

NBRC

RRT
Registry Respiratory Therapist

Questions And Answers PDF Format:

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Version = Product



Latest Version: 6.0

Question: 1

Upon review of the patient record, the respiratory therapist notices that the chart indicates that the patient has a code status of "Do not resuscitate." During a routine assessment, the patient becomes apneic, and subsequently asystolic. Which of these should the respiratory therapist do?

- A. Begin bag-mask ventilation with an FiO₂ of 1.00 and a flow of 15 L/min.
- B. Call for emergency intubation, and initiate mechanical ventilation.
- C. Begin chest compressions.
- D. Report this to the charge nurse as soon as possible.

Answer: D

Explanation:

When the patient becomes apneic and subsequently asystolic, the obligation is to report this to the charge nurse as soon as possible. Chest compressions, intubation, and bag-mask ventilation are all under the category of resuscitation, which goes against this patient's wishes as expressed in their not resuscitate code status.

Question: 2

A review of physician orders for a patient admitted to an acute care facility with an exacerbation of chronic obstructive pulmonary disease (COPD) shows that the medications ordered include Combivent q4h and DuoNeb q4h. The respiratory therapist has a responsibility to perform which of these actions?

- A. Dispense/administer medication as ordered.
- B. Contact the ordering physician to verify orders.
- C. Alternate medications every hours.
- D. Do not administer whichever medication is contraindicated.

Answer: B

Explanation:

It is not within the scope of practice for a respiratory therapist to change physician orders or simply ignore or modify them. However, the Combivent and the DuoNeb are identical medications (albuterol + Atrovent) with different names and methods of administration. The respiratory therapist should contact the physician to advise them of the duplication and request further guidance.

Question: 3

Upon having difficulty getting a reading with the finger probe of a pulse oximeter, the respiratory therapist decides to check the patient's peripheral circulation and capillary refill. The nail bed on the right index finger, after a brief compression, becomes pink again after one second. This is an indication of which of the following?

- A. insufficient blood flow to extremities
- B. normal peripheral circulation and capillary refill
- C. anemia
- D. cyanosis

Answer: B

Explanation:

With normal circulation and perfusion, the nail bed will become pink again in less than two seconds. Cyanosis means the nail bed would be bluish. With insufficient blood flow, the nail bed would not "pink up." Anemia has no effect on this particular test unless the anemia is severe.

Question: 4

A 20-year-old female patient is brought to the emergency department (ED) by paramedics after suffering a brief loss of consciousness after a collision with another player on the basketball court. Upon arrival, the patient's SpO₂ is 98% on room air, her respiratory rate is 16, and her heart rate is 95. The venous blood draw shows that hemoglobin is 11.0 and hematocrit is 44. How do you report these findings?

- A. Patient is saturating well on room air and has a normal heart rate and respiratory rate. Hemoglobin and hematocrit are within normal limits.
- B. Patient is saturating well on room air and has a normal heart rate and respiratory rate. Hemoglobin is low at 11.0, and hematocrit is within normal limits.
- C. Patient is saturating well on room air and is tachypneic with a normal heart rate. Hemoglobin and hematocrit are within normal limits.
- D. Patient is saturating well on room air and is tachycardic at 95 with a normal respiratory rate. Hemoglobin is high at 11.0, and hematocrit is within normal limits.

Answer: B

Explanation:

The heart rate, respiratory rate, SpO₂, and hematocrit are all normal. Hemoglobin is low. Normal limits are as follows: SpO₂ 94%–99%, pulse 60–80 bpm, respiratory rate 12–20 rpm, hemoglobin 12–15 g/dL, hematocrit 37%–46%.

Question: 5

The first patient we see today for an evaluation is a 45-year-old female who started smoking cigarettes at age 15. She reports that she smokes one and a half packs a day and that she quit for a year when she was pregnant with each of her two children. Her husband is also a smoker. How do you report this smoking history in the patient chart?

- A. Patient is currently a daily cigarette smoker, 1.5 packs per day, with a 42-pack-year history.
- B. Patient is currently a heavy smoker.
- C. Patient smokes about 30 cigarettes a day and has for almost 30 years.
- D. Patient suffers from a nicotine addiction and smokes too much.

Answer: A

Explanation:

This is the concise, standard way to report this information that is most useful for assessing patient and her current status. It is universally accepted as the standard metric to gauge smoking history.

Number of packs per day x number of years smoked = pack-years

The other answers are imprecise.

Question: 6

When introducing herself to a patient for the first time, the respiratory therapist notices that the patient is only able to respond to questions in two- or three-word phrases, breaking up longer responses to take breaths after every couple of words. What conclusions can the respiratory therapist safely make from this speech pattern?

- A. The patient is most likely not a native English speaker
- B. The patient has a decreased vital capacity, and there could be several different causes for this.
- C. The patient has COPD.
- D. The patient has a neuromuscular illness that impairs respiration.

Answer: B

Explanation:

The fact that there is a decreased vital capacity (shallow breathing) is all that we know for certain. Some patients will take smaller breaths due to pain after a chest wall injury or after thoracic or abdominal surgery. Also, there are several lung pathologies as well as neuromuscular disorders that can cause a patient to have a shallow breathing pattern. The other answers make conclusions not supported by our observation.

Question: 7

Auscultation of breath sounds during an examination of a 20-year-old male reveals high-pitched wheezing throughout the lung field. The patient reports that he is slightly short of breath and that the wheezing, though noticeable, bothers him very little. He notices that it

usually happens when he mows the lawn. Which of the following might we recommend to the physician?

- A. Write a prescription for an albuterol inhaler to use when necessary (pro re nata [PRN]).
- B. Send the patient for a chest X-ray (CXR) and full pulmonary function tests (PFTs).
- C. The best course is to "wait and see" for this minor problem.
- D. The patient's respiratory health is uncertain and would be better understood by performing basic spirometry and a methacholine challenge test.

Answer: D

Explanation:

The wheezing throughout the lung field, even though not very acute, suggests the possibility of the presence of asthma. The association of these episodes with mowing the lawn further supports this as a possible diagnosis. Basic spirometry and the methacholine challenge test will support or rule out the diagnosis of asthma. Although the albuterol inhaler (choice a) might relieve the wheezing, it will tell us very little about its etiology. A CXR (Choice B) will almost certainly not help us understand the wheezing. A "wait and see" stance might represent a danger to the patient's health.

Question: 8

A 50-year-old female patient presents with a three-month history of a cough productive of sputum that is more acute in the morning upon waking. The sputum is moderate in consistency, pale yellow in color, and varies from small to moderate in quantity. There is no fever or recent sick contacts. Auscultation reveals scattered rhonchi bilaterally, mostly in the lower lobes. The patient has no smoking history. What do you recommend?

- A. A more complete history including vocation, exposure to environmental hazards, and family history is required. Also, PFTs are indicated for this patient with a pre- and post-bronchodilator FEV1/FVC.
- B. Tell the physician that the patient has COPD and needs a long-acting beta agonist and an inhaled corticosteroid to start at once.
- C. An order for a stat CXR and a complete blood count (CBC) with differential is necessary to rule out pneumonia.
- D. The patient needs pulmonary rehabilitation with exercise and nutritional counseling.

Answer: A

Explanation:

The patient is showing the hallmark clinical symptoms of COPD, chronic bronchitis type. Though she is not a smoker, smokers are not the only persons who develop this chronic disease. Family history of COPD and persistent exposure to lung irritants are also thought to be causative. There is not enough information to recommend prescribing specific regimen of medications. Clinical symptoms of pneumonia typically include fever and acute onset. Pulmonary rehabilitation cannot be indicated until the disorder is diagnosed.

Question: 9

A patient presents to the ED of your hospital with productive cough, fever, and bilateral rhonchi in the lower lobes. The CXR shows possible bilateral infiltrate, according to the radiologist. To confirm a diagnosis of pneumonia, what level of white blood cells (WBCs) would we expect to find per microliter (mCL)?

- A. 2,000 to 3,000 WBCs/mCL
- B. 4,000 to 6,000 WBCs/mCL
- C. 7,000 to 10,000 WBCs/mCL
- D. 12,000 to 14,000 WBCs/mCL

Answer: D

Explanation:

The average normal range for white blood cell count is 4,500 to 10,000. Pneumonia is an infectious process, and we would expect to see elevated levels of white blood cells, greater than 10,000 WBC/mCL. Bacterial and viral infections will, in most cases, cause an elevation in the WBC count.

Question: 10

While performing routine care on a patient with a tracheostomy, you notice that there are traces of blood apparent on the dressing between the stoma and the flange of the tube. Which of these is the correct course of action?

- A. Put on a new, clean dressing and set a reminder to check for additional problems when doing tracheostomy care the following day.
- B. Clean the area of the stoma with normal saline; do a careful inspection of the condition of the stoma; replace the old dressing with a new, clean dressing; carefully note your observation in the patient chart; and directly notify the unit manager that the stoma needs the attention of the patient's physician or advanced practice registered nurse (APRN) when one of them next does rounds.
- C. Clean the area of the stoma with a cotton swab saturated with hydrogen peroxide and sterile water in a 50/50 mix; replace the dressing with a clean, new dressing; and ask that the patient be seen by the physician on call stat.
- D. Continue regular tracheostomy care as per usual protocol, make a mental note of the trace blood, and tell the next therapist about it when you give your report at the change of shift.

Answer: B

Explanation:

Choices A and D do not include charting the observation. Answer C indicates too high a level of urgency for an observation of "traces" of blood. The appearance of trace blood on the dressing may be indicative of granuloma, infection, or another problem related to the stoma. It is very

important for the physician to be notified, but it is not an emergency. It must be documented in the patient chart.

Question: 11

A patient brought into the ED by paramedics from a car accident appears to have possibly suffered a chest wall injury. The physician orders an arterial blood gas (ABG) analysis (on room air). The results come back as follows:

pH	7.41
PaCO ₂	58 mm Hg
PaO ₂	84 mm Hg
HCO ₃ ⁻	24 mEq/L

What respiratory treatment might we recommend to the physician?

- A. stat CXR and possible noninvasive positive pressure ventilation (NIPPV)
- B. supplemental O₂: at 5 L/min via nasal cannula
- C. stat intubation and mechanical ventilation
- D. CXR and 2 L/min supplemental O₂ via nasal cannula

Answer: A

Explanation:

The patient is hypercapnic and would benefit from NIPPV support to help increase VT. A CXR must be performed to rule out contraindications such as pneumothorax or unstable fractures. Choices A and D are insufficient because supplemental O₂ may help but will not resolve the hypercapnia. Intubation is not indicated in a patient not in respiratory failure who is able to protect his airway. It is too aggressive at this point.

Question: 12

A patient in your care has appropriate tidal volumes; clear bilateral breath sounds throughout his lung fields; normal CBC; no signs or symptoms of infection; and although he is on a venturi mask delivering an FiO₂ of 0.45, he has an SpO₂ of 87%. The patient chart shows a history of a clotting disorder, although he is not currently taking an anticoagulant. What test would you recommend be performed next?

- A. prothrombin time (PT) and international normalized ratio (INR)
- B. ventilation-perfusion (V/Q) scan
- C. CXR
- D. ultrasound exam of aorta and echocardiogram

Answer: B

Explanation:

The patient history and current condition suggest a ventilation/perfusion problem — possibly a pulmonary embolism. This is seen by computing the P_a and P_a difference. The clotting

disorder points in the direction of possible PE. The other tests are unlikely or unable to demonstrate the presence or absence of a pulmonary embolism.

Question: 13

A patient in the telemetry unit sets off an alarm when her SpO₂ drops below 90% — all the way to 85%. The patient has a No. 6 Shiley tracheostomy tube in place; she has a disposable inner cannula in place, and the cuff is deflated. Upon entering her room, what is the first thing you must do?

- A. Assess the patient for signs of distress and check the pulse oximetry probe to see that it is securely in place.
- B. Check that the FiO₂ setting on the entrainment device is set properly, as ordered.
- C. Begin bag-mask ventilation with 100% oxygen at 15 L/min.
- D. Attempt to pass a suction catheter through the tracheostomy tube to remove accumulated secretions and to ensure that the tube is patent.

Answer: A

Explanation:

When an oxygen saturation alarm is triggered, the patient must first be assessed, as pulse oximetry requires specific contact with the skin and often becomes inaccurate due to patient movement, hair on the skin, patient diaphoresis, or sensor connections. Assess the patient for signs of respiratory distress and check the site of the pulse oximetry probe. If this patient were to be demonstrating signs of distress, the next step would be to suction the tracheostomy tube.

Question: 14

Acute or chronic lung disease is best shown in which of the following arterial blood gas (ABG) results (on 4 L/min O₂ via nasal cannula)?

- | | | | |
|------------|--------------------|---------------------|---------------------|
| A. pH 7.36 | PO ₂ 86 | PCO ₂ 52 | HCO ₃ 30 |
| B. pH 7.11 | PO ₂ 79 | PCO ₂ 61 | HCO ₃ 24 |
| C. pH 7.40 | PO ₂ 70 | PCO ₂ 40 | HCO ₃ 25 |
| D. pH 7.30 | PO ₂ 91 | PCO ₂ 52 | HCO ₃ 30 |

Answer: A

Explanation:

These results show the slightly increased acidity with a high level of CO₂ partially compensated by an elevated HCO₃. "Acute" is indicated by the decreased PaCO₂. "Chronic" is indicated by the elevated HCO₃. The other answers do not show both of these features.

Question: 15

If we need to determine a patient's functional residual capacity (FRC), which of these tests should the physician order?

- A. bedside spirometry

-
- B. ABG analysis
 - C. V/Q scan
 - D. body plethysmography

Answer: D

Explanation:

None of the other tests can measure FRC. FRC can be computed only once the total lung capacity is known, measured either by nitrogen washout or by body plethysmography.

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