ACLS

Free Practice Test — 30 Real Exam-Style Questions

with full answer key & explanations

Practice Questions

Try all 30 first, then check the answer key at the back.

1. During a cardiac arrest resuscitation, the team leader assigns roles before CPR begins. A new nurse asks why the team leader is not doing compressions. Which response BEST explains effective team dynamics?

A. Compressions are only performed by the most experienced provider present.
B. The team leader avoids compressions to prevent fatigue from affecting their judgment later.
C. The team leader must remain free to direct, monitor, and make decisions for the entire team.
D. The team leader should rotate into compressions every 2 minutes to maintain team morale.

2. The drug of choice for most forms of narrow-QRS tachycardia is:

A. Amiodarone
B. Atropine
C. Adenosine
D. Epinephrine

3. You arrive at a patient found unresponsive. Which action is the FIRST priority in the BLS primary survey?

A. Check for a carotid pulse for up to 10 seconds.
B. Verify scene safety before approaching the patient.
C. Open the airway using a head-tilt chin-lift.
D. Attach the AED and analyze rhythm.

4. Vasopressin may be used in the management of:

A. Symptomatic first-degree atrioventricular block
B. Ventricular fibrillation
C. Narrow-QRS tachycardia
D. Atrial fibrillation with a rapid ventricular response

5. A provider performing chest compressions on an adult patient is pushing down approximately 1.5 inches at a rate of 110/min. What correction should the team leader call out?

A. Increase compression depth to at least 2 inches; rate is acceptable.
B. Decrease rate to 80-100/min and maintain current depth.
C. Both rate and depth are within guideline targets; no correction needed.
D. Increase depth to at least 2 inches and slow rate to below 100/min.

6. Which of the following could be administered endotracheally if necessary?

A. Amiodarone, dopamine, procainamide, naloxone, and adenosine
B. Naloxone, atropine, vasopressin, epinephrine, and lidocaine
C. Lidocaine, amiodarone, procainamide, vasopressin, and naloxone
D. Procainamide, epinephrine, lidocaine, adenosine, and dopamine

7. Mid-resuscitation, a team member states: 'I've pushed 1 mg of epinephrine IV.' The team leader nods without responding verbally. According to ACLS team communication principles, what problem does this represent?

A. Absence of closed-loop communication — the team leader must verbally confirm receipt of the message.
B. Nodding is an acceptable form of confirmation in a high-noise resuscitation environment.
C. The team member should have waited for explicit instruction before administering the drug.
D. The dose of epinephrine reported is incorrect, which is the primary concern.

8. The most common side effects of giving amiodarone are:

A. Nausea and asystole
B. Bradycardia and hypotension
C. AV block and hypertension
D. Blurred vision and abdominal pain

9. During the primary ACLS survey (ABCDE), the team has confirmed a shockable rhythm and delivered one shock. The next immediate action is:

A. Check the pulse for up to 10 seconds to determine whether perfusion has returned.
B. Administer 300 mg amiodarone IV before resuming compressions.
C. Reanalyze the rhythm with the defibrillator within 30 seconds of the shock.
D. Resume high-quality CPR immediately for 2 minutes before reassessing rhythm.

10. A 75-year-old man has suffered a cardiac arrest. The arrest was not witnessed. CPR is in progress. The cardiac monitor reveals ventricular fibrillation. A monophasic waveform defibrillator is available to you. Your next action will be to:

A. Deliver three stacked shocks using 200, 300, and 360 joules after 5 cycles (about 2 minutes) of CPR
B. Give a 2.5- to 5-mg IV bolus of verapamil over 3 minutes
C. Deliver a single shock using 360 joules after 5 cycles of CPR and then immediately resume CPR
D. Give magnesium sulfate 1 to 2 g IV over 10 minutes

11. A team member who is an experienced paramedic disagrees with the team leader's decision to withhold a second dose of epinephrine. What is the MOST appropriate way for that team member to communicate concern?

A. Ask the charge nurse to intervene immediately to override the team leader's decision.
B. Wait until after the resuscitation and document the disagreement in the medical record.
C. State the concern calmly and directly to the team leader using a clear, assertive statement, then defer if the leader acknowledges it.
D. Administer the epinephrine independently because clinical judgment supersedes team hierarchy.

12. Which of the following approaches is recommended during an initial patient evaluation?

A. Oxygen, IV, monitor
B. Level of responsiveness, airway, breathing, circulation, defibrillation if necessary
C. Temperature, pulse, respiration, blood pressure
D. Oxygen, IV fluid challenge, vital signs, level of responsiveness

13. You are leading a resuscitation and observe that compressions are being interrupted for 18 seconds each time the defibrillator charges. What target metric is being violated?

A. CPR fraction should be kept above 60%, requiring pre-shock pauses of no more than 10 seconds.
B. The ratio of compressions to ventilations must remain 30:2 during defibrillator charging.
C. The compression rate must not fall below 100/min during any pause.
D. Post-shock pauses longer than 15 seconds require documentation only, not correction.

14. A 37-year-old woman is complaining of shortness of breath and palpitations. You have placed the patient on oxygen and an IV has been established. Her mental status is rapidly decreasing and she is very pale. Her initial blood pressure was 148/70. It is now 62/38. Breathing is shallow at 8 to 12 breaths/minute. Your best course of action will be to:

A. Perform synchronized cardioversion starting with 50 joules
B. Give sublingual nitroglycerin
C. Perform CPR for 2 minutes, then defibrillate with 200 joules
D. Perform CPR and give epinephrine 1 mg IV push

15. A resuscitation team has four members: team leader, compressor, airway provider, and IV/medication nurse. The monitor shows asystole. The airway provider spontaneously begins preparing for intubation and announces 'I'll intubate now.' What principle of team dynamics is at risk?

A. CPR fraction — verbal announcements during compressions distract other team members.
B. Closed-loop communication — intubation should only be announced after it is completed.
C. Mutual respect — announcing actions aloud undermines the team leader's authority.
D. Clear role definition — team members should not take on tasks outside their assigned role without direction from the team leader.

16. At doses recommended for use in cardiac arrest, epinephrine and vasopressin:

A. Cause significant peripheral vasoconstriction
B. Neutralize acid accumulated during cardiac arrest
C. Slow conduction through the atrioventricular node
D. Cause profound peripheral vasodilation

17. A 58-year-old collapses in the ICU. CPR is in progress. The monitor shows a narrow-complex organized rhythm at 70/min with no pulse. Epinephrine 1 mg has been given. Which statement BEST guides the next 2 minutes of care?

A. Continue high-quality CPR, search for and treat reversible causes of PEA, and reassess rhythm and pulse after 2 minutes.
B. Administer atropine 1 mg IV because the rate of 70/min represents relative bradycardia in PEA.
C. Cease compressions briefly to allow the organized rhythm to generate a pulse spontaneously.
D. Attempt synchronized cardioversion at 200 J because the organized rhythm may respond to electrical therapy.

18. The first antiarrhythmic administered in the management of the patient in pulseless ventricular tachycardia or ventricular fibrillation is:

A. Epinephrine or vasopressin
B. Amiodarone or lidocaine
C. Vasopressin or amiodarone
D. Epinephrine or lidocaine

19. During handoff at shift change, the outgoing team leader states: 'We've given two rounds of epi and one dose of amiodarone 300 mg; total downtime is 14 minutes.' The incoming team leader asks what role this information plays in ACLS framework. Which answer is MOST accurate?

A. It informs the timing of the next epinephrine dose and whether a second amiodarone dose of 150 mg is appropriate if VF/pVT persists.
B. It signals that resuscitation should be considered futile because more than 10 minutes have elapsed.
C. It allows the team to document medication errors that occurred during the prior shift.
D. It triggers mandatory administration of sodium bicarbonate based on elapsed arrest time.

20. During cardiac arrest:

A. Chest compressions should be interrupted for 2 to 3 minutes to start an IV and insert an advanced airway
B. Chest compressions should never be interrupted
C. Interruptions in chest compressions to analyze the ECG, charge the defibrillator, place an advanced airway, check a pulse, or other procedures must be kept to a minimum
D. Chest compressions and ventilations should be interrupted every 3 to 5 minutes to permit the members of the resuscitation team to change positions

21. You are team leader during a resuscitation. After 20 minutes, the rhythm remains asystole, no reversible causes are identified, and end-tidal CO2 is consistently below 10 mmHg despite optimal CPR. A team member asks whether resuscitation should continue. Which response BEST reflects current AHA guidance?

A. An ETCO2 below 10 mmHg is diagnostic of irreversible brain death and mandates immediate cessation.
B. Resuscitation must continue for a minimum of 30 minutes regardless of ETCO2 values per AHA mandate.
C. ETCO2 is only useful during ROSC to confirm tube placement and has no prognostic value in asystole.
D. Persistent ETCO2 below 10 mmHg after 20 minutes of ALS is associated with very poor prognosis and can inform (though not alone determine) the decision to terminate efforts.

22. A 56-year-old woman is complaining of palpitations. When questioned, she denies chest discomfort or shortness of breath. Her blood pressure is 134/82, pulse 180, respirations 18. The cardiac monitor shows a narrow-QRS tachycardia without visible P waves. Recommended treatment for this patient includes:

A. ABCs; O2; IV; sedation; and synchronized cardioversion with 200 joules
B. ABCs, O2, IV, vagal maneuvers, and lidocaine 1- to 1.5-mg/kg IV bolus
C. ABCs, O2, IV, and atropine 0.5-mg IV every 3 to 5 minutes to a maximum of 3 mg
D. ABCs, O2, IV, vagal maneuvers, and adenosine 6-mg rapid IV bolus

23. A resuscitation team member assigned as the 'timer/recorder' calls out '3 minutes since last shock' while VF continues on the monitor. The compressor has been performing compressions for 2 minutes without rotation. What is the MOST important action the team leader should take NEXT?

A. Pause compressions for a rhythm check since it has been 3 minutes since the last shock.
B. Administer amiodarone 300 mg IV before delivering the next shock.
C. Direct a compressor swap and charge the defibrillator simultaneously to minimize the pre-shock pause at the 2-minute mark.
D. Increase compression rate to 130/min to compensate for fatigue in the current compressor.

24. A 78-year-old woman is found unresponsive. From across the room, your first impression of the patient is that she is not moving, you can see no rise and fall of her chest or abdomen, and her skin color is pale. When you arrive at the patient's side, you confirm that she is unresponsive. As you shout for help, your next action in this situation should be to:

A. Apply the automated external defibrillator
B. Open her airway and check for breathing
C. Begin chest compressions
D. Prepare to insert an advanced airway

25. During post-cardiac-arrest care following ROSC, the primary survey reveals: SpO2 88% on 100% O2, BP 78/40 mmHg, HR 118/min sinus tachycardia, GCS 6. The team leader orders a specific FiO2 target. Which order is MOST consistent with AHA post-ROSC guidelines?

A. Reduce O2 to room air immediately because tachycardia indicates catecholamine excess from high FiO2.
B. Titrate O2 to maintain SpO2 92-98% to avoid hyperoxia-induced reperfusion injury.
C. Target SpO2 above 99% for the first hour post-ROSC per the post-arrest neuroprotection protocol.
D. Continue 100% FiO2 until SpO2 reaches 100% to maximize oxygen delivery to the ischemic brain.

26. If no head or neck trauma is suspected, which of the following techniques should healthcare professionals use to open the airway?

A. Jaw-thrust without head tilt
B. Head tilt-neck lift
C. Head tilt-chin lift
D. Tongue-jaw lift

27. In a megacode scenario, VF is refractory after three shocks plus epinephrine. The medication nurse announces: 'I have amiodarone ready — should I push it?' The team leader has not yet given the order. Which closed-loop communication sequence is CORRECT?

A. Nurse administers the drug immediately because the algorithm mandates amiodarone after three shocks.
B. Team leader states the order clearly; nurse repeats it back; team leader confirms; nurse administers and announces completion.
C. Team leader nods to indicate approval; nurse administers and documents in the chart.
D. Nurse asks the charge physician to co-sign the verbal order before administering.

28. The primary survey reveals that the patient is unresponsive and not breathing. A weak pulse is present at a rate of about 70. Your course of action will be to:

A. Begin mouth-to-mouth breathing
B. Begin ventilating with a bag-valve-mask
C. Begin chest compressions
D. Insert an endotracheal tube, Combitube, or laryngeal mask airway

29. During a resuscitation, a respiratory therapist is performing bag-mask ventilation. After 2 minutes of CPR, the team leader notes visible chest rise with every compression — not just with ventilations. What does this finding MOST likely indicate, and what action is appropriate?

A. The bag-mask rate may be too high causing air trapping, or mask seal is causing passive chest movement; reassess ventilation rate and technique targeting 1 breath every 6 seconds once an advanced airway is placed.
B. This confirms high-quality compressions and adequate perfusion; no intervention is needed.
C. The patient requires immediate needle decompression for tension pneumothorax causing paradoxical chest movement.
D. Chest rise with each compression indicates ROSC; stop CPR and check for a pulse.

30. An oral airway:

A. May help in the delivery of adequate ventilation with a device by preventing the tongue from blocking the airway
B. Is of proper size if it extends from the tip of the nose to the tip of the ear
C. Is usually well-tolerated in responsive or semi-responsive patients
D. Can only be used in spontaneously breathing patients

Answer Key & Explanations

1. C — The team leader must remain free to direct, monitor, and make decisions for the entire team.
AHA ACLS guidelines designate the team leader as the coordinator who directs all actions, communicates with the team, and makes real-time decisions — a role incompatible with performing compressions, which demand full physical attention.

2. C — Adenosine
Adenosine is the first-line drug for narrow-QRS (supraventricular) tachycardias due to its ability to transiently block AV nodal conduction.

3. B — Verify scene safety before approaching the patient.
The very first step of any resuscitation is confirming that the scene is safe for rescuers, as outlined in the BLS survey; proceeding into an unsafe environment risks creating additional victims.

4. B — Ventricular fibrillation
Vasopressin is a vasopressor used as an alternative to epinephrine in cardiac arrest, including ventricular fibrillation.

5. A — Increase compression depth to at least 2 inches; rate is acceptable.
AHA guidelines specify adult compression depth of at least 2 inches (5 cm) and rate of 100-120/min; the rate of 110/min is correct, but 1.5 inches is inadequate and must be corrected.

6. B — Naloxone, atropine, vasopressin, epinephrine, and lidocaine
The mnemonic NAVEL covers endotracheal drugs: Naloxone, Atropine, Vasopressin, Epinephrine, and Lidocaine.

7. A — Absence of closed-loop communication — the team leader must verbally confirm receipt of the message.
Closed-loop communication requires that the receiver verbally acknowledges the message and the sender confirms the acknowledgment; a nod alone does not complete the loop and risks miscommunication errors.

8. B — Bradycardia and hypotension
IV amiodarone commonly causes bradycardia and hypotension, especially with rapid administration.

9. D — Resume high-quality CPR immediately for 2 minutes before reassessing rhythm.
Per the AHA VF/pVT algorithm, after each shock CPR is resumed immediately for 2 minutes before the next rhythm and pulse check, minimizing post-shock no-flow time.

10. C — Deliver a single shock using 360 joules after 5 cycles of CPR and then immediately resume CPR
For unwitnessed arrest with VF, current guidelines recommend 5 cycles (approximately 2 minutes) of CPR before defibrillation, then deliver a single shock (360 J monophasic) and immediately resume CPR.

11. C — State the concern calmly and directly to the team leader using a clear, assertive statement, then defer if the leader acknowledges it.
AHA ACLS team dynamics teach 'constructive intervention': any member may calmly voice a concern to the team leader, but must still defer to the leader's final decision unless patient safety is immediately threatened.

12. B — Level of responsiveness, airway, breathing, circulation, defibrillation if necessary
The primary survey follows the sequence: level of responsiveness, then airway, breathing, circulation, and defibrillation if indicated.

13. A — CPR fraction should be kept above 60%, requiring pre-shock pauses of no more than 10 seconds.
AHA guidelines recommend minimizing all peri-shock pauses to under 10 seconds and maintaining a CPR fraction (proportion of resuscitation time with compressions) greater than 60% to optimize perfusion pressure.

14. A — Perform synchronized cardioversion starting with 50 joules
This patient is hemodynamically unstable (BP 62/38, altered mental status) with a tachyarrhythmia. Immediate synchronized cardioversion is indicated for unstable tachycardia with a pulse.

15. D — Clear role definition — team members should not take on tasks outside their assigned role without direction from the team leader.
ACLS team dynamics require clearly defined roles and that significant interventions be directed by the team leader; self-initiated role expansion without instruction can create overlap, missed tasks, or unsafe actions.

16. A — Cause significant peripheral vasoconstriction
Both epinephrine and vasopressin cause peripheral vasoconstriction, which increases coronary and cerebral perfusion pressure during CPR.

17. A — Continue high-quality CPR, search for and treat reversible causes of PEA, and reassess rhythm and pulse after 2 minutes.
Pulseless electrical activity (PEA) is treated with uninterrupted high-quality CPR, epinephrine every 3-5 minutes, and aggressive search for the 6 Hs and 6 Ts; atropine is not indicated for PEA and cardioversion has no role.

18. B — Amiodarone or lidocaine
After CPR and defibrillation, the first antiarrhythmic given for pulseless VT/VF is amiodarone (preferred) or lidocaine (alternative).

19. A — It informs the timing of the next epinephrine dose and whether a second amiodarone dose of 150 mg is appropriate if VF/pVT persists.
Accurate elapsed-time and medication tracking is essential for maintaining the ACLS algorithm: epinephrine recurs every 3-5 minutes, and a second amiodarone dose (150 mg) can be given for refractory VF/pVT after the initial 300 mg.

20. C — Interruptions in chest compressions to analyze the ECG, charge the defibrillator, place an advanced airway, check a pulse, or other procedures must be kept to a minimum
Minimizing interruptions in chest compressions is a key principle of high-quality CPR; pauses must be kept to less than 10 seconds.

21. D — Persistent ETCO2 below 10 mmHg after 20 minutes of ALS is associated with very poor prognosis and can inform (though not alone determine) the decision to terminate efforts.
AHA guidelines acknowledge that an ETCO2 persistently below 10 mmHg after 20 minutes of ALS resuscitation is associated with extremely low survival rates and may be used — alongside clinical context — as one factor in termination-of-resuscitation discussions.

22. D — ABCs, O2, IV, vagal maneuvers, and adenosine 6-mg rapid IV bolus
For stable narrow-QRS tachycardia (likely SVT), the sequence is vagal maneuvers first, then adenosine 6 mg rapid IV bolus if vagal maneuvers fail.

23. C — Direct a compressor swap and charge the defibrillator simultaneously to minimize the pre-shock pause at the 2-minute mark.
To minimize CPR interruptions, AHA guidelines recommend preparing for defibrillation — including compressor rotation — while CPR continues, so the pause between stopping compressions and delivering the shock is kept under 10 seconds.

24. B — Open her airway and check for breathing
After confirming unresponsiveness and calling for help, the next step is to open the airway and check for breathing (and pulse simultaneously per healthcare provider guidelines).

25. B — Titrate O2 to maintain SpO2 92-98% to avoid hyperoxia-induced reperfusion injury.
AHA post-cardiac-arrest care guidelines recommend titrating inspired oxygen to achieve SpO2 of 92-98% (avoiding both hypoxia and hyperoxia), as excessive oxygen delivery after ROSC can worsen neurological outcomes through oxidative injury.

26. C — Head tilt-chin lift
The head tilt-chin lift is the recommended technique to open the airway when no cervical spine injury is suspected.

27. B — Team leader states the order clearly; nurse repeats it back; team leader confirms; nurse administers and announces completion.
Closed-loop communication requires a clear verbal order from the team leader, read-back by the receiving team member, explicit confirmation by the team leader, and a completion announcement — preventing medication errors in high-stress environments.

28. B — Begin ventilating with a bag-valve-mask
A patient with a pulse but no breathing requires rescue ventilation; bag-valve-mask ventilation is the preferred initial method.

29. A — The bag-mask rate may be too high causing air trapping, or mask seal is causing passive chest movement; reassess ventilation rate and technique targeting 1 breath every 6 seconds once an advanced airway is placed.
Passive chest rise with compressions during bag-mask ventilation can signal excessive ventilation rate causing dynamic hyperinflation (auto-PEEP), poor mask seal, or high airway pressure — all of which impair venous return and cardiac output; AHA guidelines target 1 breath every 6 seconds (10/min) with an advanced airway in place.

30. A — May help in the delivery of adequate ventilation with a device by preventing the tongue from blocking the airway

An oropharyngeal airway (OPA) prevents the tongue from obstructing the airway and facilitates bag-valve-mask ventilation. It should only be used in unconscious/unresponsive patients without a gag reflex.

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