Dip IMC mock questions and explanations

St Emlyns revision resource

Updated 18 October 2026. Based on the original mock paper by Iain Beardsell linked from the St Emlyns Dip IMC preparation post.

This edition contains 75 single best answer questions. Choose one answer, A to E, for each. Original question numbers are retained for cross reference: the source paper jumps from 24 to 35; no questions are missing from this edition.

Use this as a revision aid alongside the current curriculum, national guidance and your service protocols. It is not an official RCSEd examination or a substitute for supervised procedural training. UK practice is assumed unless a question states otherwise; the major incident triage questions specifically use NHS England MITT.

Each item repeats the question and options, gives the answer and explains the key point. Numbered sources are linked in the reference list. Ambiguous or obsolete items have been replaced within their original topic; older diagrams and unsupported frequency tables have been removed.

Name _____ Date _____

Answer key

Question	Answer	Question	Answer	Question	Answer
1	B	36	D	61	B
2	D	37	B	62	E
3	C	38	E	63	C
4	A	39	A	64	A
5	E	40	C	65	D
6	C	41	B	66	B
7	B	42	D	67	E
8	D	43	E	68	C
9	A	44	A	69	A
10	E	45	C	70	D
11	B	46	B	71	B
12	D	47	D	72	E
13	C	48	E	73	C
14	A	49	A	74	A
15	E	50	C	75	D
16	B	51	B	76	B
17	D	52	D	77	E
18	C	53	E	78	C
19	A	54	A	79	A
20	E	55	C	80	D
21	B	56	B	81	A
22	D	57	D	82	C
23	C	58	E	83	D
24	A	59	A	84	A
35	C	60	C	85	B

Question 1 Requesting critical care

Subject to local dispatch arrangements, which casualty most clearly needs an early request for a prehospital critical care team?

A. An isolated finger injury with controlled bleeding
B. A casualty whose airway and ventilation remain inadequate despite basic measures
C. An ambulant casualty with a superficial abrasion
D. A stable casualty who requests helicopter transport for convenience
E. Every person involved in a low speed collision

Answer B. Escalate early when necessary airway or resuscitation interventions exceed the attending team's capability. Continue immediate care and arrange transport appropriately; requesting critical care should not create an avoidable delay. Dispatch criteria and available capabilities vary between services.

Sources 1, 2

Question 2 Scene safety

You are the first clinical responder at a road traffic collision. Which is the best initial approach?

A. Park exactly 50 metres away regardless of hazards
B. Assume command of every emergency service
C. Approach immediately because a high visibility jacket guarantees protection
D. Assess hazards, position safely, communicate and coordinate with other responders
E. Allow clinical urgency to replace a scene risk assessment

Answer D. Scene assessment is dynamic. Vehicle position, access and safe working areas depend on traffic, fire, hazardous materials and other threats. JESIP supports joint understanding of risk and coordinated decisions; first arrival does not confer command of all agencies.

Sources 3

Question 3 Personal protective equipment

Which statement about personal protective equipment is correct?

A. One type of glove protects against every chemical
B. High visibility clothing removes the need for traffic management
C. Equipment must suit the assessed hazards and the user must know its limitations
D. A helmet makes an unstable vehicle safe to enter
E. Routine clinical PPE provides respiratory protection against all gases

Answer C. PPE selection follows the hazard assessment. Fit, compatibility, condition and training matter. PPE does not eliminate the hazard or replace safe systems of work; ordinary examination gloves and masks do not provide universal chemical protection.

Sources 4, 3

Question 4 High visibility clothing

Which published standard addresses the performance of high visibility clothing, as checked for this October 2026 edition?

A. ISO 20471
B. ISO 9001
C. ISO 15189
D. ISO 14001
E. ISO 13485

Answer A. ISO 20471 specifies visibility performance, including colour, retroreflection and material layout. The published 2013 standard with its amendment remains the relevant reference at this review date; a draft revision is not a replacement standard. Select clothing for the task and local requirements.

Sources 5

Question 5 Extrication planning

Which statement best reflects the 2025 Faculty of Pre Hospital Care extrication consensus?

A. Every casualty must remain in the vehicle until a longboard is available
B. Absolute elimination of all spinal movement is the sole objective
C. A single fixed extrication sequence suits every casualty
D. Clinical assessment should begin only after rescue is complete
E. Use a coordinated plan that considers clinical urgency, entrapment and the casualty's ability to self extricate

Answer E. The current consensus emphasises timely, patient centred rescue and supports self extrication when appropriate. Clinical and rescue teams should agree a plan that fits the patient and scene, using their service's adopted decision aid.

Sources 6

Question 6 Altitude physiology

What is the main reason inspired oxygen pressure falls at high altitude?

A. The proportion of oxygen in dry ambient air falls to about 10%
B. Atmospheric pressure increases
C. Atmospheric pressure falls while the oxygen fraction remains approximately 21%
D. Red cell production immediately stops
E. Nitrogen is completely removed from the atmosphere

Answer C. Lower barometric pressure reduces inspired oxygen partial pressure. Ventilation increases during acclimatisation; increased red cell production is a later response. Oxygen fraction and oxygen partial pressure are different quantities.

Sources 7

Question 7 Acute mountain sickness prevention

Which drug promotes acclimatisation and is generally preferred when drug prophylaxis for acute mountain sickness is indicated?

A. Nifedipine
B. Acetazolamide
C. Ofloxacin
D. Furosemide
E. Morphine

Answer B. Acetazolamide assists acclimatisation. Gradual ascent remains central to prevention. Dexamethasone also has a preventive role in selected circumstances but does not promote acclimatisation, so the former question could not distinguish the two reliably.

Sources 7

Question 8 High altitude pulmonary oedema

A trekker develops breathlessness at rest, cough and marked hypoxaemia after ascent. What is the best field management of suspected high altitude pulmonary oedema?

A. Continue ascending slowly
B. Prescribe antibiotics and wait overnight
C. Give a diuretic and encourage exercise
D. Arrange urgent descent with minimal exertion and give oxygen if available
E. Assume a normal chest examination excludes the condition

Answer D. HAPE can deteriorate rapidly. Descent and oxygen are the main field treatments; minimise exertion. Medication or a portable hyperbaric device may be adjuncts when evacuation is delayed, according to specialist guidance.

Sources 7

Question 9 High altitude cerebral oedema

A trekker at altitude becomes confused and ataxic. Which action is most appropriate for suspected high altitude cerebral oedema?

A. Urgent assisted descent with oxygen and dexamethasone when available
B. Continue to the summit before seeking help
C. Use acetazolamide alone and continue ascending
D. Give alcohol to reduce anxiety
E. Observe for 24 hours before arranging evacuation

Answer A. Suspected HACE needs urgent descent. Oxygen and dexamethasone are adjuncts. A portable hyperbaric device can help when descent is impossible, but improvement must not lead to further ascent or abandonment of evacuation.

Sources 7

Question 10 Hypothermia

Which measured core temperature meets the definition of accidental hypothermia?

A. 37.5 degrees C
B. 37.0 degrees C
C. 36.5 degrees C
D. 36.0 degrees C
E. 34.0 degrees C

Answer E. Accidental hypothermia is a core temperature below 35 degrees C. Clinical staging also considers consciousness and vital signs. Frostnip and frostbite are local cold injuries and should not be used as stages of systemic hypothermia.

Sources 8

Question 11 Heatstroke

A runner collapses in hot conditions with confusion and marked hyperthermia. Which is the priority treatment for suspected exertional heatstroke?

A. Paracetamol alone
B. Rapid active cooling while supporting ABCDE and arranging emergency care
C. Wait for laboratory confirmation
D. Wrap in insulating blankets
E. Encourage the runner to complete the event slowly

Answer B. Heatstroke is a time critical emergency. Start effective active cooling immediately; cold water immersion is preferred for exertional heatstroke when practicable and safely supervised. Maintain airway access and monitor temperature. Antipyretics do not treat the underlying heat load.

Sources 9

Question 12 Snakebite in the UK

Which action is appropriate after a suspected bite from a native UK adder?

A. Cut the bite site
B. Suck out the venom
C. Apply an arterial tourniquet
D. Keep the casualty still, immobilise the affected limb and obtain urgent medical help
E. Ask the casualty to walk briskly to disperse the venom

Answer D. Avoid exertion and keep the affected limb still while arranging medical assessment. Do not cut, suck or apply a tourniquet. Snakebite management is species and region dependent; pressure immobilisation recommendations for some overseas snakes must not be generalised to UK adder bites.

Sources 9

Question 13 Drowning resuscitation

A trained rescuer has safely removed an unresponsive casualty who is not breathing normally from the water. What is the drowning specific initial resuscitation step in RCUK 2025 guidance?

A. Abdominal thrusts to drain water
B. Five minutes of observation
C. Five initial rescue breaths, followed by standard CPR as indicated
D. Delay ventilation until all wet clothing is removed
E. Chest compressions only in every case

Answer C. Give five initial ventilations, using oxygen when available, and proceed with the appropriate CPR algorithm. Avoid attempts to expel water that delay ventilation. The rescuer's safety remains essential.

Sources 8

Question 14 Drowning terminology

Which statement correctly describes drowning?

A. Respiratory impairment caused by immersion or submersion in liquid, with fatal or nonfatal outcomes
B. Death occurring within 24 hours of entering water
C. Any contact with water, even without respiratory impairment
D. A condition that requires water to be found in the lungs
E. A diagnosis that excludes anyone who survives

Answer A. Drowning describes a process, not a 24 hour mortality category. Outcomes can include death, survival with morbidity or survival without morbidity. Historical terms such as near drowning, dry drowning and secondary drowning are not useful diagnostic categories.

Sources 10

Question 15 Diving illness

A diver develops neurological symptoms after surfacing. Which is the best response to suspected decompression illness?

A. Reassure because the dive computer showed no missed stops
B. Wait until symptoms have lasted 12 hours
C. Give Entonox and send the diver home
D. Send the diver back underwater without specialist direction
E. Give high concentration oxygen and seek urgent diving medicine advice while arranging emergency care

Answer E. Decompression illness includes decompression sickness and arterial gas embolism. It can occur after an apparently compliant dive. Immediate oxygen and urgent specialist assessment are appropriate; the diving team should direct recompression and transport arrangements.

Sources 11, 12

Question 16 Pressure underwater

Assume a surface pressure of 1 atmosphere and an increase of approximately 1 atmosphere for each 10 metres of seawater. What is the absolute ambient pressure at 20 metres?

A. 1 atmosphere
B. 3 atmospheres
C. 5 atmospheres
D. 10 atmospheres
E. 20 atmospheres

Answer B. Pressure rises by approximately one atmosphere for each 10 metres of seawater. Add the one atmosphere at the surface: 1 + 2 = 3 atmospheres absolute. This is an approximation; gauge pressure would exclude the surface atmosphere.

Calculation uses the assumptions in the question

Question 17 Chemical incident response

After recognising a possible chemical contamination incident, which is the best initial approach?

A. Enter the contaminated area in routine clinical PPE
B. Wait for identification of the chemical before doing anything
C. Direct everyone into an enclosed ambulance immediately
D. Protect responders, move casualties away from exposure and initiate appropriate disrobing and decontamination
E. Apply dry decontamination to every substance regardless of corrosive effects

Answer D. Rapid removal from exposure and contaminated clothing can limit injury. Dry decontamination is suitable for many noncorrosive liquid contaminants; caustic exposures generally require prompt irrigation. Protect responders, communicate clearly and obtain agent specific advice. A fixed percentage removed by disrobing is not universal.

Sources 13, 14

Question 18 Nerve agents

What is the principal toxic mechanism of organophosphorus nerve agents?

A. Activation of acetylcholinesterase
B. Blockade of all acetylcholine receptors
C. Inhibition of acetylcholinesterase with excess acetylcholine at synapses
D. Selective inhibition of dopamine synthesis
E. Competitive blockade of opioid receptors

Answer C. Nerve agents cause a cholinergic toxidrome. Miosis, excessive secretions, bronchospasm, weakness and respiratory failure may occur. Atropine counteracts muscarinic effects; oximes can reactivate inhibited enzyme when appropriately used. Seek specialist advice and protect responders from contamination.

Sources 15

Question 19 Cyanide poisoning

Which laboratory finding supports severe cyanide toxicity in an appropriate exposure context?

A. Marked lactic acidosis
B. A normal lactate rules out every possible exposure
C. Isolated hypocalcaemia is diagnostic
D. A normal pulse oximeter reading excludes cyanide toxicity
E. A low serum sodium confirms the diagnosis

Answer A. Cyanide impairs cellular oxygen utilisation and can cause severe lactic acidosis. This finding is not specific, and a normal SpO2 does not exclude toxicity. Suspected severe poisoning requires immediate resuscitation and urgent specialist antidote advice; do not wait for a cyanide assay.

Sources 16

Question 20 Radiological incidents

Which statement correctly distinguishes irradiation from radioactive contamination?

A. Every irradiated person becomes radioactive
B. Contamination means exposure without radioactive material being present
C. All radiation incidents require the same antidote
D. Potassium iodide protects every organ against every radionuclide
E. External irradiation alone does not mean radioactive material is on or inside the casualty

Answer E. Contamination means radioactive material is present on or within the person. Irradiation is exposure to radiation and can occur without contamination. Assess and treat life threatening injuries while seeking radiation protection advice; decontamination and blocking or decorporation treatments are exposure specific.

Sources 17

Question 21 Major incident reporting

What does the first E in a METHANE report represent?

A. Equipment inventory
B. Exact location
C. Estimated journey time
D. Evacuation destination
E. Emergency department consultant

Answer B. METHANE covers Major incident declared or standby, Exact location, Type of incident, Hazards, Access, Number of casualties and Emergency services present and required. Give useful verified information early and update it as the situation develops.

Sources 3

Question 22 Major incident triage

Under the NHS England Major Incident Triage Tool, which finding makes a casualty P1 before walking ability is considered?

A. A minor abrasion
B. Age 40 years
C. A respiratory rate of 18 per minute
D. Catastrophic haemorrhage
E. A heart rate of 80 per minute

Answer D. MITT first identifies catastrophic bleeding and assigns P1 while directing immediate haemorrhage control. It replaces the older sieve thresholds in these questions. Use the actual current tool and the declared incident arrangements; triage is repeated as circumstances change.

Sources 18

Question 23 Oxygen supply calculation

A cylinder contains 460 litres of usable oxygen. At a constant flow of 10 litres per minute, what is the theoretical duration, ignoring any reserve or other consumption?

A. 23 minutes
B. 34 minutes
C. 46 minutes
D. 68 minutes
E. 460 minutes

Answer C. 460 litres divided by 10 litres per minute gives 46 minutes. This is only a calculation exercise. For operational planning check the actual cylinder contents, regulator and equipment consumption, allow a reserve and account for delays. Litres describes volume; litres per minute describes flow.

Sources 2

Question 24 Paediatric weight

A child needs urgent resuscitation and cannot readily be weighed. Which source of weight is usually preferred when a reliable recent value is available?

A. The parent’s report of the child’s weight
B. Always an age formula, even if a recent measured weight is known
C. The attending adult’s weight
D. A fixed 20 kg for every child
E. An unaided visual guess in preference to any other method

Answer A. RCUK recommends using the parent or person with parental responsibility’s reported weight when available. Otherwise, a length based method adjusted for body habitus is generally more accurate than an age formula. Drug dosing may require a different weight scalar in children with a high BMI.

Sources 19

Question 35 Traumatic cardiac arrest

Which approach best reflects the immediate priorities in traumatic cardiac arrest?

A. Give repeated adrenaline before assessing the cause
B. Complete a prolonged rhythm analysis before controlling bleeding
C. Rapidly address haemorrhage, hypoxia, tension pneumothorax and tamponade as indicated
D. Assume every case is a primary medical ventricular fibrillation arrest
E. Delay all interventions until hospital arrival

Answer C. Treat reversible causes immediately and in parallel where possible. In hypovolaemic or obstructive traumatic arrest these interventions take priority over compressions; consider a medical cause as well. Hyperkalaemia can occur after crush injury, so the original question's absolute exclusion was unsound.

Sources 8

Question 36 Haemostatic gauze

After packing a wound with standard Celox Z Fold Gauze, which initial compression time is specified in that product's instructions?

A. 10 seconds
B. 30 seconds
C. 60 seconds for every Celox product
D. 3 minutes
E. No pressure is needed

Answer D. The standard Z Fold Gauze instructions specify firm pressure for three minutes, with further action if bleeding persists. Celox Rapid is a different product with different instructions. Check the actual product in your kit, pack appropriately, maintain pressure and reassess bleeding.

Sources 20, 21

Question 37 Thoracostomy anatomy

Which muscle forms the posterior muscular boundary of the triangle of safety used for lateral chest drain insertion?

A. Pectoralis minor
B. The anterior border of latissimus dorsi
C. The medial border of trapezius
D. Rectus abdominis
E. Sternocleidomastoid

Answer B. The triangle lies between the lateral border of pectoralis major and the anterior border of latissimus dorsi, with its inferior boundary around the fifth intercostal space and apex below the axilla. Identify anatomy carefully; the nipple is not a reliable sole landmark. This description does not substitute for procedural training.

Sources 22, 23

Question 38 Tension pneumothorax

A trauma casualty has suspected tension pneumothorax with severe respiratory compromise and haemodynamic instability. Which statement is correct?

A. A chest X ray is mandatory before any decompression
B. Normal tracheal position excludes tension pneumothorax
C. A historical frequency table determines whether treatment is needed
D. Observe until cardiac arrest occurs
E. A suitably trained clinician should perform urgent decompression without waiting for imaging

Answer E. Tension pneumothorax is a clinical emergency. NICE recommends decompression before imaging when suspected tension is associated with severe respiratory compromise or haemodynamic instability. Technique depends on competence, equipment and the applicable protocol.

Sources 1

Question 39 Third stage of labour

After an unplanned birth, the mother is bleeding heavily and the placenta has not delivered. Which is the best response?

A. Treat this as an obstetric emergency, summon help and arrange urgent transfer while resuscitating
B. Delay transfer until the placenta has delivered
C. Pull firmly on the cord without uterine support or training
D. Attempt manual removal of the placenta without anaesthesia
E. Discard any subsequently delivered placenta

Answer A. Heavy bleeding with a retained placenta requires immediate obstetric escalation and resuscitation. Do not delay transfer to complete the third stage. Cord traction and manual removal are not untrained first aid procedures; NICE advises against manual removal without anaesthesia. Retain a delivered placenta for examination.

Sources 24

Question 40 Care of a well newborn

A term baby has just been born, is breathing normally and has good tone. Which action is appropriate?

A. Routine tracheal suction
B. Immediate separation from the mother for every baby
C. Dry the baby, remove wet towels, maintain warmth and offer monitored skin to skin care
D. Give chest compressions because the cord is still intact
E. Assess oxygenation solely by skin colour

Answer C. For a well term newborn, prevent heat loss, support skin to skin contact and continue observation of breathing, airway and temperature. RCUK aims for at least 60 seconds of delayed cord clamping where practicable. Babies needing support require prompt assessment and intervention; preterm thermal care differs.

Sources 25

Question 41 Shoulder dystocia

The baby's head has delivered but the shoulders do not follow with routine assistance. After calling for urgent help, which initial manoeuvres are appropriate?

A. Fundal pressure and forceful traction on the head
B. McRoberts positioning with suprapubic pressure as indicated
C. Repeated twisting of the baby's neck
D. Wait ten minutes without intervention
E. Ask the mother to stand and walk

Answer B. Shoulder dystocia is an emergency. McRoberts positioning and suprapubic pressure are standard initial manoeuvres. Avoid fundal pressure and excessive traction. Further manoeuvres require trained assistance; anticipate newborn resuscitation and maternal haemorrhage.

Sources 26

Question 42 Postpartum haemorrhage

Which period is used by RCOG to describe secondary postpartum haemorrhage?

A. Only the first hour after birth
B. Only the first 24 hours after birth
C. From conception to delivery
D. From 24 hours to 12 weeks after birth
E. Only after 12 weeks

Answer D. Secondary PPH is abnormal or heavy bleeding after the first 24 hours and up to 12 weeks after birth. Primary PPH is traditionally blood loss of at least 500 mL within 24 hours. Escalate significant bleeding or deterioration promptly rather than waiting for an estimated volume threshold.

Sources 27

Question 43 Breech presentation

Which statement about a term breech baby is correct?

A. Every breech birth must occur in a supine position
B. All breech presentations are an indication for immediate prehospital caesarean delivery
C. A footling breech means the head is presenting
D. A clinician should routinely pull on the baby's legs to speed delivery
E. Birth planning requires skilled obstetric assessment; if birth is already imminent, management must reflect that situation

Answer E. Planned caesarean birth and selected planned vaginal breech birth have different risks and require informed obstetric planning. An unexpected advanced labour needs urgent skilled help and preparation for birth and newborn care. A categorical instruction about route or position is inappropriate for every presentation.

Sources 28

Question 44 Cord prolapse

A prolapsed umbilical cord is visible after the membranes rupture. Which is the best response?

A. Call for immediate obstetric help, minimise cord handling and reduce compression while arranging urgent birth
B. Push the cord back into the uterus
C. Ask the mother to walk to the ambulance
D. Wait for the cord to stop pulsating
E. Treat this as a normal finding after membrane rupture

Answer A. Cord prolapse can interrupt fetal oxygen delivery. Arrange emergency obstetric care. Appropriate positioning and, for trained clinicians, elevation of the presenting part may reduce compression while definitive birth is organised. Avoid unnecessary handling or attempted replacement of the cord.

Sources 29

Question 45 Pelvic binders

Where should a circumferential pelvic binder be centred when indicated for suspected bleeding from a pelvic ring injury?

A. At the waist above the iliac crests
B. Over the umbilicus
C. At the level of the greater trochanters
D. Around the lower ribs
E. Around the knees

Answer C. Position the binder over the greater trochanters, following the device instructions. NICE recommends a purpose made binder when active bleeding from a pelvic fracture is suspected after blunt high energy trauma. Avoid unnecessary movement and do not delay resuscitation or transport.

Sources 30, 1

Question 46 Falls from height

A casualty lands on both feet after a substantial fall and has a calcaneal fracture. Which associated injury is particularly important to assess for?

A. Isolated finger dislocation
B. Spinal fracture from axial loading
C. Only a superficial scalp abrasion
D. An elbow injury to the exclusion of all other sites
E. No other injury if the casualty can speak

Answer B. Axial loading can injure both the calcaneus and spine. Assess the whole casualty and the mechanism rather than assuming one injury pattern is inevitable or that other serious injuries are excluded. Do not use a list of supposedly unlikely injuries to limit assessment.

Sources 31, 32

Question 47 Dashboard injury

A force applied through a flexed knee into the dashboard can classically cause which hip injury?

A. Anterior hip dislocation only
B. An isolated acromioclavicular joint injury
C. A scaphoid fracture
D. Posterior hip dislocation
E. No injury if the pelvis is initially painless

Answer D. A dashboard impact can drive the femoral head posteriorly. Associated acetabular, femoral and knee injuries are possible; document distal neurovascular findings and arrange urgent specialist care. Mechanism informs assessment but does not establish the diagnosis on its own.

Sources 33

Question 48 Tourniquets

A limb wound continues to bleed catastrophically despite direct pressure. Where should a tourniquet ordinarily be placed when the wound is visible and placement is feasible?

A. Distal to the wound
B. Directly over the nearest joint
C. Loosely over the wound
D. Anywhere, provided it is released every five minutes
E. About 5 to 7 cm proximal to the wound, avoiding a joint

Answer E. Apply and tighten the device until bleeding stops, record the time and reassess. If required, add a second tourniquet proximal to the first. Do not intermittently release it. Use manufacturer instructions and the appropriate clinical protocol, including adaptations when the wound cannot be identified.

Sources 9

Question 49 Thermal burns

What is the recommended initial cooling treatment for a recent thermal burn?

A. Cool running water for 20 minutes, while preventing hypothermia
B. Ice directly against the skin
C. Butter over the burn
D. A fixed 120 litres of water irrespective of flow or duration
E. No cooling once ten minutes have elapsed

Answer A. Start cooling promptly; benefit is possible within three hours of injury. Keep the rest of the casualty warm. Remove nearby jewellery and loose clothing, but do not pull off material stuck to the burn. Avoid ice and topical household remedies.

Sources 34

Question 50 Chemical burns

Liquid household drain cleaner has splashed onto the skin. Which initial action is appropriate?

A. Neutralise it with another household chemical
B. Apply an occlusive dressing before removing the contaminant
C. Protect the rescuer, remove contaminated clothing and irrigate promptly with copious water
D. Apply grease to prevent evaporation
E. Wait for a skin blister before treating

Answer C. Rapid decontamination limits contact injury. For this liquid caustic exposure, irrigate thoroughly and obtain urgent care and agent specific advice. Do not attempt chemical neutralisation. Dry chemicals need careful removal first, and unusual agents may require specific precautions.

Sources 14

Question 51 Spinal transport devices

Which statement about a longboard is correct under NICE spinal injury guidance?

A. It is the preferred prolonged transport surface for every injured person
B. It is an extrication device and should not be used as the transport surface for suspected spinal injury
C. It removes the need to assess airway and breathing
D. Its use permits forced correction of any spinal deformity
E. Every ambulant casualty must be strapped to one

Answer B. A longboard may assist extrication but is not the recommended transport surface for suspected spinal injury. Use an appropriate movement restriction and transfer method based on assessment, patient factors and the service protocol. Avoid delaying urgent life saving care.

Sources 32

Question 52 Canadian C spine rule

In an alert, stable adult assessed using the Canadian C spine rule, after high risk factors have been excluded and a low risk factor permits safe assessment, what active neck rotation is required to clear this step?

A. 10 degrees in one direction
B. 20 degrees in both directions
C. 30 degrees in both directions
D. 45 degrees left and right
E. 90 degrees left and right

Answer D. The person must actively rotate 45 degrees in each direction. Do not test rotation before the relevant eligibility and risk assessment. Age 65 years or older is a high risk factor in this rule. Apply the complete rule rather than mixing selected elements from different algorithms.

Sources 32

Question 53 Self extrication

Which statement best reflects current UK extrication practice?

A. Any possible spinal injury prohibits all self extrication
B. All neck pain requires a prolonged equipment led extrication
C. Normal vital signs prove there is no spinal injury
D. A longboard is mandatory before anyone exits a vehicle
E. Self extrication can be appropriate after assessment using the service's adopted decision aid

Answer E. The 2025 Faculty consensus supports self extrication as a primary approach where appropriate. This is not a direction to make every casualty walk: physical entrapment, clinical condition, ability and immediate hazards matter. NICE and newer consensus pathways differ in detail, so apply the adopted local process.

Sources 6, 32

Question 54 METHANE

What does T stand for in METHANE?

A. Type of incident
B. Time of call
C. Treatment completed
D. Transport destination
E. Temperature

Answer A. T means Type of incident. Time information can still be clinically and operationally important, but it is not the expansion of this letter in METHANE.

Sources 3

Question 55 Difficult intubation

After an unsuccessful intubation attempt, which is the best principle?

A. Repeat the identical attempt indefinitely
B. Prioritise tube placement even if oxygenation is failing
C. Reoxygenate, call for help, optimise conditions and change the next attempt or move to the rescue plan
D. Advance the laryngoscope blade through the vocal cords
E. Exclude a more experienced operator from further attempts

Answer C. Prioritise oxygenation, limit attempts and follow the team's difficult airway plan. Any further attempt should have a purposeful change, such as operator, position, device or technique. Failure to oxygenate requires prompt progression to the appropriate rescue pathway.

Sources 35, 2

Question 56 Analgesia

Which statement about analgesia for a painful traumatic injury is correct?

A. Opioids should never be titrated to effect
B. Paracetamol can be used as part of multimodal analgesia alongside an opioid when appropriate
C. Pain assessment is unnecessary after the first dose
D. Every head injury is an absolute contraindication to all analgesia
E. Entonox is suitable for every casualty with a suspected pneumothorax

Answer B. Choose analgesia for the injury, physiology and contraindications, then reassess pain and adverse effects. Paracetamol and an opioid can be combined when indicated. A blanket prohibition of ketamine solely because of a head injury is not an adequate account of contemporary practice.

Sources 36, 2, 12

Question 57 Entonox

Why is Entonox contraindicated in an untreated pneumothorax?

A. It contains no oxygen
B. It always causes irreversible apnoea
C. It is pure carbon dioxide
D. Nitrous oxide can expand a trapped gas space
E. It directly dissolves pleural blood clots

Answer D. Entonox contains equal proportions of nitrous oxide and oxygen. Nitrous oxide can enter and expand enclosed gas spaces. This is relevant to pneumothorax and several other conditions listed by the manufacturer. Follow the current product instructions for storage, preparation and use; simple inversion alone is not a universal remedy after cold storage.

Sources 12

Question 58 Anaesthesia monitoring

Which monitoring is essential to confirm and continuously monitor tracheal tube ventilation during prehospital emergency anaesthesia?

A. Skin colour alone
B. Intermittent chest observation alone
C. A carbon monoxide detector
D. A pulse oximeter alone
E. Continuous waveform carbon dioxide capnography

Answer E. Waveform capnography is essential alongside the other required monitoring, including ECG, oxygen saturation and blood pressure. Oxygen saturation alone does not establish tracheal tube placement. Neuromuscular monitoring has a role when neuromuscular blockers are used; it should not be dismissed as having no prehospital value.

Sources 2, 37

Question 59 Preparation for anaesthesia

Which is the best positioning principle before prehospital emergency anaesthesia?

A. Optimise airway access and preoxygenation, using head elevation or ramping when appropriate to the patient and injury
B. Always intubate with the casualty at ground level
C. Use the same position regardless of physiology or injury
D. Prioritise the operator's view over all oxygenation measures
E. Positioning is irrelevant if a video laryngoscope is available

Answer A. Plan position, oxygenation, access, equipment and rescue options together. Head elevation or ramping can improve preoxygenation and airway management, particularly in obesity, but must fit the injury and haemodynamic context. No fixed ground level posture suits every case.

Sources 2, 38

Question 60 Ketamine pharmacology

Which action best describes ketamine's principal anaesthetic mechanism?

A. NMDA receptor agonism
B. Selective beta 2 receptor agonism
C. NMDA receptor antagonism
D. Irreversible inhibition of acetylcholinesterase
E. Competitive opioid receptor antagonism

Answer C. Ketamine is an NMDA receptor antagonist. Its clinical effects and risks depend on dose, coadministered drugs and patient physiology. It does not guarantee preservation of airway reflexes or ventilation, so appropriate monitoring and airway capability remain necessary.

Sources 39, 2

Question 61 Capnography

During ventilation, a capnogram develops a prolonged sloping expiratory upstroke and an upward sloping plateau, producing a shark fin appearance. Which is the best interpretation?

A. This proves oesophageal intubation
B. Expiratory airflow obstruction, such as bronchospasm, should be assessed
C. The waveform proves pulmonary embolism
D. It is diagnostic of hypoglycaemia
E. It excludes a problem with the breathing circuit

Answer B. An obstructive waveform can accompany bronchospasm. Assess the patient, tube and circuit: tube obstruction or other expiratory flow limitation can produce similar changes. A waveform pattern supports clinical assessment rather than establishing a unique diagnosis.

Sources 40, 37

Question 62 ECG electrode placement

Which description of standard precordial electrode placement is incorrect?

A. V1 at the fourth intercostal space at the right sternal edge
B. V2 at the fourth intercostal space at the left sternal edge
C. V4 at the fifth intercostal space in the left midclavicular line
D. V5 and V6 at the same horizontal level as V4
E. V3 at the second intercostal space at the right sternal edge

Answer E. V3 belongs midway between V2 and V4. V5 is on the anterior axillary line and V6 on the midaxillary line, both horizontally level with V4. Identify the intercostal spaces and anatomical landmarks rather than following the downward curve of a rib.

Sources 41

Question 63 Blood pressure measurement

Which technique improves the reliability of an upper arm blood pressure measurement?

A. Use the smallest cuff available for every adult
B. Place the cuff over thick clothing
C. Use a correctly sized cuff and support the arm at heart level
D. Allow the arm to hang unsupported below the body
E. Accept any implausible reading without reassessment

Answer C. Choose the cuff using the manufacturer's arm circumference range and support the arm appropriately. Movement, poor perfusion, arrhythmia and incorrect cuff size can reduce reliability. Reassess unexpected readings and interpret them alongside the casualty's clinical state.

Sources 42

Question 64 Ultrasound in trauma

Which statement about a negative FAST examination after major trauma is correct?

A. It does not exclude intra abdominal or retroperitoneal haemorrhage
B. It rules out all significant abdominal injury
C. It makes repeat clinical assessment unnecessary
D. It proves hypotension is due to sepsis
E. It excludes a pelvic fracture

Answer A. A negative FAST cannot safely rule out important bleeding or injury. Ultrasound findings must be integrated with the mechanism, physiology and definitive imaging pathway. Do not delay time critical transport or treatment to obtain a scan that will not change immediate management.

Sources 1

Question 65 Emergency driving

For the ambulance purpose speed limit exemption in section 87 of the Road Traffic Regulation Act 1984, which is the relevant principle?

A. Fitting a blue beacon creates a general exemption for any journey
B. A clinical qualification alone authorises emergency driving
C. The exemption removes all other driving responsibilities
D. The vehicle must be used for the specified purpose on that occasion and observing the limit would be likely to hinder that use
E. A patient request is sufficient to create an exemption

Answer D. The exemption is tied to the statutory purpose and circumstances, not merely to lights or professional status. It is not a blanket exemption from road traffic law. Applicable legal requirements, training, competence and service driving policy must still be followed.

Sources 43

Question 66 Mental capacity

Under the Mental Capacity Act 2005 in England and Wales, which statement is correct?

A. An adult must prove capacity before every decision
B. Capacity is presumed unless established otherwise, and an unwise choice alone does not prove incapacity
C. Every person with dementia lacks capacity for every decision
D. Capacity is assessed once and never revisited
E. A relative always has authority to consent for an adult

Answer B. Capacity is decision specific and time specific. Give practicable support for decision making. If a person lacks capacity, act within the relevant legal framework, considering best interests and the least restrictive option. Diagnosis, disagreement or an apparently unwise choice is not sufficient by itself.

Sources 44

Question 67 Ballistic energy

Using kinetic energy = one half times mass times velocity squared, what happens to a projectile's kinetic energy if its speed doubles and its mass is unchanged?

A. It is halved
B. It is unchanged
C. It doubles
D. It increases eightfold
E. It increases fourfold

Answer E. Squaring twice the velocity gives four times the kinetic energy. This does not mean the clinical injury is necessarily four times as severe: energy transfer, projectile behaviour, tissue characteristics and the structures traversed all matter. Wound location is clinically important.

Calculation uses the assumptions in the question

Question 68 Blast injury

Which is an example of primary blast injury?

A. A laceration caused by a flying glass fragment
B. A fracture caused by being thrown into a wall
C. Lung injury caused by the pressure wave
D. A thermal burn from the associated fire
E. A crush injury under collapsed masonry

Answer C. Primary blast injury results from the pressure wave and particularly affects gas containing structures. Fragment injury is secondary and displacement injury is tertiary. A single casualty may have several mechanisms of injury, so perform a full assessment.

Sources 45

Question 69 Firearms incident response

A shooting incident is still active. Which approach is appropriate for an ordinary responding clinical team?

A. Coordinate with incident command and work only within a jointly assessed safe operating plan and the team's capability
B. Enter immediately in routine PPE because a casualty is visible
C. Assume all vehicle bodywork stops bullets
D. Apply a historical mnemonic instead of reassessing the threat
E. Treat a blue light vehicle as ballistic protection

Answer A. Dynamic threat assessment, communication and a coordinated response determine where and how clinicians can operate. Specialist teams may have different training and equipment. Do not turn general medical revision advice into a universal tactical entry rule.

Sources 3

Question 70 Clinical priorities after a violent incident

Once safe access has been established, how should treatment priority be determined?

A. By whether the casualty is suspected of causing the incident
B. By social status
C. By who can describe their injury most loudly
D. By clinical need within the applicable triage and operational arrangements
E. By media interest in the casualty

Answer D. Clinical decisions should be fair and based on need. Scene threats and custody arrangements still require coordination with the responsible agencies, but assumptions about culpability do not determine the medical priority.

Sources 46, 3

Question 71 Ventilation gas calculation

For a simple calculation, a ventilator delivers a tidal volume of 0.5 litres at 10 breaths per minute for 30 minutes using 100 percent oxygen. Ignoring driving gas, leaks, bias flow and reserve, what volume is delivered to the patient?

A. 50 litres
B. 150 litres
C. 300 litres
D. 500 litres
E. 1500 litres

Answer B. 0.5 litres × 10 per minute × 30 minutes = 150 litres. This is delivered patient volume, not necessarily total cylinder consumption. Real supply planning must include the specific ventilator's gas use, other equipment, reserve and potential delays.

Sources 2

Question 72 Acute asthma

Which finding is a life threatening feature of acute asthma in an adult?

A. Normal speech and no breathlessness
B. A peak flow of 90 percent of personal best
C. A respiratory rate of 16 per minute with normal effort
D. Mild wheeze with rapid complete response to usual treatment
E. A silent chest with poor respiratory effort

Answer E. A silent chest can indicate critically reduced airflow. Other dangerous features include exhaustion, altered consciousness, hypoxaemia and haemodynamic compromise. Peak flow severity thresholds use percent of best or predicted, not an absolute 33 to 50 litres per minute.

Sources 47

Question 73 NATO phonetic alphabet

Which word is not part of the official NATO phonetic alphabet?

A. Alfa
B. Juliett
C. October
D. Whiskey
E. Oscar

Answer C. O is Oscar, not October. The official spellings include Alfa, Juliett and Whiskey. D is Delta and I is India. Using the standard words reduces ambiguity in spoken communications.

Sources 48

Question 74 Adult sepsis fluids

A nonpregnant adult at high risk from sepsis requires IV fluid resuscitation and has no contraindication. Under NICE NG253, what initial crystalloid bolus is recommended?

A. 250 mL followed by reassessment
B. 2 litres without reassessment
C. 30 mL per kg in one uninterrupted infusion for every patient
D. No IV fluid can ever be used in sepsis
E. 5 litres before seeking senior help

Answer A. NICE recommends an initial 250 mL crystalloid bolus, ideally over 10 to 15 minutes, with reassessment after each bolus. Further boluses depend on response and contraindications; seek senior advice if improvement is inadequate after a total of 1 litre, including earlier fluids. Antibiotic urgency is risk stratified; high risk patients need prompt treatment. The former seven item Sepsis Six list was incorrect.

Sources 49

Question 75 Anticholinergic toxicity

Which combination is most consistent with an anticholinergic toxidrome?

A. Miosis with profuse secretions and diarrhoea
B. Pinpoint pupils with isolated opioid respiratory depression
C. Bradycardia with marked salivation
D. Mydriasis, dry skin, tachycardia and agitated delirium
E. Normal observations exclude toxicity after an ingestion

Answer D. Antimuscarinic effects can produce dilated pupils, dryness, tachycardia, urinary retention and delirium. Severe or mixed poisoning can have additional effects. Assess ABCDE and obtain poisons advice rather than relying on a mnemonic or a single sign.

Sources 50

Question 76 Drug dosing in obesity

Which is the safest general principle for emergency anaesthetic drug dosing in an adult living with obesity?

A. Use total body weight for every drug and dose
B. Use drug specific guidance for the relevant weight scalar and adjust for physiology and response
C. Use ideal body weight for every drug without exception
D. Choose doses solely from whether the drug is lipid soluble
E. Give a fixed dose regardless of body size or shock

Answer B. Different agents and indications require different weight scalars, and dosing also depends on physiology and intended effect. SOBA guidance distinguishes drugs rather than endorsing a universal total or ideal body weight rule. Use an approved dosing aid and monitor the response; the original answer did not match its own explanation.

Sources 38, 2

Question 77 Paediatric anaphylaxis

A child develops sudden airway swelling, wheeze and circulatory compromise after an allergen exposure. Which drug is first line?

A. Oral antihistamine before any other treatment
B. Hydrocortisone alone
C. Nebulised salbutamol instead of adrenaline
D. An IV adrenaline bolus given routinely by any responder
E. Intramuscular adrenaline in the anterolateral thigh at the appropriate paediatric dose

Answer E. Give IM adrenaline promptly and support ABCDE. Use the current age or weight appropriate dose and repeat if indicated by the resuscitation guideline. Bronchodilators may be adjuncts but must not delay adrenaline. Antihistamines and corticosteroids are not first line treatment for airway or circulatory compromise.

Sources 19, 8

Question 78 Clinical governance

Which activity best demonstrates a completed clinical audit cycle?

A. Collecting case numbers without an agreed standard
B. Using one anecdote to judge every colleague
C. Measuring care against a standard, making an improvement and measuring again
D. Avoiding discussion of adverse events
E. Changing policy without checking its effect

Answer C. Audit compares practice with explicit standards and supports improvement. Reassessment shows whether the change worked. Clinical governance also includes learning, education, risk management and patient involvement; a disputed list of seven labels is a poor substitute for understanding these activities.

Sources 46

Question 79 Emergency consent for a child

An unconscious child needs immediate treatment to save life. No person with parental responsibility can be contacted in time. What is appropriate?

A. Provide necessary emergency treatment in the child's best interests and document the circumstances
B. Withhold treatment until a parent arrives
C. Treat only if a neighbour signs a form
D. Assume that lack of a signature prohibits all care
E. Wait for a routine court hearing before airway support

Answer A. GMC guidance permits necessary emergency treatment without consent to save life or prevent serious deterioration. Involve the child and those with parental responsibility when possible and document decisions. Competent refusal by a young person is a separate, legally complex issue; seek senior and legal advice when relevant.

Sources 51

Question 80 Self harm assessment

Which approach is consistent with NICE guidance after self harm?

A. Use a low score to guarantee that suicide will not occur
B. Use a score alone to decide discharge
C. Ignore previous self harm when assessing current needs
D. Assess the person's needs and immediate and longer term safety, with appropriate psychosocial assessment
E. Use a risk category instead of talking with the person

Answer D. Do not use risk scales or global low, medium or high categories to predict suicide or to decide treatment or discharge. Assess distress, context, clinical needs, protective factors and safety with the person, and arrange appropriate mental health assessment and follow up.

Sources 52

Major incident triage scenarios

For questions 81 to 85, use the NHS England Major Incident Triage Tool (MITT, April 2023) for initial triage at a declared major incident. The scenarios concern adults. Choose the category reached by this tool, not a routine emergency department triage system. Act on immediate life threats and repeat triage as required.

Question 81 MITT catastrophic bleeding

An adult has uncontrolled catastrophic external bleeding. What is the initial MITT category?

A. P1 immediate
B. P2 urgent
C. P3 delayed
D. DEAD in the initial MITT pathway
E. No category can be assigned from the information provided

Answer A. Catastrophic bleeding is the first MITT decision and makes the casualty P1, with immediate haemorrhage control. Walking ability does not override this branch.

Sources 18

Question 82 MITT walking casualty

An adult has no catastrophic bleeding and can walk when directed. What is the initial MITT category?

A. P1 immediate
B. P2 urgent
C. P3 delayed
D. DEAD in the initial MITT pathway
E. No category can be assigned from the information provided

Answer C. A casualty who can walk, after the catastrophic bleeding check, is initially P3. This does not exclude significant injury or later deterioration, so arrange assessment and repeat triage.

Sources 18

Question 83 MITT absent breathing

An adult with no catastrophic external bleeding is not breathing and remains apnoeic after airway opening. There is no special circumstance specified. What category does the initial MITT pathway assign?

A. P1 immediate
B. P2 urgent
C. P3 delayed
D. DEAD in the initial MITT pathway
E. No category can be assigned from the information provided

Answer D. The initial MITT pathway assigns DEAD when breathing remains absent after airway opening. This is an operational triage category, not the same as an expectant category or a standalone formal verification of death. Follow incident resuscitation arrangements and special circumstance guidance; this does not mean CPR is prohibited at every major incident.

Sources 18

Question 84 MITT abnormal respiratory rate

An adult cannot walk, has no catastrophic bleeding, is breathing and responds to voice. The respiratory rate is 32 per minute. What is the initial MITT category?

A. P1 immediate
B. P2 urgent
C. P3 delayed
D. DEAD in the initial MITT pathway
E. No category can be assigned from the information provided

Answer A. For this branch of MITT, a respiratory rate outside 12 to 23 per minute assigns P1. The former sieve threshold of over 30 must not be carried across into MITT.

Sources 18

Question 85 MITT within physiological thresholds

An adult cannot walk, has no catastrophic bleeding, is breathing and responds to voice. The respiratory rate is 20 per minute and the heart rate is 80 per minute. What is the initial MITT category?

A. P1 immediate
B. P2 urgent
C. P3 delayed
D. DEAD in the initial MITT pathway
E. No category can be assigned from the information provided

Answer B. After the preceding MITT checks, a respiratory rate of 12 to 23 and a heart rate below 100 lead to P2. A heart rate of 100 or more would lead to P1. P2 still requires timely care and reassessment.

Sources 18

References

Sources checked for the 18 October 2026 edition. A source may predate this edition where it remains the relevant published guidance. Manufacturer instructions apply to the particular product. Follow the linked source for full context and subsequent updates.

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