes

C. 15 minutes

D. 20 minutes

Getting a 12-lead ECG quickly is essential because it allows early identification of a STEMI or other acute coronary syndrome, enabling rapid activation of reperfusion therapy and reducing heart muscle damage. In EMS practice, the target is to obtain the 12-lead within ten minutes of first medical contact with the patient. This timeframe balances the need for speed with practical field considerations. Five minutes is often very challenging in real-world scenes, while waiting fifteen or twenty minutes would delay diagnosis and treatment, worsening outcomes. So, ten minutes is the best answer because it represents a prompt, achievable standard for early ACS assessment in the field.

4. How many acceptable reasons for diversion of a status 1 or 2 patient are listed?

A. 4

B. 5

C. 7

D. 6

Diversion decisions are guided by a fixed list of acceptable reasons, chosen to keep patient care consistent and EMS flow efficient. The question tests your recall of how many reasons are officially listed, and the policy specifies six. Knowing there are six helps you apply the rule quickly in the field rather than improvising. The six reasons cover a mix of hospital capacity and capability issues, patient-specific considerations, and system-flow needs, ensuring patients are taken to an facility that can provide the required care without unnecessarily delaying treatment. For your own study, check your local protocol to see the exact wording and categories, but remember the count is six.

5. What is the first-line medication for pediatric bronchospasm?

A. Epinephrine via injection

B. Ipratropium bromide inhalation

C. Theophylline oral

D. Albuterol via inhalation

Albuterol delivered by inhalation is the fastest, most effective relief for acute bronchospasm in children. It's a short-acting beta-2 agonist that directly relaxes airway smooth muscle, rapidly opening the airways and improving breathing. Because it works in the lungs, it provides quick relief with fewer systemic effects, which is why it's the first-line choice. In kids, using a spacer with a metered-dose inhaler or a small-volume nebulizer helps ensure the medication reaches the lungs. Epinephrine injections are reserved for life-threatening or anaphylactic situations, not routine pediatric bronchospasm. Ipratropium bromide inhalation can be added for more severe or unresponsive cases but isn't the initial stand-alone choice. Theophylline, given orally, is outdated for acute management due to a narrow therapeutic window and potential side effects, so it isn't used first-line.

6. A Glasgow Coma Scale score of 8 typically indicates which of the following?

A. Mild confusion

B. Severe disturbance of consciousness; airway protection and likely intubation

C. Awake and oriented

D. Localized pain

Understanding the Glasgow Coma Scale and what a score around eight means is the focus here. The GCS adds three areas—eye opening, verbal response, and motor response—to give a total score from 3 to 15. A score of eight or less signals severe impairment of consciousness, typically described as coma. In this range, the person often cannot protect their airway, so securing the airway with intubation is likely needed to prevent aspiration and ensure ventilation. So, a score of eight reflects significant brain dysfunction and a high risk to breathing safety, which is why airway protection and probable intubation are the expected actions. This is in contrast to higher scores such as a fully awake and oriented person (score around 15) or milder confusion (scores well above eight). Localized pain refers to a motor response component alone and doesn't describe overall consciousness, so it wouldn't equate to a score of eight by itself.

7. How many proximal long bone fractures qualify as a trauma positive finding in the secondary assessment?

A. One

B. Two

C. Three

D. Four

In the secondary assessment, a finding is considered trauma positive when it signals a high likelihood of significant, multisystem injury. Proximal long bones include areas like the femur and humerus near the joints. Fractures in these bones can result from high-energy trauma and are associated with substantial blood loss and potential injuries to other body systems. Having two proximal long bone fractures indicates a more severe pattern of injury than a single fracture, so it meets the threshold for a trauma positive finding. A single fracture can be isolated, while two or more suggest multisystem trauma requiring heightened care and rapid escalation.

8. Which of the following is a trauma secondary finding (status 2)?

A. Laceration to scalp

B. Contusion to thigh

C. Pelvic fracture

D. Fracture of the clavicle with no neuro compromise

The idea being tested is how injuries found during the secondary survey are classified by severity. In trauma care, the primary survey handles life-threatening problems right away, while the secondary survey looks for additional injuries that aren't immediately life-threatening but still require urgent attention. A status 2 secondary finding is a significant injury that suggests potential complications (like hidden blood loss or instability) and needs prompt evaluation and transport, even though it isn't an immediate airway, breathing, or massive circulation threat. A pelvic fracture fits this well. It isn't usually something you treat at once to save the airway or stop an obvious bleed, but it signals a high risk of serious internal bleeding, pelvic instability, and injury to surrounding organs. That combination makes it a classic status 2 finding: important, potentially deteriorating, and requiring rapid but not emergent life-saving action. The other options tend to be either minor or less likely to indicate hidden, life-threatening consequences. A scalp laceration is a superficial wound, a thigh contusion is a soft-tissue injury, and a clavicle fracture without neuro compromise, while painful and requiring immobilization, does not on its own imply the same level of internal risk as a pelvic fracture.

9. In a patient with suspected ectopic pregnancy, what is a critical action during transport?

A. Rapid transport

B. Delay for ultrasound

C. Administer analgesia only

D. On-scene surgery

In suspected ectopic pregnancy, the danger lies in rapid rupture and internal bleeding, so getting the patient to definitive care quickly is the priority. The best action during transport is to pursue rapid transport to a facility capable of emergency surgical management, rather than delaying for imaging, on-scene procedures, or giving analgesia alone. While en route, continue stabilization—monitor vital signs, maintain airway and breathing, start IV access, and provide oxygen as needed—without delaying the ride. Ultrasound in the field or delaying transport won't reliably rule out rupture and can postpone life-saving treatment.

10. How should pediatric drug dosing be determined in the field?

A. Use weight-based dosing tools (Broselow tape or pediatric dose charts) and verify dose with protocols

B. Use age-based dosing

C. Fixed adult doses

D. Guess dose

In pediatric field dosing, accuracy comes from weight-based dosing using quick tools that translate length or appearance into a safe weight estimate and then map that weight to the correct dose. The Broselow tape and pediatric dose charts are designed for rapid, reliable dosing by mg per kg, which helps prevent the common errors that happen when relying on age or size guesses. After selecting the weight-based dose, always verify with your protocols or medical control to confirm concentration, route, and any maximums or special considerations. Age-based dosing is unreliable because children of the same age can have widely different weights and drug handling, so it doesn't account for individual size. Fixed adult doses are inappropriate for kids and can easily lead to overdosing or underdosing. Guessing doses is dangerous and unacceptable in emergency care. Use the weight-based method, verify with protocols, and adjust only as allowed by guidance and the patient's condition.

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://qicacadianambulance.examzify.com

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