COMPREHENSIVE RESPIRATORY AND BURN CARE PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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.

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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!

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Questions

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1. Which option is NOT a symptom of a pulmonary embolism?

A. Fever

B. Tachypnea

C. Tachycardia

D. Diaphoresis

2. Which electrolyte disturbance is commonly seen early in burn resuscitation?

A. Hyperkalemia

B. Hyperkalemia with hyponatremia

C. Hypokalemia

D. Hyponatremia

3. What is the target PTT range for a patient receiving heparin after a pulmonary embolism?

A. 46-70 seconds

B. 20-40 seconds

C. 10-20 seconds

D. 70-90 seconds

4. In a smoke inhalation case, which statement is not listed as an immediate management step?

A. Administer corticosteroids.

B. Sit them up and provide oxygen.

C. Monitor ABG.

D. Assess airway patency.

5. How is Parkland formula fluid distribution typically administered over time?

A. Half in first 8 hours, remainder over 16 hours

B. All within first 6 hours

C. Equally over 24 hours

D. First 12 hours

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6. In a burn patient with tachycardia and fever, what is the best initial assessment step?

A. Evaluate for infection signs.

B. Start broad-spectrum antibiotics immediately.

C. Increase IV fluids only.

D. Apply ice to burn area.

7. Which device delivers CPAP or BiPAP noninvasively?

A. Nasal cannula

B. Venturi mask

C. CPAP/BiPAP machine

D. Endotracheal tube

8. In Berlin ARDS criteria, which feature relates to the timing of onset?

A. Acute onset

B. Bilateral opacities

C. $PaO_2/FiO_2 \leq 300$

D. PEEP ≥5 cm H_2O

9. How is bronchodilator responsiveness assessed at the bedside?

A. Increase in FEV1 on spirometry

B. Observation of clinical improvement in symptoms after bronchodilator

C. Decrease in $PaCO_2$ after bronchodilator

D. Improvement in DLCO after bronchodilator

10. What is a primary purpose of prone positioning in ARDS management?

A. Reduces sedation requirements

B. Improves ventilation-perfusion matching and oxygenation

C. Increases infection risk

D. Shortens ICU stay

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Answers

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

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Explanations

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1. Which option is NOT a symptom of a pulmonary embolism?

A. Fever

B. Tachypnea

C. Tachycardia

D. Diaphoresis

Pulmonary embolism typically presents with rapid breathing, a fast heart rate, and sweating because the sudden blockage in the pulmonary arteries causes hypoxemia and a sympathetic stress response. Fever is not a typical feature of PE; it's more commonly seen with infection or inflammatory processes. While fever can occur if there's an accompanying infection or a pulmonary infarct, it does not reflect the usual pattern of symptoms from PE itself. Therefore, fever is not a characteristic symptom of a pulmonary embolism, whereas tachypnea, tachycardia, and diaphoresis are.

2. Which electrolyte disturbance is commonly seen early in burn resuscitation?

A. Hyperkalemia

B. Hyperkalemia with hyponatremia

C. Hypokalemia

D. Hyponatremia

Early after a burn, potassium leaks out of damaged cells into the extracellular space, and acidosis from tissue injury further drives potassium out of cells. This combination makes hyperkalemia the most common electrolyte disturbance seen during initial burn resuscitation. As fluids are resuscitated and perfusion improves, potassium can shift back into cells, potentially causing hypokalemia later. Hyponatremia isn't the hallmark of the immediate phase, though it can occur with large-volume resuscitation or evaporative losses. So the best answer reflects the tendency for elevated potassium early on.

3. What is the target PTT range for a patient receiving heparin after a pulmonary embolism?

A. 46-70 seconds

B. 20-40 seconds

C. 10-20 seconds

D. 70-90 seconds

The question tests understanding of how unfractionated heparin is monitored with the PTT to achieve therapeutic anticoagulation after a pulmonary embolism. Heparin prolongs clotting time, so we adjust the dose to keep the PTT within a target range that provides enough anticoagulation to prevent clot extension without causing excessive bleeding. A typical therapeutic target is about 1.5 to 2.5 times the normal PTT. Since normal PTT is roughly 25–35 seconds, the practical therapeutic window often falls around the mid to upper range of that proportional target, for many settings about 46–70 seconds. Therefore, the value of 46–70 seconds best represents a safe, therapeutic range for patients on heparin after a PE. Lower ranges (too short) would mean insufficient anticoagulation, while much higher values (too long) increase bleeding risk. This middle range keeps the balance between preventing further clotting and avoiding bleeding.

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4. In a smoke inhalation case, which statement is not listed as an immediate management step?

A. Administer corticosteroids.

B. Sit them up and provide oxygen.

C. Monitor ABG.

D. Assess airway patency.

Immediate care for smoke inhalation centers on maintaining the airway and ensuring adequate oxygenation. Sitting up helps with ventilation and reduces airway edema, and high-flow, humidified oxygen is given to treat hypoxemia and to help displace inhaled carbon monoxide. Regular arterial blood gas monitoring is used to assess gas exchange and guide further ventilation needs. Assessing airway patency is essential because swelling can progress quickly, so plans for early airway control if obstruction signs appear are crucial. Corticosteroids are not part of the standard immediate management because they do not show a proven benefit in acute inhalation injury and can cause harm, such as infection risk and metabolic side effects, so they are not routinely used in the initial treatment steps.

5. How is Parkland formula fluid distribution typically administered over time?

A. Half in first 8 hours, remainder over 16 hours

B. All within first 6 hours

C. Equally over 24 hours

D. First 12 hours

The main idea is how Parkland-based resuscitation is spread over the first 24 hours after a burn. The total fluid volume is calculated (4 mL × body weight in kilograms × percent TBSA burned) and given in a two-phase schedule: half of that total in the first 8 hours after the burn, then the remaining half over the next 16 hours. This pattern targets the period when capillary leak and fluid shifts are most intense, so a rapid initial influx helps restore intravascular volume and preserve organ perfusion, followed by a slower, sustained delivery as the leak begins to stabilize. If the patient presents later than the injury, you still aim to complete the 24-hour plan by adjusting the rates based on time since injury. After the first 24 hours, fluid management shifts to ongoing perfusion and urine output targets rather than sticking to the initial Parkland calculation.

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6. In a burn patient with tachycardia and fever, what is the best initial assessment step?

A. Evaluate for infection signs.

B. Start broad-spectrum antibiotics immediately.

C. Increase IV fluids only.

D. Apply ice to burn area.

Fever and tachycardia after a burn can come from the body's inflammatory response to injury or from an actual infection. The first step is to assess for infection signs because identifying whether an infection is present (and where it's coming from) directly guides further testing and treatment. A focused evaluation looks for local wound infection indicators (new purulence, increasing redness, foul odor, expanding erythema), checks for potential systemic infection sources (pneumonia, urinary tract infection, catheter-related infection), and reviews the patient's vitals and organ function. Baseline labs and cultures (blood cultures, wound cultures if indicated, and other targeted tests) help distinguish sepsis from noninfectious SIRS and inform the next steps. Starting broad-spectrum antibiotics right away isn't the best initial move because antibiotics should be guided by evidence of infection and culture results when possible; premature use can mask clues, promote resistance, and expose the patient to unnecessary side effects. Increasing IV fluids is important in burn management for resuscitation, but it addresses hemodynamics rather than determining whether infection is present. Applying ice to the burn isn't appropriate care and doesn't help with assessing or treating a potential infection. So, the best initial step is a careful search for infection signs to guide appropriate diagnostics and treatment.

7. Which device delivers CPAP or BiPAP noninvasively?

A. Nasal cannula

B. Venturi mask

C. CPAP/BiPAP machine

D. Endotracheal tube

Noninvasive CPAP or BiPAP is delivered through a mask or nasal interface to provide positive airway pressure without inserting a tube into the trachea. CPAP maintains a constant pressure to keep airways open, while BiPAP provides two pressures—higher during inspiration and lower during expiration—to assist breathing. The nasal cannula only supplies oxygen and does not provide airway pressure support; a Venturi mask delivers fixed oxygen concentration without pressure, and an endotracheal tube is an invasive airway accessed through the trachea.

8. In Berlin ARDS criteria, which feature relates to the timing of onset?

A. Acute onset

B. Bilateral opacities

C. PaO2/FiO2 ≤300

D. PEEP ≥5 cm H2O

The timing part of the Berlin ARDS criteria is acute onset. ARDS must develop within one week of a known clinical insult or after new or worsening respiratory symptoms. This timing threshold distinguishes an Acute Respiratory Distress Syndrome from longer-standing or chronic lung issues. The other Berlin criteria—bilateral opacities on imaging, and oxygenation impairment measured with a PaO2/FiO2 ratio at a minimum PEEP—describe where the problem is seen and how severe it is, not when it began.

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9. How is bronchodilator responsiveness assessed at the bedside?

A. Increase in FEV1 on spirometry

B. Observation of clinical improvement in symptoms after bronchodilator

C. Decrease in PaCO2 after bronchodilator

D. Improvement in DLCO after bronchodilator

Bronchodilator responsiveness at the bedside is judged by how the patient clinically improves after inhaled bronchodilator. In the bedside setting you don't have immediate access to formal lung function tests, so you look for tangible relief: reduced breathlessness, easier talking, decreased work of breathing and use of fewer accessory muscles, quieter or clearer breath sounds, and, if available, better oxygen saturation or respiratory rate. While a rise in FEV1 on spirometry is a standard objective measure of bronchodilator response, it requires specialized testing and isn't something you can do at the bedside. Changes in PaCO2 or DLCO aren't reliable or practical bedside markers for acute bronchodilator responsiveness. So the best bedside indicator is the patient's clinical improvement in symptoms after the bronchodilator.

10. What is a primary purpose of prone positioning in ARDS management?

A. Reduces sedation requirements

B. Improves ventilation-perfusion matching and oxygenation

C. Increases infection risk

D. Shortens ICU stay

Prone positioning improves ventilation-perfusion matching and oxygenation by making lung inflation more uniform and recruiting the dorsal (back) regions that are often collapsed in ARDS when lying on the back. When patients are prone, the heart and abdominal contents exert less compression on the dorsal lung, allowing better alveolar expansion there. This leads to more even distribution of air, reduction in shunt, and perfusion remains aligned with the better-ventilated areas, so blood flow meets better oxygenation. In addition, this setup can decrease ventilator-induced lung injury by spreading mechanical stress more evenly across the lung. While prone positioning can have other effects, its primary purpose is to boost oxygenation through improved V/Q matching, not to reduce sedation, increase infection risk, or shorten ICU stay.

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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:

https://comprespiratoryandburncare.examzify.com

We wish you the very best on your exam journey. You've got this!

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