

EMS IBSC-CCP-C

**The International Board of Specialty Certification: Critical
Care Paramedic-Certified**

Questions And Answers PDF Format:

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Version = Product



Latest Version: 6.0

Question: 1

During your transport of a two-day-old neonatal cardiac patient, the patient has a sudden change in mental status and a decrease in respirations and oxygen saturation. Current vital signs are RR 28 and shallow, HR 59, and SpO₂ 84%. After 30 seconds of positive pressure ventilations, the vitals remain the same.

What should you do?

- A. Begin chest compressions at a ratio of 3:1
- B. Continue positive pressure ventilations, but increase the rate to 60-60 breaths/min
- C. Place a tibial IO and administer 0.03 mg epinephrine
- D. Intubate the patient with a 2.5 ETT at a depth of 6.75 cm

Answer: A

Explanation:

Chest compressions should be administered in the neonatal patient if the heart rate remains below 60 beats/min after 30 seconds of positive pressure ventilation. Chest compressions should be performed at a ratio of 3:1 at a rate of 120/minute. Continue chest compressions for 60 seconds and then reevaluate. If the HR increases above 60 beats/min, then discontinue chest compressions. If it remains below 60/min, then continue compressions and administer epinephrine.

The next step is not intubation, as the patient must be given chest compressions because the heart rate is below 60. If there is no improvement in patient status after PPV, chest compressions, and epinephrine, then the patient must be intubated.

The correct dosage of epinephrine for neonates is 0.01 - 0.03 mg/kg. Epinephrine is administered after compressions have been performed for a minute with no clinical improvement.

PPV should be performed at a rate of 40-60 breaths/min. 60-80 breaths/min is too high for neonatal resuscitation.

Question: 2

You are transporting a 28-year-old male who was injured while burning trash in his backyard. He was thrown backwards after a gas can exploded in his burn pile. He is complaining of chest pain and shortness of breath. The patient's skin is diaphoretic, and you note JVD. Vital signs are P 43, R 28, and BP 84/44.

Of the following, what is the most likely cause?

- A. Blunt cardiac injury
- B. Tension pneumothorax
- C. Cardiac tamponade
- D. Commotio cordis

Answer: A

Explanation:

The patient's symptoms of JVD, chest pain, shortness of breath, and bradycardia are indicative of a blunt cardiac injury. At times, the patient may also exhibit palpitations and symptoms of acute heart failure.

A tension pneumothorax causes difficulty breathing, hypotension, unequal chest expansion, and diminished or absent breath sounds on the injured side.

Cardiac tamponade causes JVD, muffled heart sounds, and hypotension. It typically causes tachycardia.

Comotio cordis causes sudden cardiac arrest.

Question: 3

You are treating a 23-year-old male with an acute severe asthma exacerbation. The patient is not responding to treatment with oxygen, albuterol, Solu-Medrol, and epinephrine and has persistent hypoxemi

a. What is your next step?

A. Administer terbutaline

B. Administer a magnesium sulfate infusion

C. Administer a second dose of Solu-Medrol

D. Administer dexamethasone

Answer: B

Explanation:

Magnesium sulfate is not recommended for routine use but may be used in those who fail to respond to initial treatment and remain hypoxemic. It can be effective in inducing bronchodilation and improving airflow. The recommended dosing is 40 mg/kg IV over 10 to 15 minutes, with a max dose of 2 g.

A second dose of Solu-Medrol is not recommended for asthma exacerbation.

Dexamethasone is a corticosteroid. Solu-Medrol has already been used and was unsuccessful. A second, different corticosteroid is not recommended.

Albuterol was unsuccessful, so administering another beta-2 agonist, such as terbutaline, is not advisable.

Question: 4

A 72-year-old male developed a sudden onset of aphasia and left-sided weakness. Over the next 60 minutes, he had a rapid decline in his mental status and quickly became unresponsive. The patient began vomiting and was unable to protect his airway. What should you do next?

A. Assess the patient's BGL

B. Provide manual ventilation with a BVM

C. Perform orotracheal intubation

D. Perform a stroke scale

Answer: C

Explanation:

The patient is vomiting and unable to protect his airway, which can lead to aspiration pneumonia. The patient's airway takes priority, and the first step is to perform orotracheal intubation.

Providing manual ventilation with a BVM will occur but not before intubation and/or suctioning.

There is no need to perform a stroke at this point, as the patient is exhibiting obvious signs of a hemorrhagic stroke.

The patient's BGL can be assessed after incubating the patient. The patient's symptoms of left-sided weakness and vomiting are not symptoms of hypoglycemia.

Question: 5

While preparing to intubate your two-year-old asthmatic patient, you are mindful of the airway anatomical differences of the patient's airway in relationship to an adult airway. Of the following, which statement is true regarding pediatric airway anatomy?

- A. The pediatric trachea is more rigid than the adult trachea
- B. The pediatric tongue is smaller, which makes it difficult to control in intubation
- C. The narrowest part of the pediatric airway is the cricothyroid membrane
- D. The larynx is more anterior and palatable

Answer: D

Explanation:

The pediatric airway anatomy is much different than the adult airway anatomy and may prove to make advanced airway management more difficult in your pediatric patients. One example of the differences in the pediatric airway is the larynx is more anterior and palatable than the adult airway. Other examples are the tonsils are larger and more vascular in pediatrics. Their adenoids are also larger in comparison to the adult airway.

The pediatric trachea is more flexible and even may collapse during periods of agitation or airway obstruction.

The narrowest part of the pediatric airway is the cricoid membrane.

The tongue of the pediatric is much larger in relation to the airway. This can make controlling the tongue more difficult in pediatric intubation.

Question: 6

You are treating a 55-year-old female patient who presents with dyspnea, orthopnea, and bilateral lower extremity edem

a. The patient has a history of HTN, NIDDM, and CAD. The patient has the following labs:

- Arterial Blood Gas (ABG): pH 7.38, PaO₂ 78 mmHg, PaCO₂ 38 mmHg, HCO₃ 24 mEq/L
- Complete Blood Count (CBC): Hgb 11 g/dL, Hct 34%, WBC 8,000/mm³
- Basic Metabolic Panel (BMP): Sodium 138 mEq/L, Potassium 3.5 mEq/L, Chloride 100 mEq/L, BUN 20 mg/dL, Creatinine 1.2 mg/dL, Glucose 128 mg/dL
- Cardiac Enzymes: Elevated B-type Natriuretic Peptide (BNP) levels

Based on these lab values, which of the following interventions would be most appropriate in the initial management of this patient?

- A. Administer IV furosemide to manage fluid overload
- B. Initiate CPAP to improve oxygenation
- C. Administer IV insulin to manage hyperglycemia
- D. Administer IV sodium bicarbonate to manage acidosis

Answer: A

Explanation:

The patient's laboratory values and clinical presentation are consistent with CHF exacerbation. Elevated B-type Natriuretic Peptide (BNP) levels indicate cardiac dysfunction and fluid overload. The appropriate initial intervention is to administer IV furosemide to reduce fluid overload and alleviate pulmonary congestion.

CPAP is not indicated in this patient because lab values do not indicate ventilatory failure or failure of oxygenation. The patient is not acidotic, so sodium bicarbonate is not indicated. The patient is not hyperglycemic and does not require insulin.

Question: 7

You have just delivered a healthy, full-term baby. The patient has a 1 minute APGAR of 7. The patient's airway is patent, respirations are 44 and non-labored, and heart rate is 148 and regular. What is the normal oxygen saturation at 2 minutes of life?

- A. 65%-70%
- B. 90%-95%
- C. 85%-90%
- D. 75%-85%

Answer: A

Explanation:

Neonates typically take up to 10 minutes after birth before oxygen saturation levels reach normal values. If oxygen saturation remains low, the CCP may need to apply oxygen via mask or blow-by.

Normal neonatal oxygen saturations are as follows:

- 1 minute of life: 60%-65%
- 2 minutes of life: 65%-70%
- 3 minutes of life: 70%-75%
- 4 minutes of life: 75%-80%
- 5 minutes of life: 80%-85%
- 10 minutes of life: 85%-95%

Question: 8

While on shift at your flight service, you have been experiencing some sinus pressure and congestion. You have been dispatched to a two-vehicle MVC and begin your flight to the scene. Once in the air, your

head begins to hurt, and you have sharp pains shooting through your face. Within minutes, your nose begins to bleed.

What is the most likely cause of these symptoms?

- A. Barosinusitis
- B. Barocongestion
- C. Barodontalgia
- D. Barotitis Media

Answer: A

Explanation:

Barosinusitis is the inflammation of one or more paranasal sinuses due to the pressure gradient between the atmosphere and the sinus cavity. This can occur on both ascent and descent. Barosinusitis is generally uncommon but primarily affects the frontal sinuses when it occurs. Epistaxis is a common symptom that occurs after the rupture of the sinus membranes.

Barodontalgia is nicknamed flyer's toothache. Barodontalgia only occurs on ascent and occurs primarily because of Boyle's Law. Air bubbles trapped with an individual's tooth fillings expand and cause pain and pressure. This is common in divers and military pilots because of the severe rapid changes in pressure.

Barotitis Media occurs only on descent and is a common gas-trapping problem. Barotitis Media is air trapping in the middle ear that is unable to vent through the blocked eustachian tube. This problem occurs in individuals with a head cold.

Barocongestion is a fictional term.

Question: 9

Fentanyl is often used in the induction phase of rapid sequence intubation (RSI) and delayed sequence intubation (DSI). In doses greater than 5 mcg/kg and more commonly in neonates and pediatrics, what effect can Fentanyl cause that impedes ventilation?

- A. Bronchospasms
- B. Increase in histamine release
- C. Chest wall rigidity
- D. Decrease in surfactant

Answer: C

Explanation:

Although it is more associated with administration rate and higher than normal therapeutic doses, Fentanyl may cause chest wall rigidity, which can make ventilation difficult and possibly impossible. It is more common in neonatal and pediatric patients than in adult patients.

Fentanyl does not cause bronchospasm, a histamine release, or a decrease in surfactant.

Question: 10

You are treating a 72-year-old female who accidentally overdosed on her diltiazem. The patient is lethargic and responds to painful stimuli with moaning. Vital signs are BP 86/54, P 44, and R 8. You should first:

- A. Begin assisting ventilations
- B. Administer glucagon
- C. Administer calcium chloride
- D. Administer a 500 mL fluid bolus

Answer: A

Explanation:

The patient is experiencing signs and symptoms of a calcium channel blocker overdose. But, the patient's primary problem is respiratory failure. You should first begin assisting ventilations. Once you have addressed airway, breathing, and circulation, you may address the overdose.

Glucagon and calcium chloride are both indicated in a calcium channel blocker overdose, but in this patient, the airway must be addressed first.

Administering a 500 mL fluid bolus is an effective treatment for this patient but can occur after the patient's airway is addressed.

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