

Northwest Community EMS System – Continuing Education – Post-Test/Study-Questions – July 2011 - Trauma

Abbreviations: MVC = motor vehicle crash L1-TC = level 1 trauma center tx = treatment

<p>1. What are the 4 major components of the initial trauma care (ITC) SOP? A ABC's, SAMPLE, OPQRST B spine immobilization, O2, IV, ECG C airway, breathing, circulation, disability D scene size-up, primary assessment, transport decision, secondary assessment</p>	<p>2. What should be included in the scene size-up of a 3-vehicle MVC? A assess ABC's of all victims B determine number of patients C determine if pt(s) meets criteria for L1 TC D determine how many are refusing transport</p>	<p>3. When should the transport decision be made? A after contacting OLMC B after secondary assessment C after primary, before secondary assessment D after scene size-up, before primary assessment</p>
<p>4. When called to a MVC, what is an appropriate initial statement to make to the pt seated in the damaged vehicle? A "Did you call us?" B "Do you want to go to the hospital?" C "You don't need to go to the hospital." D "Hello, my name is..., can you tell me what happened?"</p>	<p>5. If a pt is refusing transport to the hospital, what should a PM do? A Tell pt to contact their physician - only if they get worse. B Reassure the pt that they are not injured and will be fine. C Explain risks of refusal and determine pts understanding of the risks. D Have pt sign a release only if they have a complaint or an obvious injury.</p>	<p>6. PM's are called to a gym for a pt who fell and hit his head. While enroute dispatch tells you the pts coach and PD are on the scene, and the pt does not need EMS. What should they do? A cancel the response B continue responding to call C ask to speak directly w/ PD on the scene D ask dispatch to tell the pt to call back if they change their mind</p>
<p>7. Where should an O2 sat/pulse ox reading be obtained from in a hypotensive pt? A toes B fingers C central/earlobe sensor D not needed if monitoring ETCO2</p>	<p>8. Why should capnography be monitored in all pts receiving assisted ventilation? A to help prevent hyperventilation B to determine adequacy of oxygenation C to determine which oxygen delivery device should be used D capnography only needs to be used in pts who have an advanced airway in place</p>	<p>9. What could be a cause of a decreasing ETCO2 level in a trauma pt? A decreasing BP or <u>hypo</u>ventilation B decreasing BP or <u>hyper</u>ventilation C increasing BP or <u>hypo</u>ventilation D increasing BP or <u>hyper</u>ventilation</p>
<p>10. Pt w/ head injury, BP 160/90, P 56, R 12, O2 sat 98% on O2 NRB, ETCO2 40, GCS 7, (+) gag reflex. How should pts airway be managed? A perform DAI B continue O2 via NRB C change O2 to 6L via NC D BVM ventilate to ETCO2 of 30</p>	<p>11. Pt w/ head injury, BP 160/90, P 56, R 12, O2 sat 78% on O2 NRB, ETCO2 50, GCS 7, vomiting, and gag reflex diminished. How should pts airway be managed? A perform DAI B continue O2 via NRB C change O2 to 6L via NC D BVM ventilate to ETCO2 of 30</p>	<p>12. When attempting King LT insertion, if a PM is unable to pass the tube beyond the tongue – despite use of jaw ("grab like a bass") lift, what should be attempted? A force tube into place B grab/retract tongue with gauze 4x4 while attempting to advance tube C immediately abandon procedure and perform surgical cricothyrotomy D insert an OPA and then advance King LT over OPA</p>
<p>13. Pt w/ 2" lac on forearm from table saw w/ moderate active bleeding. What method should be used first to control bleeding? A elevation B tourniquet C pressure point D direct pressure</p>	<p>14. Pt w/ 2" lac on forearm from table saw w/ moderate active bleeding. Direct pressure has been ineffective. What method should be used next to control bleeding? A elevation B tourniquet C pressure point D topical hemostatic dressing</p>	<p>15. Pt w/ 2" lac on forearm from table saw w/ moderate active bleeding. Direct pressure and topical hemostatic dressing have been ineffective. What method should be used next to control bleeding? A elevation B tourniquet C pressure point D application of cold packs</p>
<p>16. What is the goal of vascular access in trauma pts? A 2 lg bore IV's on all trauma pts B establish IV on-scene for L-1&2 TC pts C all L-1&2 TC pts should have an IV attempted - while enroute to hosp D do not delay transport, in time sensitive pts, to establish IV on scene</p>	<p>17. What is the preferred IVF for trauma pts? A D5W B cold NS C warm NS D room temperature NS</p>	<p>18. Under what circumstances is it most appropriate to establish an IV on the scene of a trauma pt? A pt w/ blunt abdominal trauma B IV needed to administer drugs C pt w/ penetrating chest trauma D whenever transporting to a L-1 TC</p>

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<p>19. What is the pulse pressure? A (DBP x 2 + SBP) / 3 B normally less than 10 C normally between 70 & 110 D difference between systolic & diastolic BP</p>	<p>20. What happens to the pulse pressure during hypovolemic shock? A increases B decreases C does not change D initially decreases, then increases</p>	<p>21. What is a normal mean arterial pressure (MAP)? A 30 – 50 mm Hg B less than 60 “ C 70 – 110 “ D greater than 120 “</p>
<p>22. When administering IVF to trauma pts w/ PENETRATING injury, what is SBP goal? A just to maintain 80 mm Hg B just to maintain 90 mm Hg C just to maintain 100 mm Hg D 110 mm Hg or greater</p>	<p>23. When administering IVF to BLUNT trauma pts, what is the SBP goal? A just to maintain 80 mm Hg B just to maintain 90 mm Hg C just to maintain 100 mm Hg D 110 mm Hg or greater</p>	<p>24. When administering IVF to HEAD trauma pts, what is the SBP goal? A just to maintain 80 mm Hg B just to maintain 90 mm Hg C just to maintain 100 mm Hg D 110 mm Hg or greater</p>
<p>25. What are <u>tachycardia</u> with <u>hypotension</u> signs of? A neurogenic shock B hemorrhagic shock C vagal response to pain D increased intracranial pressure</p>	<p>26. What are <u>bradycardia</u> with <u>hypotension</u> signs of? A neurogenic shock B hemorrhagic shock C Cushing’s response D increased intracranial pressure</p>	<p>27. What are <u>bradycardia</u> with <u>hypertension</u> signs of? A neurogenic shock B hemorrhagic shock C vagal response to pain D increased intracranial pressure</p>
<p>28. 30/F (125 lbs) c/o pain (9/10) from open tibia fx despite being given fentanyl 50 mcg, and 25 mcg. What should you do to tx this pts pain? A administer midazolam 10 mg B contact OLMC for additional fentanyl C repeat fentanyl 25 mcg x 3 if needed D explain to pt you cannot administer any more pain medications</p>	<p>29. Parents call you for 8/M (30 kg) c/o pain (9/10) from open tibia fx. What should you do to tx this pts pain? A administer 7.5 mcg fentanyl B administer 15 mcg fentanyl C administer 30 mcg fentanyl D apply traction splint to relieve pain</p>	<p>30. What is the maximum dose of fentanyl that can be given without an OLMC order? A 100 mcg B 150 mcg C 200 mcg D 300 mcg</p>
<p>31. Which L-1 TC can you contact directly (vs calling nearest system hospital) if you are transporting to that location? A Loyola B Condell C Good Samaritan D Lutheran General</p>	<p>32. What is the goal, based on national guidelines, for scene time in L-1&2 TC pts? A 10 minutes or less B 15 minutes or less C 20 minutes or less D 25 minutes or less</p>	<p>33. What is an acceptable transport time to a L-1 TC? A 25 minutes or less B 30 minutes or less C 45 minutes or less D no more than 15 minutes further than nearest hospital</p>
<p>34. Which is criteria for transport to a L-1 TC? A fall of 30’ B MVC w/ 20” intrusion C prolonged extrication D GCS 13 or less w/ head trauma</p>	<p>35. Which is criteria for transport to a L-1 TC? A MVC w/ rollover B SBP of 90 or less C pedestrian stuck by auto D death of occupant in same vehicle</p>	<p>36. Which is criteria for transport to a L-1 TC? A severe burn B MVC w/ ejection C motorcycle crash >20 mph D penetrating head, chest, spine, or abd injury</p>
<p>37. Called for 60/M pt who fell, GCS 4, blood noted coming from pts nose, BP 188/127, P 46, R 18, O2 sat 98%, glucose 96. What tx should pt receive? A perform DAI B administer atropine C transport to L-1 TC D begin transcutaneous pacing</p>	<p>38. What effect is transcutaneous pacing or atropine likely to have on a pt who is hypertensive and bradycardic, with increased intracranial pressure (ICP)? A none B decreased BP C tachycardia and lowered ICP D increased BP and increased ICP</p>	<p>39. Under what circumstance should bradycardia be treated with atropine in the pt with increased intracranial pressure? A if SBP is less than 90 B if the HR is less than 40 C if pupils are bilaterally dilated D if pt has an altered mental status</p>

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<p>40. What can help a PM differentiate a pneumothorax from a tension pneumothorax?</p> <p>A hypoxia B hypotension C dyspnea/SOB D absent breath sounds</p>	<p>41. What can help a PM differentiate a pneumothorax from a tension pneumothorax?</p> <p>A hypoxia B dyspnea/SOB C absent breath sounds D resistance to BVM ventilation</p>	<p>42. What may be used to treat respiratory distress in the pt with a flail chest and adequate ventilatory effort?</p> <p>A CPAP B tape flail segment C wrap elastic bandage around chest wall D have pt hold pillow against chest wall while breathing</p>
<p>43. What should be remembered when assessing the BP in an elderly trauma pt?</p> <p>A older pts tolerate lower BP's better B SBP is an unreliable indicator of shock in the elderly C mortality for older pts w/ SBP <100 is equal to adults w/ SBP <90 D cardiac medications prevent hypotension in the elderly</p>	<p>44. What should be remembered when assessing pain in an elderly trauma pt?</p> <p>A pain sensation is often increased B pain sensation is often diminished C pain sensation is usually unaffected D elderly pts should not be given pain medications, so pain assessment is not a priority</p>	<p>45. A geriatric pt with a traumatic brain injury and a GCS <15 has the same mortality as an adult with a GCS less than 10.</p> <p>A true B false</p>
<p>46. Which is an anticoagulant?</p> <p>A bumex / bumetanide B coreg / carvedilol C dyazide D warfarin</p>	<p>47. Which is an anticoagulant?</p> <p>A cogentin B metformin C plavix / clopidogrel D zolpidem / ambien</p>	<p>48. Which is an anticoagulant?</p> <p>A catapres B diovan / valsartan C lisinopril D pradaxa / dabigatran</p>
<p>49. Where on the Image Trend PCR should the NS IVF administered (drug name & total amount infused) be documented?</p> <p>A under procedures B in narrative/summary C under medication administered D it does not need to be documented as the NWC EMSS only carries NS</p>	<p>50. When caring for a trauma pt, on the Image Trend PCR, does a "medical assessment" need to be completed in addition to the "injury details"?</p> <p>A no B yes C sometimes - only if needed D only if required by specific dept/agency</p>	<p>51. Where on the Image Trend PCR is the best place to document the secondary (head to toe) assessment findings?</p> <p>A under "procedures" B in "narrative/summary" C it does not need to be documented D in "assessment" or "injury" assessment section</p>
<p>52. On Image Trend PCR if a pts RR is listed as 10, how can it best be determined if it is spontaneous or assisted ventilation?</p> <p>A in procedures section B in "narrative/summary" C it does not need to be documented D documentation of "assisted" under respiratory effort</p>	<p>53. On Image Trend PCR, what is the purpose of the "narrative"?</p> <p>A to repeat critical information listed in other areas of the PCR B there is no purpose, it does not need to be completed on most calls C to describe a picture of the call, incl. any information not found in other areas of PCR D to repeat in chronological order all of the information included in every area of the PCR</p>	<p>54. On the Image Trend PCR, what does it imply if "normal" is documented in an area of the assessment findings?</p> <p>A the area was examined B the pt had no complaints C the area was not examined D the area was examined only if the pt had a complaint related to that body area</p>
<p>55. 6/F w/ partial thickness burns to R arm & chest sustained when pulled a pot of hot coffee off table. How should burned tissue be treated?</p> <p>A cover w/ plastic wrap B apply Vaseline gauze dressing C cover w/ wet (NS) trauma dressings D continue irrigating w/ cool NS while enroute to hospital</p>	<p>56. What is true regarding plastic wrap as a burn dressing?</p> <p>A requires disinfection prior to application B allows for wound assessment without removing dressing C requires the application of burn ointment to prevent adhering to tissue D increases the pain pts experience requiring increased doses of fentanyl</p>	<p>57. Where should pts w/ moderate-severe burns, with a traumatic MOI, be transported to?</p> <p>A nearest burn center B nearest trauma center (L-1 or L-2) C only L-1 TC - even if is not nearest TC D Loyola Medical Center because it is the only designated burn center in our region</p>
<p>Questions 58-59-60: will be taken from new sop intro test bank (to help ensure long-term learning). Please review last months questions.</p>		