

Northwest Community EMSS – Continuing Education – Feb 2013 – Post-Test/Study-Questions

<p>1. How can the shock index be helpful to paramedics in the field?</p> <p>A. Suspect shock before hypotension B. Determines what class of shock pt is in C. To identify shock in head injured pts D. Prescribes amount of IVF to be given</p>	<p>2. What is the formula for determining the shock index?</p> <p>A. HR/SBP B. HR + BP C. BP – HR D. RR + HR + SBP</p>	<p>3. What is an abnormal shock index?</p> <p>A. < 0.5 B. $\bar{0}.5$ C. 0.7 D. ≥ 0.9</p>
<p>4. If a pt in a MVC is initially refusing evaluation, what should a PM do first?</p> <p>A. Encourage pt to allow an evaluation B. Quickly have pt sign release before s/he changes their mind C. Treat the call as a no pt contact D. Immediately restrain pt</p>	<p>5. What is the best way to determine if a pt understands the risks of refusal?</p> <p>A. Have pt repeat back what you told them, in their own words. B. Have pt search for info on smartphone. C. Ask pt if they understand what you said D. Have pt sign release form</p>	<p>6. Elderly pt slides to floor getting out of bed, denies falling or injury. Just wants help getting up. If a refusal, should it be called in?</p> <p>A. No B. Yes C. Only if an injury is apparent D. Only if pt is not A&Ox3</p>
<p>7. Which statement describes the best practices regarding IV starts?</p> <p>A. All ALS pt should have a prehospital IV B. IV attempt should be made on scene C. IV's should be started if a pt needs IVF or IV meds D. All L1 & L2 TC pts should have IV's started in the field</p>	<p>8. Which statement describes the best practices regarding IV starts?</p> <p>A. Prep equip while amb is moving, ask drive to slow/pull over for actual venipuncture B. Always stay on scene until an IV can be established C. PM's should practice IV's on real pts.</p>	<p>9. What is the harm of raising the BP in a trauma pt?</p> <p>A. May increase bleeding/blood loss B. Suppresses tachycardic response C. Decreases renal perfusion D. Contributes to metabolic acidosis</p>
<p>10. When starting a prehospital IV in a trauma pt, what IVF should be used?</p> <p>A. Cold NS B. Warm NS C. Cold D5W D. Warm D5W</p>	<p>11. What should be done with warm IVF?</p> <p>A. Label bag with expiration date when placing it on the warmer B. Return to regular stock after "warm" expiration date C. Place it in hypothermia cooler after "warm" expiration date D. Use it when treating cardiac arrest pts</p>	<p>12. How long can IVF be kept on the warmer?</p> <p>A. 5 days B. 14 days C. 30 days D. 6 months</p>
<p>13. Which is criteria for transport to a L1 TC?</p> <p>A. Penetrating neck injury B. Fall >20' C. MVC w/ 18" intrusion D. MVC w/ ejection</p>	<p>14. Which is criteria for transport to a L1 TC?</p> <p>A. Penetrating abd injury B. MVC w/ death of another car occupant C. Motorcycle crash > 20 mph D. Blunt head injury w/ GCS 14</p>	<p>15. Which is criteria for transport to a L1 TC?</p> <p>A. Pelvic fx B. Child falling > 2-3 x height C. Penetrating arm injury distal to elbow D. MVC w/ rollover</p>
<p>16. Which is criteria for transport to a L1 TC?</p> <p>A. GCS 13 or less B. MVC w/ rollover C. Fall >20' D. MVC w/ death of another car occupant</p>	<p>17. Which is criteria for transport to a L1 TC?</p> <p>A. 2 or more proximal long bone fx B. Penetrating leg injury distal to knee C. Pedestrian struck by vehicle D. MVC w/ 18" intrusion</p>	<p>18. Which is criteria for transport to a L1 TC?</p> <p>A. RR <10 or >29 B. Amputation of 3 fingers C. Fall >20' D. Motorcycle crash > 20 mph</p>
<p>19. If a trauma pts ET_{CO2} is low, what should a PM should do first?</p> <p>A. Check ventilation rate & BP B. Slow rate of ventilation C. Administer NaBicarb D. Increase rate of ventilation</p>	<p>20. Head injury pt, BP 180/98, P 58, R intubated-assisted, O₂ sat 98%, ET_{CO2} = 30. What is the most likely cause of ET_{CO2} level?</p> <p>A. Hyperventilation B. Hypoventilation C. Hypertension D. Acidosis</p>	<p>21. Pt w/ head injury, BP 180/102, P 58, R 6, O₂ sat 85%, ET_{CO2} = 50. What is the most likely cause of ET_{CO2} level?</p> <p>A. Hyperventilation B. Hypoventilation C. Hypertension D. Alkalosis E. Hypoxia</p>
<p>22. What are the 4 steps to spine immobilization assessment?</p> <p>A. MOI, reliability, pain/tenderness, motor/sensory B. MOI, GCS, pain/tenderness, motor/sensory C. MOI, reliability, pulses. motor/sensory D. Reliability, sobriety testing, pain/tenderness. motor/sensory</p>	<p>23. Which is TRUE regarding spine motion restriction (SMR)?</p> <p>A. All trauma pts should receive SMR B. Long backboards can cause harm C. It is most important to pad under waist & knee areas D. Due to the design of long backboards, pressure ulcers will not develop</p>	<p>24. What should be done prior to placing a pt on a long backboard?</p> <p>A. Pad backboard using blankets or commercial device B. Explain to pt they will likely be on the board for a couple of hours C. Premedicate with midazolam to prevent muscle spasm D. Remove cervical collar</p>

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<p>25. What is second impact syndrome?</p> <p>A. After 2nd impact brain loses ability to regulate ICP, cerebral edema & herniation may result</p> <p>B. After head injury pt sustains blunt chest or abd injury/bleeding which lowers BP and worsens concussion</p> <p>C. Two impacts are required for a concussion to develop</p> <p>D. Brain injury usually only seen in adults</p>	<p>26. Which is an indication to place an advanced airway in a pt with a head injury and a GCS of 8 or less?</p> <p>A. RR of 10</p> <p>B. O₂ sat of 95%</p> <p>C. ETCO₂ of 40</p> <p>D. Hypoxia despite O₂ by NRB mask</p>	<p>27. Which is an indication to place an advanced airway in a pt with a head injury and a GCS of 8 or less?</p> <p>A. RR of 10</p> <p>B. ETCO₂ of 40</p> <p>C. O₂ sat of 95% on O₂ by NRB</p> <p>D. Persistent vomiting or oral bleeding</p>
<p>28. Which drug is an anticoagulant?</p> <p>A. Clopidogrel</p> <p>B. Simvastatin</p> <p>C. Lisinopril</p> <p>D. Amlodipine</p>	<p>29. Which drug is an anticoagulant?</p> <p>A. Dabigatran</p> <p>B. Omeprazol</p> <p>C. Azithromycin</p> <p>D. Metformin</p>	<p>30. Which drug is an anticoagulant?</p> <p>A. Ticlopidine</p> <p>B. Hydrochlorizide</p> <p>C. Metoprolol</p> <p>D. Alprazolam</p>
<p>31. For pts with penetrating torso trauma, what is the SBP goal?</p> <p>A. 70</p> <p>B. 80</p> <p>C. 90</p> <p>D. >110</p>	<p>32. For pts with blunt torso trauma, what is the SBP goal?</p> <p>A. 80</p> <p>B. 90</p> <p>C. 100</p> <p>D. >110</p>	<p>33. For pts with a brain injury, what is the SBP goal?</p> <p>A. 80</p> <p>B. 90</p> <p>C. 100</p> <p>D. >110</p>
<p>34. Which is TRUE about trauma in the elderly?</p> <p>A. Minor MOI can result in a fatal injury</p> <p>B. They are more likely to get tachycardic</p> <p>C. They can often maintain adequate cerebral perfusion w/ a SBP of 60</p> <p>D. They are more likely to experience pain from an injury</p>	<p>35. Which is TRUE about trauma in the elderly?</p> <p>A. More likely to sustain subdural hematomas</p> <p>B. Less likely to develop central cord syndrome</p> <p>C. Less likely to develop infection/sepsis from contaminated IV or ET tube</p> <p>D. If in doubt, you should under-triage</p>	<p>36. Which is TRUE about an elderly person who has fallen?</p> <p>A. They only need a complete exam if they say they are injured.</p> <p>B. Detailed history & exam are critical.</p> <p>C. They are reliable historians.</p> <p>D. If they have an injury, it will usually cause them severe pain.</p>
<p>37. What is the correct way to apply direct pressure to control bleeding?</p> <p>A. Use finger tips</p> <p>B. Apply trauma dressing and wrap w/ elastic bandage</p> <p>C. Use palm of hand & hold pressure for ≥5 minutes</p> <p>D. Apply pressure over pressure point</p>	<p>38. If direct pressure fails to control bleeding, what should be used next?</p> <p>A. Elevation</p> <p>B. Pressure over pressure point</p> <p>C. Topical hemostatic agent</p> <p>D. Trauma dressing wrapped w/ elastic bandage</p>	<p>39. What is an indication for a tourniquet?</p> <p>A. Unable to control bleeding w/ direct pressure or topical hemostatic</p> <p>B. Use only to save the persons life</p> <p>C. Use only if hypotensive</p> <p>D. Use only if a partial amputation is already present</p>
<p>40. What should be done differently when caring for a trauma pt who >20 weeks pregnant?</p> <p>A. Tilt back board or manually displace uterus to the side</p> <p>B. Administer only 10 mL/kg IVF boluses</p> <p>C. Maintain O₂ sat between 80 & 90%</p> <p>D. Administer fentanyl liberally to relieve any pain the mother is having</p>	<p>41. Which of the following is TRUE regarding trauma in pregnancy?</p> <p>A. Body shunts blood away from uterus/fetus to maintain maternal BP</p> <p>B. Abdominal guarding, rigidity, & rebound are easily assessed for.</p> <p>C. Most fetal death are due to major maternal injury.</p> <p>D. Abruptio is the least likely cause of fetal death</p>	<p>42. Which is TRUE regarding trauma in pregnancy?</p> <p>A. Permissive hypotension is used in pregnant patients</p> <p>B. If SBP <110, IVF bolus should be given</p> <p>C. Oxygen should only be given if the O₂ sat is <90%</p> <p>D. Fentanyl can be given without an OLMC order</p>
<p>43. When treating a pt w/ suspected crush injury, ideally what should be done prior to release of pressure?</p> <p>A. ECG, lg bore IV NS, capnography</p> <p>B. Nothing is needed</p> <p>C. Administer calcium</p> <p>D. ECG & IVF of LR at a moderate rate</p>	<p>44. When treating a pt w/ suspected crush injury, ideally what should be done right after release of pressure?</p> <p>A. Run IVF wide open</p> <p>B. Nothing is needed</p> <p>C. Administer calcium</p> <p>D. Apply PASG to lower legs</p>	<p>45. Per SOP, what drug is used to treat crush syndrome?</p> <p>A. Calcium</p> <p>B. Magnesium</p> <p>C. Na bicarbonate</p> <p>D. Verapamil, because it is a calcium channel blocker</p>

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<p>46. Why are high-pressure injection injuries a concern?</p> <p>A. Wound often looks minor, but may result in need for amputation</p> <p>B. They cause obvious, massive wounds</p> <p>C. They are minor, but the pt has a lot of pain</p> <p>D. It is difficult to control the bleeding due to the chemical exposure</p>	<p>47. What factors are important to determine on-scene when treating a pt w/ a high-pressure injection injury?</p> <p>A. Fluid, pressure, amount</p> <p>B. Pts insurance status</p> <p>C. Name of occupational health MD</p> <p>D. If company physician has been contacted</p>	<p>48. Called for a worker w/ puncture wound to hand from a high-pressure injection. What should PM's remember when caring for this pt?</p> <p>A. Delayed tx = higher risk of amputation</p> <p>B. Fine for pt to follow-up with own MD within 24 hours</p> <p>C. Pt should be encouraged to move his hand around to encourage blood flow into the area.</p> <p>D. If it's serious, it will be painful</p>
<p>49. What is the most common cause of compartment syndrome?</p> <p>A. Restriction of swelling due to inflexible muscle fascia</p> <p>B. Rupture of muscle fascia</p> <p>C. Clot in artery supplying blood to muscle</p> <p>D. Massive external hemorrhage from muscle tear</p>	<p>50. What are the consequences of compartment syndrome?</p> <p>A. Pressure within the space compresses neuro-vascular structures</p> <p>B. Release of calcium into bloodstream</p> <p>C. Renal failure</p> <p>D. Muscles become soft & flabby</p>	<p>51. What are signs of compartment syndrome?</p> <p>A. Pain, parasthesia, pale, cool skin</p> <p>B. Flushed, warm skin</p> <p>C. Painless & pulseless</p> <p>D. Muscle atrophy</p>
<p>52. What is another name for hydrofluoric acid?</p> <p>A. Hydrogen fluoride</p> <p>B. Calcium carbonate</p> <p>C. Stannous fluoride</p> <p>D. Sodium fluoride</p>	<p>53. Why should PM's remember when caring for a pt w/ a possible hydrofluoric acid exposure?</p> <p>A. Surface area of burn will predict effects</p> <p>B. After exposure, serious symptoms may be delayed</p> <p>C. Calcium should not be given</p> <p>D. Injury is local and not systemic</p>	<p>54. For the pt with a hydrofluoric acid exposure, which of the following should probably always be initiated?</p> <p>A. ECG monitoring</p> <p>B. Epinephrine nebulizer</p> <p>C. Oxygen to displace hydrogen</p> <p>D. Irrigate burns with Na Bicarb</p>
<p>55. Per NWC EMSS policy, who should make the ultimate decision to transport a pt by helicopter?</p> <p>A. Police</p> <p>B. Paramedic</p> <p>C. Shift commander</p> <p>D. Physician</p>	<p>56. If scene personnel are considering helicopter transport, who should they contact first?</p> <p>A. OLMC physician @ NCH</p> <p>B. Helicopter agency</p> <p>C. Dispatch</p> <p>D. Pts insurance company</p>	<p>57. Why does NWC EMSS strongly encourage ground transport over helicopter transport?</p> <p>A. Past experience demonstrates no time saved, when helicopters have been used in this area</p> <p>B. There are fewer helicopter programs available in the area to respond</p> <p>C. Helicopter transport is not profitable</p> <p>D. Helicopter programs are so tightly regulated that it is difficult to get them to respond</p>
<p>58. Which is the PREFERRED method of moving a supine pt, who requires spine motion restriction to a stretcher?</p> <p>A. Use scoop stretcher</p> <p>B. Logroll pt</p> <p>C. Have pt stand, walk, & sit down on LBB</p> <p>D. Lie LBB on ground next to pt, and have them move onto it.</p>	<p>59. What areas are the most critical to pad when using a LBB?</p> <p>A. Head, shoulders/scapula, butt, heels</p> <p>B. Neck, lumbar spine, waist, knees</p> <p>C. Arms</p> <p>D. Padding should not be used with LBB</p>	<p>60. When transporting an elderly pt to the ED on a LBB, what should PM's do when communicating w/ ED staff?</p> <p>A. Remind them, "elderly pt on LBB"</p> <p>B. Realize staff can see the LBB and say nothing</p> <p>C. Point to the LBB and then their watch</p> <p>D. Tell staff you're timing them to see how long it will take them to get pt off LBB</p>