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PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RCEV1

HP Respiratory Care Exit Exam V1

EDITION

Demo

QUESTIONS

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FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for Elsevier Remotely Proctored Exams **RCEV1**, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, **RCEV1**
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

MULTIPLE CHOICE

A patient receiving volume-controlled continuous mandatory ventilation (VC-CMV) has the following ventilator settings: tidal volume (VT) 500 mL, respiratory rate (f) 12/min, FiO2 0.40, PEEP 5 cm H2O. ABG results show: pH 7.31, PaCO2 50 mm Hg, PaO2 80 mm Hg, HCO3- 25 mEq/L. Which of the following ventilator changes are most appropriate? (Choose two.)

- ☐ A Increase tidal volume to 600 mL
- ☒ B Increase respiratory rate to 16/min
- ☒ C Decrease FiO2 to 0.35
- ☐ D Increase PEEP to 8 cm H2O
- ☐ E Add an inspiratory pause

ANSWER B - C

WHY The patient has uncompensated respiratory acidosis (pH 7.31, PaCO2 50, normal HCO3-) with adequate oxygenation (PaO2 80 on FiO2 0.40). The most appropriate changes are (B) increasing the respiratory rate to increase minute ventilation and lower PaCO2, and (C) decreasing FiO2 because PaO2 is well above goal and FiO2 should be kept as low as feasible to minimize oxygen toxicity. Increasing VT (A) risks volutrauma/barotrauma. Raising PEEP (D) is used to improve oxygenation, which is not needed here. An inspiratory pause (E) raises mean airway pressure and is not indicated for hypercapnia.

QUESTION 2

MULTIPLE CHOICE

During resuscitation of a 70 kg adult in cardiopulmonary arrest, which of the following are appropriate considerations for the respiratory therapist? (Choose two.)

- ☒ **A** Provide bag-mask ventilation with a fraction of inspired oxygen (FiO₂) of 1.0
- ☐ **B** Use a tidal volume of approximately 500–600 mL per breath
- ☒ **C** Perform endotracheal intubation if bag-mask ventilation is inadequate
- ☐ **D** Hyperventilate the patient at a rate of 25–30 breaths/min
- ☐ **E** Use the head-tilt/chin-lift maneuver only if spinal trauma is suspected

ANSWER A - C

WHY Per current adult advanced cardiac life support (ACLS) guidelines, the respiratory therapist should deliver 100% oxygen (A) and proceed to advanced airway placement such as endotracheal intubation (C) when bag-mask ventilation is inadequate. Tidal volumes during bag-mask ventilation should be sufficient to produce visible chest rise—typically about 500–600 mL delivered over 1 second—but avoiding excessive volume is more important than targeting a specific number, and option B is acceptable but not the strongest pair. Hyperventilation (D) is contraindicated because it increases intrathoracic pressure, decreases venous return, and worsens outcomes; the recommended ventilation rate is one breath every 6 seconds (10/min) with an advanced airway. The jaw-thrust (not head-tilt/chin-lift) maneuver is used when spinal trauma is suspected, so (E) is incorrect.

QUESTION 3

SINGLE CHOICE

A patient on pressure support ventilation (PSV) of 10 cm H₂O with PEEP of 5 cm H₂O has a spontaneous respiratory rate of 28/min, a VT of 250 mL, and ABG showing pH 7.30, PaCO₂ 55 mm Hg, PaO₂ 78 mm Hg. The most appropriate initial ventilator change is to:

- ☒ **A** Increase pressure support to 15 cm H₂O
- ☐ **B** Increase PEEP to 8 cm H₂O
- ☐ **C** Switch the patient to volume-controlled ventilation
- ☐ **D** Decrease pressure support to 8 cm H₂O

ANSWER A

WHY The patient is hypercapnic (PaCO₂ 55, pH 7.30) with low VT and high respiratory rate, indicating inadequate ventilatory support on PSV. Increasing pressure support (A) will increase VT and lower PaCO₂. Raising PEEP (B) improves oxygenation, which is adequate (PaO₂ 78). Switching to volume-controlled ventilation (C) is a more invasive change and not the initial step. Decreasing support (D) would worsen hypercapnia.

QUESTION 4

SINGLE CHOICE

A respiratory therapist is asked to perform pulse oximetry on a patient with suspected carbon monoxide (CO) poisoning. Which statement best describes the limitation of pulse oximetry in this situation?

- ☒ **A** Pulse oximetry will read falsely high because carboxyhemoglobin absorbs light similarly to oxyhemoglobin
- ☐ **B** Pulse oximetry will read falsely low because carboxyhemoglobin absorbs light differently than oxyhemoglobin
- ☐ **C** Pulse oximetry will not detect a pulse because peripheral vasoconstriction occurs in CO poisoning
- ☐ **D** Pulse oximetry will give a normal reading because CO does not bind to hemoglobin

ANSWER A

WHY Standard pulse oximeters cannot distinguish carboxyhemoglobin (COHb) from oxyhemoglobin because COHb absorbs light at wavelengths similar to oxyhemoglobin. As a result, SpO₂ readings are often falsely normal or high and do not reflect the true oxygen-carrying capacity. CO-oximetry is required to measure COHb directly. CO does bind avidly to hemoglobin, so (D) is incorrect, and peripheral perfusion is generally preserved, so (C) is incorrect.

QUESTION 5

SINGLE CHOICE

A patient with status asthmaticus is receiving continuous nebulized albuterol. Which side effect should the respiratory therapist monitor for most closely?

- ☐ A Bradypnea and hypotension
- ☒ B Tachycardia and tremor
- ☐ C Bronchospasm and wheezing
- ☐ D Hyperglycemia and glycosuria

ANSWER B

WHY Albuterol is a short-acting beta-2 adrenergic agonist. Beta-2 selectivity is relative, and at high doses—especially with continuous nebulization—beta-1 effects (tachycardia, palpitations) and skeletal muscle tremor can occur. The respiratory therapist should monitor heart rate and rhythm and watch for tremor. Bradypnea and hypotension (A) are not typical; bronchospasm (C) is the condition being treated; and hyperglycemia is associated more with systemic corticosteroids or beta-agonists in diabetic patients, not a primary monitoring parameter for short-acting albuterol.

QUESTION 6

SINGLE CHOICE

Immediately after endotracheal intubation, the respiratory therapist notes that breath sounds are present on the right side but absent on the left. The patient's SpO₂ is 85% and the heart rate is rising. The most likely cause is:

- ☒ **A** Right mainstem bronchus intubation
- ☐ **B** Left mainstem bronchus intubation
- ☐ **C** Esophageal intubation
- ☐ **D** Pneumothorax on the right

ANSWER A

WHY Because the right mainstem bronchus branches off the trachea at a less acute angle than the left, the endotracheal tube is most commonly advanced too far into the right mainstem bronchus. This ventilates only the right lung, producing breath sounds on the right and absent breath sounds on the left, along with hypoxemia and tachycardia. The correct action is to deflate the cuff, withdraw the tube 2–3 cm, reinflate, and reassess. Esophageal intubation (C) typically produces absent breath sounds bilaterally with gastric distention. Pneumothorax on the right (D) would produce decreased (not absent) breath sounds on the right.

QUESTION 7

SINGLE CHOICE

A patient with acute respiratory distress syndrome (ARDS) is being ventilated in the volume-control mode with VT 8 mL/kg ideal body weight, PEEP 10 cm H₂O, and FiO₂ 0.60. Current ABG shows pH 7.35, PaCO₂ 45 mm Hg, PaO₂ 58 mm Hg. The PaO₂/FiO₂ ratio is approximately 97. The most appropriate ventilator change is to:

- ☐ A Increase tidal volume to 10 mL/kg to improve alveolar recruitment
- ☒ B Increase PEEP while assessing for improved oxygenation and hemodynamic tolerance
- ☐ C Decrease PEEP to reduce mean airway pressure
- ☐ D Switch to pressure support ventilation immediately

ANSWER B

WHY This patient has moderate-to-severe ARDS (PaO₂/FiO₂ < 200, here about 97) with inadequate oxygenation despite a moderately high FiO₂. Lung-protective ventilation with low tidal volumes ($\leq$ 6–8 mL/kg IBW) should be maintained; increasing VT to 10 mL/kg (A) violates lung-protective strategy and risks volutrauma. Increasing PEEP (B) recruits collapsed alveoli, improves oxygenation, and reduces FiO₂ requirements; current ARDSnet tables guide PEEP/FiO₂ titration. Decreasing PEEP (C) would worsen oxygenation. Switching to pressure support (D) in moderate-to-severe ARDS is premature; the patient should remain in a controlled mode until work of breathing and gas exchange improve.

QUESTION 8

SINGLE CHOICE

The respiratory therapist is preparing to suction an intubated adult patient. Which assessment finding is the strongest indication for endotracheal suctioning?

- ☐ A A routine order to suction every 2 hours
- ☒ B Audible secretions in the airway and a rise in peak inspiratory pressure
- ☐ C A decrease in SpO₂ from 98% to 95% over 30 minutes
- ☐ D The patient being placed on a heated humidifier

ANSWER B

WHY Suctioning should be performed only when clinically indicated, not on a fixed schedule. Audible secretions and an acute rise in peak inspiratory pressure (suggesting retained secretions increasing airway resistance) are clear indications for suctioning. A small SpO₂ decrease from 98% to 95% (C) is not a strong indication. The use of a heated humidifier (D) does not, by itself, indicate suctioning; routine suctioning is no longer recommended because it increases the risk of hypoxia, trauma, and infection.

QUESTION 9

SINGLE CHOICE

When setting up a mechanical ventilator for a patient with suspected active pulmonary tuberculosis, which isolation precaution should the respiratory therapist follow in addition to standard precautions?

- ☐ A Droplet precautions only
- ☐ B Contact precautions only
- ☒ C Airborne precautions with a fit-tested N95 respirator and a negative-pressure room
- ☐ D Protective (reverse) isolation

ANSWER C

WHY Mycobacterium tuberculosis is transmitted by airborne droplet nuclei smaller than 5 microns, which remain suspended in air and travel long distances. The CDC/CDC HICPAC guidelines require airborne precautions: a negative-pressure isolation room and respiratory protection with a fit-tested N95 (or higher) respirator for healthcare personnel. Droplet precautions alone (A) are insufficient because droplets do not travel beyond a few feet. Contact precautions (B) are added when multidrug-resistant organisms or skin involvement is present but are not the primary transmission-based precaution. Protective (reverse) isolation (D) is used for severely immunocompromised patients to protect them from the environment, not for infectious source patients.