RQI PEDIATRIC ADVANCED LIFE SUPPORT (PALS) 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 statement best describes the initial oxygenation during bag-valve-mask ventilation in resuscitation?

A. 21% oxygen

B. 50% oxygen

C. 30% oxygen

D. 100% oxygen

2. Which sign indicates compromised perfusion during resuscitation?

A. Warm flushed skin

B. Prolonged capillary refill, cool extremities, or weak pulses

C. Rapid capillary refill under 1 second

D. Strong palpable peripheral pulses

3. In a child with VT with a pulse who becomes unstable, what is the recommended immediate treatment?

A. Defibrillate immediately at 2 J/kg

B. Continue CPR without defibrillation

C. Administer immediate epinephrine only

D. Synchronized cardioversion at 0.5–1 J/kg (and escalate as needed)

4. For adenosine use in stable SVT in children, what is the maximum dose for the second dose if the first dose is ineffective?

A. 6 mg

B. 12 mg

C. 18 mg

D. 24 mg

5. Which fluid bolus amount is recommended for pediatric sepsis resuscitation as the initial step?

A. 5 mL/kg

B. 10 mL/kg

C. 30 mL/kg

D. 20 mL/kg

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6. Which test best demonstrates reversible airway obstruction in suspected asthma?

A. Chest X-ray showing pneumonia

B. Spirometry showing reversible airway obstruction

C. CT scan showing calcifications

D. MRI

7. Which of the following best describes IO access advantages during code events?

A. It requires specialized equipment not available in most codes

B. It provides rapid vascular access when IV access is delayed

C. It takes longer than IV access to establish

D. It is never recommended in pediatric resuscitation

8. The endotracheal dose of epinephrine in resuscitation is 0.1 mg/kg of 1:10,000 epinephrine diluted in how many mL saline?

A. 1 mL

B. 5 mL

C. 3 mL

D. 10 mL

9. Which option accurately completes the AVPU acronym?

A. Alert; Responsive to Voice; Responsive to Pain; Unresponsive

B. Alert; Verbal; Pain; Unresponsive

C. Awake; Responsive to Touch; Responds; Unresponsive

D. Alert; Responsive to voice; Responsive to pain; Unresponsive

10. Which is most likely to be present in a child who has respiratory distress (not respiratory failure)?

A. Ability to maintain a patient airway

B. Inability to maintain a patient airway

C. No effort to breathe

D. Oxygen saturation of 60% at rest

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Answers

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

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Explanations

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1. Which statement best describes the initial oxygenation during bag-valve-mask ventilation in resuscitation?

A. 21% oxygen

B. 50% oxygen

C. 30% oxygen

D. 100% oxygen

In resuscitation, the goal is to deliver as much oxygen as possible to the tissues during the critical moment when circulation is being restored. Using a bag-valve-mask with an oxygen reservoir is designed to deliver near-full oxygen concentration, so the initial breaths should be given with 100% oxygen. Room air would provide too little oxygen for rapid restoration of oxygen delivery, and intermediate levels don't maximize the early oxygen supply you're trying to achieve. After circulation is established or the patient's saturation is confirmed, you then titrate oxygen down to meet target oxygen saturations to avoid hyperoxia.

2. Which sign indicates compromised perfusion during resuscitation?

A. Warm flushed skin

B. Prolonged capillary refill, cool extremities, or weak pulses

C. Rapid capillary refill under 1 second

D. Strong palpable peripheral pulses

Assessing tissue perfusion during resuscitation means looking for signs that blood is reaching the body's tissues. Prolonged capillary refill, cool extremities, and weak pulses all point to reduced blood flow and poor perfusion. When perfusion is compromised, the body conserves blood by constricting vessels, which makes the skin feel cool and clammy, slows the return of color to the capillary beds (capillary refill takes longer than normal), and makes peripheral pulses feel weak because there isn't enough blood being delivered to the periphery. In contrast, warm flushed skin, rapid capillary refill (well under a couple of seconds), and strong palpable pulses indicate better perfusion. So the combination of prolonged capillary refill with cool extremities and weak pulses best signals compromised perfusion.

3. In a child with VT with a pulse who becomes unstable, what is the recommended immediate treatment?

A. Defibrillate immediately at 2 J/kg

B. Continue CPR without defibrillation

C. Administer immediate epinephrine only

D. Synchronized cardioversion at 0.5–1 J/kg (and escalate as needed)

When a child has ventricular tachycardia with a pulse but becomes unstable, the priority is to restore a stable rhythm with synchronized cardioversion. The rhythm is shockable, but because a pulse is present you synchronize the shock to the QRS complex to avoid delivering a shock that could worsen the rhythm. Start with a energy of 0.5 to 1 joule per kilogram, and if needed, escalate to 2 J/kg for subsequent shocks. After cardioversion, reassess the patient and repeat shocks if instability persists, then consider antiarrhythmic options as guidelines suggest. Defibrillating unsynchronized would be used if there were no pulse (pulseless VT or VF), which isn't the scenario here. Continuing CPR without delivering a synchronized shock isn't appropriate when a shockable rhythm with a pulse is present. Administering epinephrine alone does not promptly correct unstable VT with a pulse and is not the first-line treatment in this situation.

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4. For adenosine use in stable SVT in children, what is the maximum dose for the second dose if the first dose is ineffective?

A. 6 mg

B. 12 mg

C. 18 mg

D. 24 mg

The main idea is that in children with stable SVT, adenosine is given in two rapid IV boluses with fixed weight-based limits to quickly terminate the tachycardia by briefly blocking AV nodal conduction. The first dose is 0.1 mg/kg, up to 6 mg. If that doesn't convert the rhythm, a second dose is given at 0.2 mg/kg, up to a maximum of 12 mg. The second dose is intentionally higher to increase the chance of producing the AV nodal block needed to interrupt the reentrant circuit, while still keeping safety in mind given adenosine's very short half-life. So the maximum dose for the second dose is 12 mg. The other options aren't correct because 6 mg is the limit for the first dose, and 18 mg or 24 mg exceed the recommended cap for the second dose and raise safety concerns.

5. Which fluid bolus amount is recommended for pediatric sepsis resuscitation as the initial step?

A. 5 mL/kg

B. 10 mL/kg

C. 30 mL/kg

D. 20 mL/kg

Restoring perfusion quickly in pediatric sepsis starts with a modest, effective fluid bolus of isotonic crystalloid. The best initial amount is 20 mL/kg, given promptly, because this volume is large enough to expand intravascular volume and improve tissue perfusion, yet small enough to minimize the risk of fluid overload in most children. After delivering the bolus, reassess again for signs of improved perfusion (capillary refill, level of consciousness, urine output, pulses). If perfusion remains inadequate, you can give additional boluses up to a total of about 60 mL/kg within the first hour, guided by clinical response. Smaller initial boluses (5–10 mL/kg) may not correct shock, while starting with a larger amount (like 30 mL/kg) risks fluid overload before reassessment. Use isotonic crystalloids such as normal saline or lactated Ringer's and monitor closely for signs of fluid overload.

6. Which test best demonstrates reversible airway obstruction in suspected asthma?

A. Chest X-ray showing pneumonia

B. Spirometry showing reversible airway obstruction

C. CT scan showing calcifications

D. MRI

Reversible airway obstruction is best demonstrated by a functional lung test that shows improvement after a bronchodilator. Spirometry provides objective measures of airflow, revealing an obstructive pattern with reduced FEV1 and a low FEV1/FVC ratio. When a fast-acting bronchodilator is given and spirometry is repeated, a meaningful improvement in FEV1 confirms reversibility. The standard criterion is an increase in FEV1 of about 12% plus at least 200 mL from baseline. Imaging studies like chest X-ray for pneumonia, CT for calcifications, or MRI do not assess how the airways respond to bronchodilators, so they don't demonstrate reversibility of obstruction.

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7. Which of the following best describes IO access advantages during code events?

A. It requires specialized equipment not available in most codes

B. It provides rapid vascular access when IV access is delayed

C. It takes longer than IV access to establish

D. It is never recommended in pediatric resuscitation

In emergencies, getting vascular access quickly is crucial, and intraosseous (IO) access shines because it provides a rapid route to the circulation when IV access is difficult or delayed. By delivering fluids and medications into the bone marrow, IO access bypasses the challenges of finding a usable vein in a child who may have poor venous access during a code. That makes IO a fast and reliable option when IV access isn't promptly obtainable, which is exactly what the correct choice is highlighting. It's not true that IO requires inaccessible equipment—code carts and EMS kits typically include IO devices. It also isn't true that IO takes longer to establish than IV; in many pediatric resuscitations it can be faster to establish an IO line than to secure IV access. And IO is not never recommended in pediatric resuscitation; guidelines support its use as a rapid access method when IV access is delayed.

8. The endotracheal dose of epinephrine in resuscitation is 0.1 mg/kg of 1:10,000 epinephrine diluted in how many mL saline?

A. 1 mL

B. 5 mL

C. 3 mL

D. 10 mL

Endotracheal epinephrine is given at a fixed weight-based dose (0.1 mg per kg) using a 1:10,000 concentration, but it is prepared in a small, fixed total volume to maximize absorption through the airway. The standard preparation is to use 1 mL of the 1:10,000 epinephrine per kilogram and dilute it with saline so the total administration volume is 3 mL. In other words, you prepare the dose so that the final solution you deliver is 3 mL, which helps ensure the drug reaches the tracheal mucosa effectively. This is why the commonly cited dilution is to 3 mL of solution for endotracheal administration. Using a different volume wouldn't align with this established practice, as too little could limit absorption and too much could impair absorption or increase aspiration risk.

9. Which option accurately completes the AVPU acronym?

A. Alert; Responsive to Voice; Responsive to Pain; Unresponsive

B. Alert; Verbal; Pain; Unresponsive

C. Awake; Responsive to Touch; Responds; Unresponsive

D. Alert; Responsive to voice; Responsive to pain; Unresponsive

The main idea is using the AVPU scale to quickly gauge a child's level of consciousness. It moves from the highest level of alertness to no response: Alert means the child is awake and interactive. If the child isn't fully awake but will respond when spoken to, that's Responsive to voice. If there's no response to voice but there is a response to a painful stimulus, that's Responsive to pain. If there's no response to either voice or pain, that's Unresponsive. So the accurate completion is: Alert; Responsive to voice; Responsive to pain; Unresponsive. This ordering and terminology are the standard way clinicians assess consciousness quickly in resuscitation and bedside care.

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10. Which is most likely to be present in a child who has respiratory distress (not respiratory failure)?

A. Ability to maintain a patient airway

B. Inability to maintain a patient airway

C. No effort to breathe

D. Oxygen saturation of 60% at rest

In respiratory distress the child is still able to keep the airway open and ventilate, even though they are working hard to breathe. You'll see signs of increased work of breathing—tachypnea, nasal flaring, retractions, and use of accessory muscles—but the airway remains patent and oxygenation is not hopelessly compromised yet. That contrasts with respiratory failure, where airway protection is lost or ventilation and oxygenation become inadequate. So the best description is that the child has the ability to maintain the airway. The other descriptions—no effort to breathe (apnea) or very low resting oxygen saturation (like 60%)—point more toward respiratory failure and severe hypoxemia rather than distress.

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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:

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

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