RQI PEDIATRIC ADVANCED LIFE SUPPORT (PALS) PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Table of Contents

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. Who should perform ventilation and prepare for intubation for infants and children at risk for respiratory failure?

A. A team member with significant pediatric expertise

B. A general physician

C. A nurse

D. A paramedic

2. What is the dexamethasone dose for pediatric croup?

A. 0.3 mg/kg

B. 0.9 mg/kg

C. 1.0 mg/kg

D. 0.6 mg/kg (maximum around 10 mg)

3. Which is an appropriate intervention for an apnea child?

A. Provide one breath every 2 to 3 seconds

B. Deliver continuous chest compressions without ventilation

C. Observe for spontaneous breathing for 60 seconds

D. Withhold ventilation until the child becomes fully responsive

4. Which tool, if available, provides real-time guidance to maintain chest compression quality during CPR?

A. Defibrillator alone

B. CPR feedback device

C. Pulse oximeter

D. Thermometer

5. Which component of effective high-performance teams is represented by the use of real-time feedback devices?

A. Quality

B. Communication

C. Situational awareness

D. Leadership

6. What endotracheal tube sizing adjustment is recommended to avoid subglottic injury in a child at risk for respiratory failure?

A. A half size smaller than indicated

B. The same as indicated

C. One size larger

D. Two sizes smaller

7. In pediatric CPR, what is the chest compression to ventilation ratio for a single rescuer?

A. 20 compressions to 2 breaths

B. 30 compressions to 2 breaths

C. 15 compressions to 2 breaths

D. 15 compressions to 1 breath

8. In pediatric septic shock, when should vasopressors be started if fluids do not restore perfusion?

A. After initial adequate fluid resuscitation (e.g., 20 mL/kg boluses) and persistent hypotension or poor perfusion

B. Immediately before any fluid boluses

C. Only after 60 minutes of resuscitation

D. Never until after shock ends

9. In a child with VT with a pulse who becomes unstable, what is the recommended immediate treatment?

A. Defibrillate immediately at 2 J/kg

B. Continue CPR without defibrillation

C. Administer immediate epinephrine only

D. Synchronized cardioversion at 0.5–1 J/kg (and escalate as needed)

10. What are the Hs and Ts that guide treatment during arrest?

A. Hypoxia, Hypovolemia, Hydrogen ion (acidosis), Hyper-/hypokalemia, Hypothermia, Toxins; Tamponade, Tension pneumothorax, Thrombosis

B. Hypoxia, Hypertension, Hyperglycemia, Tachycardia

C. Hypothermia, Hyperthermia, Anemia, Dehydration

D. Hypoxia, Hypovolemia, Hyperlipidemia, Thrombosis

Answers

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

Explanations

1. Who should perform ventilation and prepare for intubation for infants and children at risk for respiratory failure?

A. A team member with significant pediatric expertise

B. A general physician

C. A nurse

D. A paramedic

The key idea is that securing a airway and preparing for intubation in infants and children who are at risk for respiratory failure requires specialized pediatric airway experience. Pediatric airways are very different from adults: they're smaller and more easily obstructed, with unique anatomy and physiologic responses. A clinician with substantial pediatric expertise is best equipped to anticipate difficulties, choose the correct endotracheal tube size, select appropriate ventilation settings, and manage potential complications such as rapid desaturation, bradycardia, or hemodynamic instability during intubation. This expertise also supports rapid decision-making about when preoxygenation, sedation, or neuromuscular blockade is appropriate, and how to optimize the airway plan for a child with a potentially difficult airway. While nurses, general physicians, and paramedics play critical roles in resuscitation and can assist, the act of ventilation and preparing for a secure airway in a high-risk pediatric patient benefits from leadership by someone with deep pediatric airway experience. This ensures the team uses pediatric-specific equipment, techniques, and crash-cart readiness, reducing risk and improving outcomes for these vulnerable patients.

2. What is the dexamethasone dose for pediatric croup?

A. 0.3 mg/kg

B. 0.9 mg/kg

C. 1.0 mg/kg

D. 0.6 mg/kg (maximum around 10 mg)

In pediatric croup, a single anti-inflammatory dose of dexamethasone is standard because it reduces airway swelling and improves symptoms for about a day or two. The best choice is a single dose of 0.6 mg per kilogram of body weight, with a maximum total dose of roughly 10 mg. This dose provides effective relief while keeping the risk of side effects low, thanks to dexamethasone's long duration of action. Routes can be oral, IV, or IM, whichever is most feasible, and the dose remains the same regardless of route. Lower doses like 0.3 mg/kg may be less reliably effective, while higher values such as 0.9 or 1.0 mg/kg exceed the typical maximum and don't offer added benefit.

3. Which is an appropriate intervention for an apnea child?

A. Provide one breath every 2 to 3 seconds

B. Deliver continuous chest compressions without ventilation

C. Observe for spontaneous breathing for 60 seconds

D. Withhold ventilation until the child becomes fully responsive

When a child is not breathing but still has a pulse, the priority is to provide ventilation to restore oxygen delivery. Give rescue breaths at about one breath every 2 to 3 seconds (roughly 20 breaths per minute), making sure each breath causes the chest to rise. This supports oxygenation and helps maintain circulation until the child resumes breathing or the condition worsens. Continuous chest compressions without ventilation aren't appropriate here because the body still needs oxygen supplied through breaths. Waiting to see if spontaneous breathing returns or withholding ventilation until the child is fully responsive would delay critical support.

4. Which tool, if available, provides real-time guidance to maintain chest compression quality during CPR?

A. Defibrillator alone

B. CPR feedback device

C. Pulse oximeter

D. Thermometer

Maintaining chest compression quality hinges on knowing how your compressions are being performed in real time. A CPR feedback device provides that guidance by giving immediate, objective cues about how deep each compression is, how fast you're compressing, and whether you're allowing the chest to recoil fully between compressions. It may show depth in centimeters, rate in compressions per minute, and alerts if you're leaning or pausing too long. This real-time feedback helps the rescuer adjust technique on the spot to stay within guideline targets (for pediatric patients, adequate depth and a rate around 100–120 per minute with complete recoil), which improves perfusion during CPR. A defibrillator is crucial for delivering shocks when indicated, but it isn't primarily a tool for guiding chest compression technique in real time. A pulse oximeter monitors oxygen saturation, not compression quality, and a thermometer has no role in guiding resuscitation technique.

5. Which component of effective high-performance teams is represented by the use of real-time feedback devices?

A. Quality

B. Communication

C. Situational awareness

D. Leadership

Real-time feedback devices primarily support quality by providing immediate, objective data on performance and outcomes, which teams use to detect defects, measure adherence to standards, and drive rapid improvements. In high-performance teams, quality centers on delivering reliable results and meeting established benchmarks, so having real-time metrics allows the group to identify gaps quickly and implement corrective actions before problems escalate. These devices capture metrics like error rates, timing, protocol compliance, and patient outcomes, turning raw activity into actionable quality information that guides continuous improvement. Communication is about how information is shared among team members; while real-time feedback can enhance situational updates, the core value of these devices is generating data to improve the quality of care. Situational awareness involves understanding the current status of patients and operations; feedback data contributes to that awareness but ultimately serves the goal of maintaining high-quality performance. Leadership concerns guiding the team and decision-making; devices themselves don't provide leadership—they supply the information that leaders and teams use to uphold quality standards.

6. What endotracheal tube sizing adjustment is recommended to avoid subglottic injury in a child at risk for respiratory failure?

A. A half size smaller than indicated

B. The same as indicated

C. One size larger

D. Two sizes smaller

In children, the subglottic airway is the narrowest part of the airflow path and is especially vulnerable to injury from an endotracheal tube. Using a tube that is too large presses on the delicate mucosa, increasing the risk of edema, impaired perfusion, and later traumatic stenosis. To protect this area while still providing adequate ventilation, you select a tube that is half a size smaller than the size indicated by the standard age-based calculation (for cuffed tubes, this means using a size 0.5 mm smaller than the uncuffed equivalent). This smaller sizing reduces circumferential pressure on the subglottic mucosa. After selecting the tube, confirm an appropriate fit with clinical assessment and ventilation monitoring, using methods such as a cuff leak test to ensure the tube is not causing excessive obstruction or injury.

7. In pediatric CPR, what is the chest compression to ventilation ratio for a single rescuer?

A. 20 compressions to 2 breaths

B. 30 compressions to 2 breaths

C. 15 compressions to 2 breaths

D. 15 compressions to 1 breath

When one rescuer performs pediatric CPR, the priority is to maintain blood flow while providing needed breaths, and the best balance for that scenario is a cycle of 30 chest compressions followed by 2 rescue breaths. This 30:2 pattern allows compressions to keep perfusion to the heart and brain continuous, while the two breaths help oxygenate the lungs without causing long pauses. Deliver compressions at a rate about 100 to 120 per minute and to a depth of about one third of the chest, then after 30 compressions open the airway and give two breaths, each for roughly one second with visible chest rise. Resume compressions immediately after the breaths. If another rescuer arrives, the approach switches to 15 compressions to 2 breaths to reduce pauses and improve ventilation efficiency with two rescuers.

8. In pediatric septic shock, when should vasopressors be started if fluids do not restore perfusion?

A. After initial adequate fluid resuscitation (e.g., 20 mL/kg boluses) and persistent hypotension or poor perfusion

B. Immediately before any fluid boluses

C. Only after 60 minutes of resuscitation

D. Never until after shock ends

In pediatric septic shock, the initial priority is to restore intravascular volume with fluid resuscitation. If perfusion is not restored after giving adequate fluid boluses (for example, up to 40–60 mL/kg total in staged amounts and reassessment after each), vasopressors are started to raise mean arterial pressure and improve organ perfusion. This sequence—fluids first, then vasopressors when perfusion remains compromised—helps correct hypovolemia before adding vasoconstriction, and it targets ongoing shock promptly to prevent further tissue hypoperfusion. So the best approach is to initiate vasopressors after initial adequate fluid resuscitation if the patient remains hypotensive or shows signs of poor perfusion. Immediate vasopressors before any fluids, waiting a fixed time before starting them, or delaying indefinitely until shock ends do not fit the recommended management.

9. In a child with VT with a pulse who becomes unstable, what is the recommended immediate treatment?

A. Defibrillate immediately at 2 J/kg

B. Continue CPR without defibrillation

C. Administer immediate epinephrine only

D. Synchronized cardioversion at 0.5–1 J/kg (and escalate as needed)

When a child has ventricular tachycardia with a pulse but becomes unstable, the priority is to restore a stable rhythm with synchronized cardioversion. The rhythm is shockable, but because a pulse is present you synchronize the shock to the QRS complex to avoid delivering a shock that could worsen the rhythm. Start with a energy of 0.5 to 1 joule per kilogram, and if needed, escalate to 2 J/kg for subsequent shocks. After cardioversion, reassess the patient and repeat shocks if instability persists, then consider antiarrhythmic options as guidelines suggest. Defibrillating unsynchronized would be used if there were no pulse (pulseless VT or VF), which isn't the scenario here. Continuing CPR without delivering a synchronized shock isn't appropriate when a shockable rhythm with a pulse is present. Administering epinephrine alone does not promptly correct unstable VT with a pulse and is not the first-line treatment in this situation.

10. What are the Hs and Ts that guide treatment during arrest?

A. Hypoxia, Hypovolemia, Hydrogen ion (acidosis), Hyper-/hypokalemia, Hypothermia, Toxins; Tamponade, Tension pneumothorax, Thrombosis

B. Hypoxia, Hypertension, Hyperglycemia, Tachycardia

C. Hypothermia, Hyperthermia, Anemia, Dehydration

D. Hypoxia, Hypovolemia, Hyperlipidemia, Thrombosis

During arrest, focus on reversible causes that you can actively treat to restore circulation. This is captured by the Hs and Ts framework, which guides what you assess and address right away. Hs: - Hypoxia: ensure a patent airway and give high-flow oxygen to fix lack of oxygen. - Hypovolemia: suspect fluid loss and administer appropriate IV fluids to restore volume. - Hydrogen ion (acidosis): improve ventilation and oxygenation to correct acidosis; address underlying causes. - Hyper- or hypokalemia: correct potassium abnormalities that can destabilize rhythm and worsen arrest. - Hypothermia: warm the patient to reduce metabolic derangements and improve response to CPR. - Toxins: identify and treat toxin exposure with antidotes or supportive care as indicated. Ts: - Tamponade (pericardial): perform pericardiocentesis to relieve compression. - Tension pneumothorax: perform needle decompression to re-expand the lung. - Thrombosis: consider causes like pulmonary embolism or coronary thrombosis and pursue thrombolysis or definitive care as appropriate. Why this set is the best fit: it focuses on reversible, treatable causes encountered during resuscitation, guiding you to specific interventions that can change the outcome. The other options list conditions not typically framed as the immediate reversible drivers of cardiac arrest in children, so they don't align with the standard Hs and Ts approach.

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!