1. Which statement is TRUE comparing airway protection from gastric secretions?
   - A KLTSD less effective than ETT.
   - B KLTSD & ETT equally effective.
   - C KLTSD more effective than ETT.
   - D KLTSD provides no airway protection.

2. What is a limitation of using an 18 fr soft suction catheter in the KLTSD gastric access lumen?
   - A The lumen is too wide
   - B It is too short to reach stomach
   - C An 18 fr soft suction catheter is not manufactured/available.
   - D Requires interruption of vent to insert

3. How should the salem-sump nasogastric tube (NGT) be measured for insertion depth?
   - A Ear to xyphoid
   - B Nose to xyphoid
   - C Nose to ear to xyphoid
   - D Nose to ear to xyphoid to V6 position

4. Which is **NOT** an indication for insertion of a salem-sump nasogastric tube (NGT) w/ a KLTSD?
   - A Pt vomiting
   - B Gastric distention
   - C Esophageal varicies
   - D Prolonged BVM vent prior to insertion

5. How should suction be applied to the salem-sump nasogastric tube (NGT)?
   - A Intermittent @ 30-40 mmHg
   - B Intermittent @ 300-400 mmHg
   - C Continuous @ 30-40 mmHg
   - D Continuous @ 120 mmHg

6. Which lumen should be used for suctioning with salem-sump nasogastric tube (NGT)?
   - A Either lumen
   - B Both lumens
   - C Smaller, blue lumen
   - D Larger, clear lumen

7. What is the purpose of the secondary lumen on a salem-sump nasogastric tube (NGT)?
   - A Lumen for med administration
   - B Back up if primary becomes obstructed
   - C Prevents damage to gastric mucosa
   - D Increases amount of secretions suctioned

8. When should the salem-sump nasogastric tube (NGT) be inserted?
   - A Prior to insertion of KLTSD
   - B Only after secretions are noted coming from gastric access lumen
   - C After insertion and confirmation of correct KLTSD placement
   - D After insertion, but before confirmation, of KLTSD placement

9. If concern about placement of salem-sump nasogastric tube (NGT) in stomach, which is the best/preferred method to confirm correct placement?
   - A Aspirate secretions
   - B Place tip of NGT in water
   - C Inject 60mL air into stomach
   - D Attach capnography sensor to NGT using adapter from ETT

10. What is the correct order for KLTSD insertion?
    - A Inflate, Insert, Ventilate, Auscultate, Withdraw
    - B Insert, Inflate, Auscultate, Ventilate, Withdraw
    - C Insert, Withdraw, Inflate, Ventilate, Auscultate
    - D Insert, Withdraw, Ventilate, Auscultate, Inflate

11. When using the KLTSD – initially, how deep should the tube be inserted?
    - A Until ~1" of clear tube can be seen outside mouth
    - B Until ~2" of clear tube still visible outside mouth
    - C Until ~3" of clear tube still visible outside mouth
    - D Until clear tube can no longer be seen outside mouth

12. If after insertion and confirmation of correct KLTSD placement an air leak is heard around the mouth what should be done?
    - A Remove KLTSD
    - B Remove air from cuff
    - C Add additional air to cuff
    - D Nothing, as a small air leak is expected

13. If difficulty is encountered passing the KLTSD airway past the tongue, what should be done?
    - A Push harder on KLTSD
    - B Use a larger size KLTSD
    - C Use a smaller size KLTSD
    - D Retract tongue using gauze 4x4

14. When inserting the KLTSD, what area/location should be auscultated first?
    - A Trachea
    - B Stomach
    - C Lateral lung field
    - D Posterior chest wall

15. Which is TRUE about KLTSD insertion?
    - A If doubt about size, use smaller size.
    - B Lube should not be used on KLTSD.
    - C Do not advance tube after beginning withdrawal, can cause tongue to obstruct airway.
    - D EDD should be used when KLTSD has been inserted to maximum depth.

16. EMS on scene of nonbreathing pt, w/ radial pulse. In preparing to ventilate, which is the LEAST critical piece of equipment to use during the first few breaths?
    - A Mask
    - B Oxygen tank
    - C Bag-valve device
    - D Oral/nasal airway

17. When should an oral/nasal pharyngeal airway (OP/NPA) be used?
    - A Before beginning BVM ventilation.
    - B Only if BVM ventilation will be prolonged.
    - C Only if resistance to BVM ventilation is felt.
    - D Only if advanced airway placement is unsuccessful.

18. Which describes best use of oral/nasal pharyngeal airway (OP/NPA)?
    - A Insert OP/NPA only if prolonged ventilation.
    - B Always insert OP/NPA prior to BVM ventilation.
    - C Insert OP/NPA only if resistance is felt w/ BVM ventilation.
    - D Insert OP/NPA only if advanced airway placement unsuccessful.

19. Why is an OP/NPA important when BVM ventilating?
A Use of an OP/NPA is not important
B Use of an OP/NPA will prevent stimulation of gag reflex
C Not using OP/NPA requires increased force/pressure to ventilate past tongue obstruction

20. Why is it important to prevent using an increased amount of force/pressure when ventilating with a BVM?
A Increased force/pressure will decrease amt of O2 delivered to pt
B Increased force/pressure will decrease amt of CO2 eliminated from pt
C Increased force/pressure opens esophageal sphincter and allows gastric distention

21. What amount of pressure rarely causes gastric distention?
A < 15 cm H2O
B < 25 cm H2O
C < 50 cm H2O
D < 75 cm H2O

22. How should an oral airway be sized?
A Front of teeth to earlobe
B Front of teeth to angle of jaw
C Corner of mouth to earlobe
D Corner of mouth to angle of jaw

23. How should an oral airway be inserted into both peds & adult pts?
A Lubricate well and rotate into place
B Insert straight into mouth without blade use
C Insert upside down & rotate into place
D Use tongue blade to depress tongue and insert straight into mouth

24. An oral airway that does not stay seated behind tongue in posterior pharynx and keeps popping out of pts mouth is likely:
A too large.
B too small.
C the right size.
D not lubricated.

25. Which is most important when determining the correct size of a nasal airway?
A Width
B Length
C Curvature
D Flange design

26. How should a nasal airway be sized?
A Tip of nose to earlobe
B Tip of nose to angle of jaw
C Corner of mouth to earlobe
D Corner of mouth to angle of jaw

27. How should a nasal airway be inserted?
A Rotate 360° into place
B Along floor of nasal cavity
C Bevel to septum for right & left nostrils
D With curvature pointed upward, toward top of head, then rotated into place

28. When assessing breathing what are the FIRST 2 things that should be determined?
A Respiratory rate & lung sounds
B Respiratory rate & depth
C Breath sounds & O2 sat
D O2 sat & ETCO2

29. What should be used first to determine if resp <u>depth</u> is adequate?
A O2 sat
B ETCO2
C Breath sounds
D Respiratory rate

30. When doing <u>quick</u> check of breath sounds (to determine if present bilat) where is first place you should listen?
A Over trachea
B Anteriorly above 1st ribs
C Mid-axillary line (under armpits)
D Upper lobes on posterior chest wall

31. How is ventilation different than oxygenation?
A It is measured with pulse oximetry
B It is the elimination of carbon dioxide
C ETCO2 value is subtracted from O2 sat

32. How is ventilation measured?
A O2 sat
B ETCO2
C Measure tidal volume
D Peak expiratory flow rate

33. What is a sign of inadequate ventilation?
A Low O2 sat
B High O2 sat
C Low ETCO2
D High ETCO2

34. What is the primary purpose of head elevation in airway management?
A To protect c-spine
B To prevent aspiration.
C To increase lung tidal volume.
D To align oral, pharyngeal, laryngeal axis.

35. What is an alternative way (to EC method) of holding a mask on pts face w/ 2-handed BVM ventilation?
A Stand next to pt and place thumbs under pts chin.
B Stand below pts head and use entire hand to push mask onto face.
C Use thumb aspect of hand to hold mask on face and 4 fingers to lift jaw.

36. Why is bag portion of a BVM so large, compared to the amt of tidal volume that should be delivered to a pt?
A Designed to allow for 1-handed ventilation
B Smaller bags will not allow adequate CO2 elimination
C Smaller bags will not hold an adequate amount of oxygen
D Many pts need entire bag squeezed to deliver an adequate tidal volume

37. How will hyperventilation affect ETCO2?
A Decreases
B Increases
C No change

38. How will hypoventilation affect ETCO2?
A Decreases
B Increases
C No change

39. How will hypoperfusion/shock affect ETCO2?
A Decreases
B Increases
C No change

40. How does ventilation affect cerebral & coronary vessels?
A Hyperventilation constricts
B Hyperventilation dilates
C Hypoventilation constricts
D No change

41. How does hyperventilation affect pH?
A Causes alkalosis
B Causes acidosis
C Does not affect pH

42. How does hyperventilation affect cardiac output/BP?
A Decreases
B Increases
C No change

43. How is respiratory failure different from respiratory distress?
A ETCO2 will be normal in resp failure
B Compensatory mechanism have failed
C Pt in resp failure will not be tachycardic
D Pt in resp failure will not have tachypnea

44. Where are accessory muscles of respiration?
A Neck only
B Neck & chest only
C Neck & abdomen only
D Neck, chest, and abdomen

45. How is respiratory failure different from respiratory distress?
A ETCO2 will be normal in resp failure
B Compensatory mechanism have failed
C Pt in resp failure will not be tachycardic
D Pt in resp failure will not have tachypnea

46. Which is an indication of respiratory failure (vs resp distress)?
A Tachypnea
B Tachycardia
C Altered mental status
D Accessory muscle use

47. Which is an indication of respiratory failure (vs resp distress)?
A Tachypnea
B Tachycardia
C Accessory muscle use
D Hypoxia despite O2 administration

48. Which is an indication of respiratory failure (vs resp distress)?
A Tachypnea
B Tachycardia
C Increased ETCO2
D Accessory muscle use

49. Prior to advanced airway attempt, how long should a pt be preoxygenated for?
A 1 minute
B 2 minutes
C 3 minutes
D 5 minutes

50. What describes best actions for preoxygenation time?
A Preoxygenation time can be eliminated if pt is apneic
B Preoxygenation time can be eliminated if pt is severely hypoxic
C Prepare confirmation & securing supplies during preoxygenation time

51. How important is it to not use an ET tube that has been contaminated?
A Only if pt is immunocompromised
B Only if contaminated w/ gastric secretions
C Not very, as pts will be put on prophylactic antibiotics
D Very; contaminated ETT's can lead to pneumonia, sepsis & death

52. During an ETI attempt, what should a partner be doing?
A Auscultating chest wall
B Watching monitor & time
C Preparing securing supplies
D Preparing confirming supplies

53. How long is allowed for an attempt at advanced airway placement?
A 15 seconds
B 30 seconds
C 45 seconds
D 1 minute

54. If an ET attempt is unsuccessful, should the ET tube be removed prior to another attempt?
A No
B Yes

55. What is a major difference between spontaneous breathing and assisted ventilation?
A Adequacy of ventilation
B Adequacy of oxygenation
C Negative vs positive pressure
D Amount of tidal volume delivered

56. What is a major risk/complication of increased/positive pressure ventilation?
A hypotension
B hypertension

57. What is a major risk/complication of increased/positive pressure ventilation?
A Cardiac tamponade
B Open pneumothorax
C Tension pneumothorax
D Spontaneous pneumothorax

58. Pt c/o SOB has PMH of COPD and HF. Lung sounds wheezes bilat. Capnography shows sharkfin. Which is true?
A Sharkfin rules out COPD exacerbation
B Sharkfin rules out HF exacerbation
C Sharkfin rules in COPD and rules out HF exacerbation
D Sharkfin rules in COPD - but does not rule out HF exacerbation

59. Pt c/o SOB has PMH of both COPD and HF. How may SNS stimulation and hypoxia from resp distress affect the pts myocardial function and HF?
A Will have no effect
B Should have no effect
C May cause exacerbation of HF

60. What is an example of critical thinking by a paramedic?
A Recognition that more than 1 SOP may be needed to adequately treat pts.
B Following an algorithm without consideration of complicating factors.

******NOTE: Do NOT discard October CE handout and independent study material as content will also be used for November post-test/study-questions.******